DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

263 Chapman Road, Suite 200, Cambridge Bldg
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Polaris Healthcare & Rehab Ctr LLC

DATE SURVEY COMPLETED: April 11, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from April 7, 2024 through April 11, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 77. The investigative sample totaled 24 residents.	
3201	**Regulations for Skilled and Intermediate Care Nursing 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: F550, F552, F558, F582, F584, F609, F641, F645, F656, F657, F686, F689, F690, F695, F756, F758, F812.	Please cross reference the 2567 for State Plan of Correction for F550, F552,F558,F582,F584,F609,F641, F645,F656,F657,F686,F689,F690, F695, F756,F758, F812

Provider's Signature Brenda Keyser, NHA Title Administrator Date 5/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085058	A. BUILDING _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS HEALTHCARE AND REHABILITATION CENTER	21 W CLARKE AVENUE MILFORD, DE 19963

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E 000	Initial Comments An unannounced Annual and Complaint survey was conducted at this facility from April 7, 2024 through April 11, 2024. The facility census was 77 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 and Complaint Survey was conducted at this facility from April 7, 2024 through April 11, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 77. The investigative sample totaled 24 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; DOR - Director of Rehabilitation; EMT - Emergency Medical Technician; FM - Family Member; ICP - Infection Control Preventionist; IDT - Interdiscplinary Team; LPN - Licensed Practical Nurse;	F 000		

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

Electronically Signed | 05/01/2024

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	F 000		

MDSC - MDS Coordinator;
NHA - Nursing Home Administrator;
RN - Registered Nurse;
RT - Respiratory Therapist;
UM - Unit Manager.
Anoxic brain damage - brain loses oxygen supply, which results in the death of brain cells;
Braden Scale - tool used to determine risk for development of pressure ulcers;
Brief Interview for Mental Status (BIMS) - test to measure thinking ability with score ranges from 0 to 15.
13-15: Cognitively intact
8-12: Moderately impaired
0-7: Severe impairment;
Corroborate - to support with evidence or authority;
Hematoma - a bruise, a black and blue mark;
Hoyer Lift - sling-type hydraulic lift;
Hypoxic-ischemic encephalopathy (HIE) - is a type of brain damage. It's caused by a lack of oxygen to the brain before or shortly after birth. It affects the central nervous system. Babies born with HIE may have neurological or developmental problems;
Laceration - cut/tear in skin;
Minimum Data Set (MDS) - a standardized set of assessments completed in nursing homes;
Morbid Obesity - excess body fat to the extent that it may have a negative effect on health;
Paralysis - loss of voluntary movement;
Quadriplegia - paralysis of arms and legs;
Spinal muscular atrophy (SMA) - is a condition that causes muscle weakness and atrophy (when muscles get smaller);
Tracheostomy - an opening made in the throat to assist breathing;
Wedge (pillow) - A relatively firm foam cushion that forms an acute angle opposite the base used

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F 000	Continued From page 2 to prop up their head and neck or support their back and shoulders when in bed. They can also be used to elevate the legs and help improve circulation.	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 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	F 550		6/3/24

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F 550	Continued From page 3 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 observations, interviews and record review, it was determined that for three (R7, R23 and R57) out of three sampled residents reviewed for dignity, the facility failed to promote care in a manner and environment that maintained or enhanced their dignity and respect. Findings include: 1.Review of R7's clinical record revealed: 2/23/24 - R7 was admitted to the facility. 4/10/24 10:08 AM - An observation of E33 (CNA) and E34 (CNA) in room with R7 providing care with door open. R7's unclothed, lower body from thigh down to feet was able to be observed from open door. 4/10/24 10:50 AM - An interview with E33 and E34 confirmed that care was completed with the door open leaving R7 exposed to the hallway. 2. Review of R23's clincal record revealed: 5/24/23 - R23 was admitted to the facility. 4/11/24 10:17 AM - An observation of E35 (CNA) in room with R23 providing care with the door open. R23's care occurred till 10:27 AM. R23's	F 550	A. R7 no longer resides in the facility. R23 and R57 still reside in the facility. All Nursing Staff was inserviced on providing dignity and respect on 4/22/24. E12 and E16 no longer work at Polaris. B. All residents who are dependent on care have the potential to be affected by this deficient practice. C. A root cause analysis identified that nursing staff failed to provide care in a manner that provided the patient with dignity and respect. All staff will be educated on Resident Rights during new employee orientation. Staff will also be retrained yearly through Relias. D. An audit will be completed weekly x□s 3 weeks and monthly x□s 3 months. Results will be brought forward to QAPI until 100% compliance is achieved.	

