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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care At Silver Lake Llc

DATE SURVEY COMPLETED: February 12, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from February 5, 2024, through February 12, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census the first day of the survey was one hundred nine (109). The survey sample totaled twenty-four (24) residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, 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 February 12, 2024: cross refer: F644,	Cross refer to the CMS 2567-L survey completed February 12, 2024: Cross refer: F644, F656, F657, F688, F756, F791, and F842. The plan of correction for these deficiencies was submitted through the ePOC system on 3/4/2024. F644 Coordination of PASARR and Assessments 1. R77 had a diagnosis of bipolar disorder and paranoid personality disorder documented on 10/12/23. At this time a new level 1 PASARR should have been initiated. Once this was identified during the annual survey, a new level 1 PASARR was submitted for R77 by the social services director. No negative resident outcome has been reported because of this deficient practice. 2. Current residents within the facility will be reviewed to ensure psychological diagnoses are current and the most recent PASRR assessments reflect residents' current psychological diagnoses. Any psychological diagnoses that were not captured on the most recent PASRR assessments will be identified. A new PASARR assessment will be submitted for any affected resident. 3. MDS staff will notify the social services department any time there is a new psychological diagnosis is added to a resident's diagnosis list. 4. The administrator or designee will audit all new PASARR assessments to confirm compliance weekly x 4, then monthly x 2. Results of all audits will be presented monthly for three months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F656 Develop/Implement Comprehensive Care Plan 1. R66 no longer resides in facility as of 2/9/2024. The respiratory care plan for oxygen therapy related to ineffective gas exchange was added on 2/9/2024. R269 currently resides in the facility. R269 was educated on 2/2/2024 regarding the new behavior when it was initially identified.	3/28/24 3/4/24 3/28/24 3/4/24

Provider's Signature _____ Title NHA Date 3/4/24

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	F656, F657, F688, F756, F791 and F842.	The behavior care plan was implemented on 2/8/2024. No negative resident outcomes have been reported because of this deficient practice. 2. Current residents with a Pulmonary diagnosis will be reviewed to ensure an appropriate care plan is in place. The pulmonary care plans will be reviewed to determine that appropriate interventions are in place. Pulmonary care plans will be revised as necessary to reflect appropriate interventions to improve resident status and progress per their care plan goal. Progress notes will be reviewed for all current residents from the past 14 days to identify new behaviors. New behaviors identified will be care planned accordingly. 3. Nurse Practice Educator/NPE and/or designee will educate licensed nursing staff on the Comprehensive Person-Centered Care Plan Policy. 4. The Director of Nursing and/or designee will randomly audit 5 scheduled care plans to determine compliance weekly x 4, then 10 care plans monthly x 2. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F657 Care Plan Timing and Revision 1. There was insufficient documentation to show that all interdisciplinary team (IDT) members provided input for the post-admission care conferences/comprehensive care conferences for the residents cited in the 2567 (R9, R14, R66, R94, R96, and R 307). There was insufficient documentation to show R66 had a recent care plan meeting. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents who resided in the facility as of 2/12/24 were reviewed as having the potential for being affected by this deficient practice. 3. Administrator or designee will educate members of the interdisciplinary team (IDT) on the Complete Care Management Policy on comprehensive, person-centered care plans. The social services director will ensure that care plan meetings are conducted for each resident. Care plans will be prepared by the interdisciplinary team and	~~3/4/24~~ 3/28/24

Provider's Signature _____ Title NHA Date 3/4/24

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		input will be provided by the physician, registered nurse, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and to the extent practicable, the resident and the resident's representative. A care plan tracking tool was created to manage the post admission and comprehensive care plans for the facility. Interdisciplinary team members will utilize this tool to provide input into each resident's post admission and comprehensive care plans. This information will be reviewed by interdisciplinary team members in the resident's care plan meeting. The Social Services Director or designee will document each interdisciplinary team member's input in designated care plan documentation. 4. The administrator or designee will audit all post admission and comprehensive care plan meetings weekly x 4 for one month, then every 2 weeks for one month, and then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for three months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F688 - Increase/Prevent Decrease in ROM/Mobility 1. R39 and R62 currently reside in the facility. R39's bilateral palm protectors were in the laundry department and were applied to R39 on 2/7/2024. R62 had her knee splints applied on 2/7/2024. E10 was educated by E11 regarding splint application and process of training staff when new splint recommendations are made by therapy. No negative resident outcome has been reported because of this deficient practice. 2. Director of Nursing and designee will audit current resident's orders for splint, brace, and palm protector orders to identify current residents who have the potential to be affected by the same deficient practice. All new splint, brace, and palm protector orders identified will be added to the respective resident's electronic medical record. 3. Nurse Practice Educator/NPE and/or designee will educate all licensed and non-licensed nursing staff on the Use of Assistive Devices policy and the Prevention of Decline in Range of Motion policy. 4. The Director of Nursing and/or designee	3/28/24 3/4/24

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		will audit all current residents with splint, brace, or palm protector orders weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F756 - Drug Regimen Review, Report Irregular, Act On 1. There were no residents impacted by this deficient practice. The facility updated the policy on 2/15/2024 to be in compliance with federal regulation. 2. All MRR's (Medication Regimen Review) received will be responded to in accordance with the Medication Regimen Review policy and procedure. 3. The Nurse Practice Educator and/or designee will educate the nursing management team on the Medication Regimen Review Policy with emphasis on the time frames for the different steps in the MRR process. 4. The Director of Nursing and/or designee will manage the MRR process to ensure that time frames for the different steps of each process are being adhered to. The Director of Nursing will audit for compliance weekly x 4 weeks, then monthly x 2. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F791 Routine/Emergency Dental Srvcs In NFs 1. R77 is currently in the facility and there have been no negative outcomes because of this deficient practice. An Oral Health Assessment was completed on 2/27/2024 which noted well fitted full upper denture and natural bottom teeth without decay or broken teeth. The contracted Dentist was contacted via email to schedule a date to provide a routine cleaning for the bottom teeth of R77. 2. An Oral Health Assessment will be completed on all current long-term care residents to identify any who require routine dental services.	3/28/24 3/4/24 3/28/24 3/4/24

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		The Oral Health Assessment will identify and document those residents who refuse dental treatment. 3. The Nurse Practice Educator and/or designee will educate Licensed nurses, Unit Clerk, members of the Social Services Department on the Dental Services policy. 4. The Social Services Director and/or designee will offer dental services in accordance with scheduled annual assessments. The Social Services Director and/or designee will document the resident's response to offered dental services. The Social Services Director and/or designee will report compliance to policy monthly x 3 to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F842 Resident Records - Identifiable Information 1. R61 no longer resides in the facility as of 2/16/2024. The incorrect encounter note written by the provider that was documented in the electronic medical record (EMR) for R61 was stuck out. No negative outcome was reported because of this deficient practice. R306 no longer resides in the facility as of 12/23/2023. The employee who recorded the inaccurate responses to the pain assessment was educated on 2/27/2024. 2. Current residents who received services on 1/25/2024 by the provider with inaccurate encounter notes will be reviewed for accuracy in the EMR. Pain assessments completed within 14 days of acceptance of survey plan of correction will be reviewed for accuracy and residents with inaccurate pain assessment responses will be reassessed. 3. Nurse Practice Educator/NPE and/or designee will educate licensed nursing staff and Vista Medical Services providers on the Maintenance of Electronic Clinical Records. 4. The Director of Nursing and/or designee will audit all encounter notes written by Vista Medical Services provider and all pain assessments completed weekly x 4, then 10 encounter notes by	3/28/24 3/4/24

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		Vista Medical Services and 10 pain assessments x 2 months. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.	

Provider's Signature _____ Title NHA Date 3/4/24

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	085027	A. BUILDING _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from February 5, 2024 through February 12, 2024. The facility census was 109 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from February 5, 2024 through February 12, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census the first day of the survey was one hundred nine (109). The survey sample totaled twenty-four (24) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse Aide; DON - Director of Nursing; DOT - Director of Therapy; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2024

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

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F 000	Continued From page 1 OT - Occupational Therapy; PT - Physical Therapy; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SW - Social Worker; UM - Unit Manager. ADL - Activities of daily living; Bilateral - affecting both sides; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best: 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Bipolar Disorder - mood disorder; Care Plan - outlines the plan of action that will be implemented during a patient's medical care; Cervical - having to do with the neck; Cognition - mental process; thinking; Contact Guard Assistance - the resident performs 100% of the activity, caregiver maintains contact for safety only, but is not providing physical assistance; Contracture - joint limitations with fixed high resistance to passive stretch of a muscle; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Dental radiographs - are internal images of your teeth and jaws;	F 000		

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F 000	Continued From page 2 Depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; Extensive Assistance - means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance; Flexion - bending of an extremity or splint; Limited assistance - resident highly involved in activity and received physical help in guided maneuvering of limbs or other non-weight bearing assistance three or more times during the last 7 days; Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; O2 - Oxygen; Osteoarthritis - a type of joint disease that results from breakdown of joint cartilage and underlying bone; Paranoid personality disorder (PPD) - a mental condition in which a person has a long-term pattern of distrust and suspicion of others; PASARR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions; Passive Range of Motion (PROM) - extent to which a joint can be moved safely with staff OR done by staff; Range of Motion (ROM) - extent to which a joint	F 000		

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F 000	Continued From page 3 can be moved safely; Spinal stenosis - a narrowing of the spinal canal for the spinal cord and nerve roots; Splint - a rigid or flexible device that maintains in position a displaced or movable part;	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R77) out of two residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: Review of R77's clinical record revealed: 7/5/22 - A PASARR Level 1 evaluation was	F 644	F644 Coordination of PASARR and Assessments 1. R77 had a diagnosis of bipolar disorder and paranoid personality disorder documented on 10/12/23. At this time a new level 1 PASARR should have been initiated. Once this was identified during	3/28/24

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F 644	Continued From page 4 completed for R77 with an outcome stating no Level 2 evaluation required. 7/13/22 - R77 was admitted to the facility. 10/12/23 - A new diagnoses of bipolar disorder and paranoid personality disorder was identified. 2/8/24 12:56 PM - In an email correspondence, S1 (PASARR State Authority) confirmed that the facility should have submitted an up PASARR. 2/9/24 1:02 PM - An interview with E6 (Social Worker) confirmed that the facility did not submit a request for a new PASARR for R77 after the new diagnoses were added. E6 stated, "I thought the depression diagnosis would encompass the bipolar diagnosis and so he did not need a resubmission [a PASARR reevaluation]." 2/12/24 2:45 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 644	the annual survey, a new level 1 PASARR was submitted for R77 by the social services director. No negative resident outcome has been reported because of this deficient practice. 2. Current residents within the facility will be reviewed to ensure psychological diagnoses are current and the most recent PASRR assessments reflect residents' current psychological diagnoses. Any psychological diagnoses that were not captured on the most recent PASRR assessments will be identified. A new PASARR assessment will be submitted for any affected resident. 3. The root cause of this deficient practice was MDS staff not notifying social services when a new psychological diagnosis was added to the resident's diagnosis list. The system change will include the following: MDS staff will notify the social services department any time there is a new psychological diagnosis added to a resident's diagnosis list. 4. The administrator or designee will audit all new PASARR assessments to confirm compliance weekly x 4, then monthly x 2. Results of all audits will be presented monthly for three months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		3/28/24

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F 656	Continued From page 5 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 6 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R66 and R269) out of twenty-four (24) residents reviewed for care plans, the facility failed to develop and implement a comprehensive person-centered care plan for an identified need. Findings include: 1. Review of R66's clinical record revealed: 8/19/23 - A physician's order was entered for "Oxygen at 4 L/min via 4 Nasal Cannula, via humidification continuously every shift ...." 2/9/24 approximately 1:17 PM - During an interview, E1 (NHA) confirmed that there was no care plan for R66's continuous oxygen use or reference to R66's diagnosis of chronic obstructive pulmonary disease. E1 stated that normally a unit manager would initiate a care plan. E1 will make inquiries and provide an update to the surveyor. 2/9/24 approximately 2:25 PM - E1 provided documentation of an updated care plan initiated on 2/9/24, as follows: "The resident has oxygen therapy related to ineffective gas exchange", which also documented R66's continuous use of oxygen. The facility failed to have a care plan for R66's	F 656	F656 Develop/Implement Comprehensive Care Plan 1. R66 no longer resides in facility as of 2/9/2024. The respiratory care plan for oxygen therapy related to ineffective gas exchange was added on 2/9/2024. R269 currently resides in the facility. R269 was educated on 2/2/2024 regarding the new behavior when it was initially identified. The behavior care plan was implemented on 2/8/2024. No negative resident outcomes have been reported because of this deficient practice. 2. Current residents with a Pulmonary diagnosis will be reviewed to ensure an appropriate care plan is in place. The pulmonary care plans will be reviewed to determine that appropriate interventions are in place. Pulmonary care plans will be revised as necessary to reflect appropriate interventions to improve resident status and progress per their care plan goal. Progress notes will be reviewed for all current residents from the past 14 days to identify new behaviors. New behaviors identified will be care planned accordingly.	

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F 656	Continued From page 7 continuous use of oxygen or the chronic obstructive pulmonary disease diagnosis. 2. Review of R269's clinical record revealed the following: 1/22/24 - R269 was admitted to the facility with absence a left below knee amputation (BKA). 1/29/24 - The admission MDS assessment indicated that R269's cognition was moderately impaired. In addition, R269's skin conditions revealed a surgical wound that required surgical wound care. 1/31/24 - R269's revised care plan on his left BKA had interventions including but not limited to encourage compliance with treatment. 2/2/24 9:47 PM - A nurse progress note documented, "...Resident [R269] observed picking at his stitches with his bare hands...". 2/5/24 11:59 AM - During an observation, R269 was seen in his room sitting on his wheelchair. R269's Left BKA stump had no wound dressing and was not covered. 2/7/24 3:45 PM - In an interview, E5 (RN) stated that the residents' [R269] left stump (residual limb) dressing falls off easily and that [R269] "sometimes touches it." 2/8/24 1:20 PM - During an interview, E9 (RN) stated that "Resident [R269] has a behavior of non compliance with adhering to wound dressing. I have to remind him and educate him all the time for infection prevention."	F 656	3. R66 received a new order for the oxygen and the care plan was not initiated at the time the new order was received resulting in this deficient practice. R269 exhibited a new behavior with education provided to R269, however a behavior care plan was not initiated resulting in this deficient practice. The Nurse Practice Educator/NPE and/or designee will educate licensed nursing staff on the Comprehensive Person-Centered Care Plan Policy with emphasis on initiating care plans based on new orders and/or new behaviors. 4. The Director of Nursing and/or designee will randomly audit 5 scheduled care plans against new orders and respective progress notes to determine compliance with the initiation of care plans, weekly x 4, then 10 care plans monthly x 2. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	

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F 656	Continued From page 8 2/8/24 1:31 PM - In an interview, E8 (RN/UM) stated that she was aware of the residents' [R269] behavior of touching the area of his left BKA stump over the dressing, pulling it down and taking it off. In addition, E8 confirmed and stated, "These behaviors were not care planned. I will check his care plan and add a care problem." 2/9/24 - A copy of R269's behavior care plan documenting picking/rubbing the left BKA dressing was provided to the survey team. The facility failed to develop a person centered care plan reflecting R269's behavior problem with picking and rubbing his left left BKA wound dressing until the surveyor intervened on 2/8/24. 2/12/24 2:45 PM - Findings were reviewed with E1 and E2 (DON) and E3 (Corporate) during the exit conference.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (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).	F 657		3/28/24

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F 657	Continued From page 9 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (6) out of twenty-four (24) residents reviewed, the facility failed to have input from all required interdisciplinary team members at these residents' care plan meetings. Findings include: The facility policy entitled "Care Plans, Comprehensive Person-Centered" (updated 10/2019) states that the IDT (Interdisciplinary Team) includes: a. The Attending Physician; b. A registered nurse who has responsibility for the resident; c. A nurse aide who has responsibility for the resident; d. A member of the food and nutrition services staff; e. The resident and the resident's legal representative (to the extent practicable)... 1. Review of R9's clinical record revealed: 4/1/23 - Resident was admitted to the facility. 1/20/24 - A Care Plan Note lacked evidence of input from the resident's physician, nurse, dietary or CNA.	F 657	F657 Care Plan Timing and Revision 1. There was insufficient documentation to show that all interdisciplinary team (IDT) members provided input for the post-admission care conferences/comprehensive care conferences for the residents cited in the 2567 (R9, R14, R66, R94, R96, and R 307). There was insufficient documentation to show R66 had a recent care plan meeting. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents who resided in the facility as of 2/12/24 were reviewed as having the potential for being affected by this deficient practice. 3. The root cause of this deficient practice was that our Social Services Director was new to the process of documenting care plan meetings and due to turnover in the department, the prior	

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F 657	Continued From page 10 2/8/24 approximately 2:00 PM - During an interview, E6 (Social Worker) confirmed that if there is no checkmark next to the department, that person did not attend or provide input. The band in the clinical record contains all the IDT team that should participate, but it is automated and cannot be altered, so that participants must ensure there is a checkmark next to their department to confirm they provided input. E6 also confirmed that there have been some issues with completion of care plan meeting notes and/or post admission conference forms due to recent staff turnover. E6 will check to see if there is documentation of a post admission conference for January for R9. 2/9/24 approximately 2:30 PM - During an interview, E1 (NHA), the facility does not have sign in sheets for the care plan meetings. E1 stated that the nursing team meets with physician, CNA and dietary and will convey information shared by these entities. If a CNA can come off the floor, he/she will attend the meeting. The physician typically sees residents right around time of the quarterly care plan. 2/9/24 untimed - The surveyor was provided a copy of the 1/20/24 Care Plan Note that lacked evidence of input from the resident's physician, nurse, dietary or CNA. 2/12/24 9:00 AM - During an interview, E8 (Unit Manager) stated she has a process for gathering information for the care plan meetings. E8 stated that the CNA's provide information and then E8 will update the physician. E8 makes notes and attends the care plan meeting. E6 gets all the information that E8 has.	F 657	documentation process was not adequately carried over. Administrator or designee will educate the Social Services Director on the Complete Care Management Policy on comprehensive, person-centered care plans. The social services director will ensure that care plan meetings are conducted for each resident. Care plans will be prepared by the interdisciplinary team and input will be provided by the physician, registered nurse, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and to the extent practicable, the resident and the resident's representative. A care plan tracking tool was created to manage the post admission and comprehensive care plans for the facility. Interdisciplinary team members will utilize this tool to provide input into each resident's post admission and comprehensive care plans. This information will be reviewed by interdisciplinary team members in the resident's care plan meeting. The Social Services Director or designee will document each interdisciplinary team member's input in designated care plan documentation. 4. The administrator or designee will audit all post admission and comprehensive care plan meetings weekly x 4 for one month, then every 2 weeks for one month, and then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for three months to the Quality Assurance	

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F 657	Continued From page 11 2/12/24 9:09 AM - E1 stated that he met with E6 on 2/9/24 and created a spreadsheet for care plan meetings, so all required disciplinary team members can add their information to confirm their participation. 2. Review of R14's clinical record revealed: 5/20/21 - Resident was admitted to the facility. 1/10/24 - A post admission conference lacked evidence of input from dietary staff or CNA. 3. Review of R66's clinical record revealed: 12/23/20 - Resident was admitted to the facility. 2/12/24 11:08 AM - The surveyor requested documentation regarding R66's care plan meetings and/or post admission conferences to confirm the IDT's attendance. 2/12/24 approximately 2:45 PM - E1 (NHA) and E2 (DON) confirmed that there was no documentation of R66's most recent care plan meeting due to staff turnover. 4. Review of R94's clinical record revealed: 9/22/23 - Resident was admitted to the facility. 1/14/24 - A post admission conference lacked evidence of input from the physician, dietary staff or CNA. 5. Review of R96's clinical record revealed: 10/12/23 - Resident was admitted to the facility.	F 657	Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	

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F 657	Continued From page 12 10/23/23 - A post admission conference lacked evidence of input from dietary staff or CNA. 1/31/24 - A post admission conference lacked evidence of input from the physician, dietary staff or CNA. 6. Review of R307's clinical record revealed: 1/2/24 - R307 was admitted to the facility. 1/6/24 - A post admission conference was held with the following attendees: patient, social services, nurse UM and therapy. 2/8/24 - An interview with E6 (Social Worker) revealed that the physician, CNA, and dietary were not present or shared input during the post admission conference for R307. 2/12/24 2:45 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		3/28/24

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F 688	Continued From page 13 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R39 and R62) out of four residents reviewed for range of motion and mobility, the facility failed to provide appropriate services, equipment, and assistance to maintain function and mobility. Findings include: 1. R39's clinical record revealed: 11/21/21 - R39 was readmitted to the facility with a diagnosis of a stroke. 12/1/21 - R39's care plan revised 12/6/23 for decreased ROM (range of motion) due to contractures related to stroke documented ... "1. Resident will not have an increase in contractures and maintain skin integrity this review ... 2. Bilateral palm protectors on in the AM (morning) off in PM (evening) as tolerated ... 3. Off for ROM, routine skin check and hygiene. ROM measurements by therapy PRN (as needed)." 2/15/23 - An annual ROM Measurement for R39 documented ... "1. Moderate contracture to the left wrist and left fingers ... 2. Minimal contractures to the right wrist and fingers." 4/21/23 - A physician's order for R39 documented, "bilateral (involving two sides) palm	F 688	F688 - Increase/Prevent Decrease in ROM/Mobility 1. R39 and R62 currently reside in the facility. R39□s bilateral palm protectors were in the laundry department and were applied to R39 on 2/7/2024. R62 had her knee splints applied on 2/7/2024. E10 was educated by E11 regarding splint application and process of training staff when new splint recommendations are made by therapy. No negative resident outcome has been reported because of this deficient practice. 2. Director of Nursing and designee will audit current resident's orders for splint, brace, and palm protector orders to identify current residents who have the potential to be affected by the same deficient practice. All new splint, brace, and palm protector orders identified will be added to the respective resident's electronic medical record. 3. There was a new Unit Manager for the unit with deficient practice. The Unit Manager was educated at the time the deficient practice was identified. There were new staff assigned to the unit who	

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F 688	Continued From page 14 protectors on in the AM off PM (evening) as tolerated. Off for ROM, routine skin check and hygiene every day and evening shift." 8/26/23 - A quarterly MDS assessment documented R39 had impairment to both upper extremities (arms). 11/20/23 - A significant change MDS assessment documented R39 had impairment to both upper extremities. 2/6/24 9:23 AM - During a combined interview and observation E14 (CNA) confirmed R39 was not wearing bilateral palm protectors, and that the night shift was supposed to apply the palm protectors. In addition, E14 searched for R39's palm protectors during the interview and had not found them. E14 said, "I will put rolled up washcloths in R39's hands, that's what I do if R39 does not have palm protectors." 2/7/24 8:18 AM - A combined observation and interview with E15 (RN) confirmed that R39 was not wearing palm protectors on either hand. 2/7/24 8:54 AM - During an interview E12 (DOT) confirmed that R39 should be wearing palm protectors to both hands and not washcloths. The facility failed to ensure R39, a dependent resident with contractures to the right and left hands, wrists and fingers, was wearing palm protectors. 2. Review of R62's clinical record revealed: 3/20/20 - R62 was admitted to the facility with left and right shoulder and knee osteoarthritis.	F 688	were also unaware of the process regarding splints. The Nurse Practice Educator/NPE and/or designee will educate all licensed and non-licensed nursing staff on the Use of Assistive Devices policy and the Prevention of Decline in Range of Motion policy. 4. The Director of Nursing and/or designee will audit all current residents with splint, brace, or palm protector orders weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	

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F 688	Continued From page 15 7/21/22 - R62 was readmitted to the facility with spinal stenosis of the cervical region. 12/21/23 - R62's care plan documented patient demonstrates loss of range of motion related to functional deterioration with a goal to prevent further contractures. The interventions for R62 included to use bilateral knee flexion splints daily. On with AM care and off with PM care. 2/5/24 10:10 AM - An observation of R62 without bilateral knee splints. 2/5/24 2:11 PM - An observation of R62 without bilateral knee splints. 2/7/24 10:04 AM - During an interview, R62 confirmed that she never had her knee splints applied on 2/5/24. 2/7/24 10:00 AM - During an interview, E10 (CNA) confirmed the bilateral knee splints were not put on R62 on 2/5/24. E10 stated she marks 'not applicable' on the task documentation because she was not trained how to put the splints on R62. 2/7/24 10:17 AM - During an interview, E13 (PT) stated the knee splints were used to maintain R62's range of motion. 2/7/24 10:33 AM - During an interview, E12 (DOT) stated that when a resident has a new device such as a splint or brace that therapy will train the nursing staff and care givers over the course of 1 week then the nursing unit manager takes over and trains nurses and staff. A review of the sign in sheet for R62's knee splints did not	F 688		

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F 688	Continued From page 16 show E10 in attendance for training. 2/7/24 11:14 AM - During an interview, E11 (RN/UM) stated that when a resident has a new device such as a splint that therapy does a training and orientates staff for a time period, then nursing will orientate the additional nurses or staff. 2/7/24 11:32 AM - During an interview, E4 (ADON), E8 (RN/UM) and E11 confirmed the aforementioned therapy training process. E11 stated that her and E10 put the knee splints on R62 together and therapy did some training with E10. 2/12/23 2:45 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 688		
F 756 SS=C	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		3/28/24

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F 756	Continued From page 17 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop policies and procedures for the monthly MRR (Medication Regimen Reviews) that included time frames for different steps in the MRR process. Findings include: 2/8/24 12:58 PM - Review of the facility's policy titled, "Medication Regimen Review", revised 3/13/23, lacked the information of the facility's time frame to respond to the pharmacy recommendations based on identified irregularities. 2/8/24 1:56 PM - During an interview, E7 (RN/Staff) stated that the facility's policy did not	F 756	F756 □ Drug Regimen Review, Report Irregular, Act On 1. There were no residents impacted by this deficient practice. The facility updated the policy on 2/15/2024 to be in compliance with federal regulation. 2. All MRR's (Medication Regimen Review) received will be responded to in accordance with the Medication Regimen Review policy and procedure. 3. The corporate policy did not include a specific date of completion for MMR's resulting in deficient practice. The Nurse	

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F 756	Continued From page 18 have a specific timeframe when responding to the pharmacy recommendations. 2/12/24 10:05 AM - In an interview, E2 (DON) confirmed the missing time frame to respond to the pharmacy recommendations and stated, "...Just for the staff to respond as soon as possible." 2/12/24 2:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 756	Practice Educator and/or designee will educate the nursing management team on the Medication Regimen Review Policy with emphasis on the time frames for the different steps in the MRR process. 4. The Director of Nursing and/or designee will manage the MRR process to ensure that time frames for the different steps of each process are being adhered to. The Director of Nursing will audit for compliance weekly x 4 weeks, then monthly x 2. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident-	F 791		3/28/24

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F 791	Continued From page 19 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R77) out of three sampled residents for dental services, the facility failed to assist the resident in obtaining routine dental services. Findings include: A facility policy and procedure titled, "Dental Services," with last revision of 4/5/23, documented, "Routine dental services means an annual inspection of the oral cavity for signs of disease ... dental radiographs as needed, dental cleaning. ...The facility will, if necessary or requested, assist the resident with making dental	F 791	F791 Routine/Emergency Dental Srvcs in NFs 1. R77 is currently in the facility and there have been no negative outcomes because of this deficient practice. An Oral Health Assessment was completed on 2/27/2024 which noted well fitted full upper denture and natural bottom teeth without decay or broken teeth. The contracted Dentist was contacted via email to schedule a date to provide a routine cleaning for the bottom teeth of	

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F 791	Continued From page 20 appointments .... For residents or resident representatives who do not wish to be referred for dental services: The physician shall be notified .... The resident's plan of care will be revised to reflect preferences." Review of R77's clinical record revealed: 7/13/22 - R77 was admitted to the facility. 7/18/22 - The admission MDS assessment documented that R77 did not have any broken or chipped teeth, no inflamed or bleeding gums, and no mouth or facial pain. 11/15/23 - The significant change MDS assessment documented that R77 did not have any broken or chipped teeth. 8/14/23 1:42 PM - During an observation and interview, R77 stated they have false upper teeth and all natural teeth on the bottom. R77 stated he has not seen a dentist since he has been here and needs to have his bottom teeth cleaned. 2/9/24 11:43 AM - During an interview E4 (ADON) stated the residents are asked if they want to see a dentist during their care plan meeting. E4 confirmed there was no evidence of dental services provided to R77. There was lack of evidence of any routine dental consultation since 7/13/22. 2/12/24 2:45 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 791	R77. 2. An Oral Health Assessment will be completed on all current long-term care residents to identify any who require routine dental services. The Oral Health Assessment will identify and document those residents who refuse dental treatment. 3. Dental services are/were being offered, however, there was no documentation to support this resulting in a deficient practice. The Nurse Practice Educator and/or designee will educate Licensed nurses, Unit Clerk, members of the Social Services Department on the Dental Services policy with emphasis on supporting documentation to include referral or refusal. 4. The Social Services Director and/or designee will offer dental services in accordance with scheduled annual assessments. The Social Services Director and/or designee will document the resident's response to offered dental services. The Social Services Director and/or designee will report compliance to policy monthly x 3 to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
F 842 SS=D	Resident Records - Identifiable Information	F 842		3/28/24

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F 842	Continued From page 21 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 22 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R61 and R306) out of twenty-five residents clinical records reviewed, the facility failed to ensure that each residents' record was complete and accurately documented. Findings include: 1. Review of R61's clincal record revealed: 1/18/24 - R61 was admitted to the facility.	F 842	F842 Resident Records - Identifiable Information 1. R61 no longer resides in the facility as of 2/16/2024. The incorrect encounter note written by the provider that was documented in the electronic medical record (EMR) for R61 was stuck out. No negative outcome was reported because of this deficient practice.	

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F 842	Continued From page 23 1/25/24 1:27 PM - A review of R61's progress notes revealed a provider visit with the Psychologist occurred with following documentation, "This is a 71-year old female admitted on 1/18/24...". 1/25/24 1:29 PM - A review of R61's progress notes revealed a provider visit with the Psychologist occurred with following documentation, "This is an 85-year old female admitted on 1/23/24...". 2/12/24 1:05 PM - An interview with E4 (ADON) confirmed that the second progress note was not written for R61. 2. Review of R306's clincal record revealed: 11/3/23 - R306 was admitted to the facility. 12/9/23 3:51 PM - A pain assessment was completed for R306 which lacked evidence of accurate responses. The section labeled coping which determined pain location, length of time pain occurred, description, non-pharmocological interventions, and what makes pain worse were all coded "NA". 2/9/24 2:15 PM - An interview with E5 (RN) confirmed the assessment was not accurately completed. 2/12/24 2:45 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (Corporate) during the exit conference.	F 842	R306 no longer resides in the facility as of 12/23/2023. The employee who recorded the inaccurate responses to the pain assessment was educated on 2/27/2024. 2. Current residents who received services on 1/25/2024 by the provider with inaccurate encounter notes will be reviewed for accuracy in the EMR. Pain assessments completed within 14 days of acceptance of survey plan of correction will be reviewed for accuracy and residents with inaccurate pain assessment responses will be reassessed. 3. The Vista Medical Services Nurse Practitioner documented in the wrong resident's EMR resulting in this deficient practice. Nurse Practice Educator/NPE and/or designee will educate Vista Medical Services providers on the Maintenance of Electronic Clinical Records. One nurse incorrectly completed a pain assessment resulting in this deficient practice. The Nurse Practice Educator and/or designee will educate all licensed nurses on how to complete a pain assessment. 4. The Director of Nursing and/or designee will audit all encounter notes written by Vista Medical Services provider and all pain assessments completed weekly x 4, then 10 encounter notes by Vista Medical Services and 10 pain assessments x 2 months. Results of	

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F 842	Continued From page 24	F 842	audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.	