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F 550	Continued From page 4 unclothed, lower body from thigh down to feet was able to be observed from hallway. 4/11/24 10:28 AM - An interview with E35 confirmed that R23's care was completed with door open and R23's unclothed body was exposed to the hallway. 3. Review of R57's clinical record revealed: 7/13/23 - R57's quarterly MDS documented that R57 had a documented BIMS score of 15, revealing an intact cognitive state and was totally dependent of two staff for toilet use. R57 had impairments on both sides for upper and lower extremities. 11/13/23 - A facility incident report documented that on 11/11/23 at 6:45 AM, E16 (former CNA) was argumentative with R57 when E16 came into R57's room to change her. 11/20/23 - A facility follow-up report documented that it was determined that E16 did speak inappropriately to R57. 11/27/23 - E16 was terminated from the facility. 4/10/24 9:39 AM - An interview with E12 (Agency RN) revealed that she went into R57's room to help E16 to perform care. E16's tone became hostile towards R57. E12 was not able to recall the words exchanged but stated that E16 and R57 were talking back and forth during which time E16's tone " ...went from a normal tone of 1 to a 10." E12 stated, "she stepped in and said to E16 that she cannot talk to the resident that way." 4/10/24 12:09 PM - An interview with R57	F 550		

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F 550	Continued From page 5 revealed that on the morning of 11/16/23 at approximately 6:50 AM, E16 was in the room and woke R57 up due to a noise. R57 asked E16 if she was going to change her. R57 stated, "[E16] began to get loud and asked her, do you want to be changed?" R57 then replied, "Yes, I do." At that point [E57] turned her head to the nurse and said, "do you hear this?" E12 said, "she heard [E16]." E16 was asking R57 in a loud and aggressive manner, "do you need to be changed because I got to go Are you refusing to be changed? I need to go." E12 had told E16 that the patient is always right. While E16 and E12 was proceeding to change R57, E16 kept telling me to be quiet, because I kept saying it was a problem. Then E16 told E12 that R57 did not like her and R57 said, "I don't have a problem with anyone, I don't know her." Afterwards, R57 stated she was upset and crying. R57 stated she has not had any issues with other staff since. 4/11/24 8:48 AM - An interview with E17 (former DON 1) revealed that E16 denied speaking inappropriately to the resident but E12 did corroborate what R57 had reported. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or	F 552		6/3/24

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F 552	Continued From page 6 her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Review of the facility policy titled, "Change in a Resident's Condition or Status" last dated 2/2021 documented... 1. "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status, changes in level of care, billing/payments, resident rights, etc." Review of R8's clinical record revealed: 7/1/21 - R8 was admitted to the facility with a diagnosis including but not limited to hypertension, stroke, left side weakness and depression. 1/5/24 - Review of the facilities diet requisition form revealed R8 was on a regular textured diet and thin liquids. 2/15/24 12:47 PM - A physician's order written by E4 (MD) for R8 documented ... 1. "Regular diet dysphagia mechanical soft texture thin liquids consistency. Patient may have regular pleasure	F 552	A. R8 remains in the facility and family was notified of the diet change. B. All residents have the potential to be affected by this deficient practice. Registered Dietician will audit all change in diet and will notify family of the change. A note will also be entered in PCC. If a resident has a BIMS of 15, it will be discussed with the individual resident. C. A root cause analysis identified that the facility failed to follow protocol related to family notification of a resident□s change in condition. The facility RD failed to follow protocol related to change in condition and dietary needs. The RD completed a significant change review and update the care plan. DON will provide inservice to RD about clinical protocol, when reporting changes in condition on 4/22/24. D. The Registered Dietician will audit the diet notification at time of admission and any significant changes. An audit will be done of 20% of residents weekly until	

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F 552	Continued From page 7 foods." 2/15/24 1:25 PM A plan of care note written by E14 (RD) revealed that R8's diet was downgraded for safety. In addition, a facility diet requisition form revealed R8's diet was changed to dysphagia mechanical soft texture on 2/15/24. 4/9/24 12:07 PM - An interview with E13 (LPN) revealed that if a resident's diet had changed nursing would notify the contact person. 4/9/24 2:37 PM - During an interview E14 revealed, "I downgraded R8's diet texture, but did not notify R8's contact person of the change." In addition, E14 said, "I assumed that nursing would have notified R8's contact person." 4/9/24 3:00 PM - Further review of R8's clinical record lacked evidence that R8's contact person was notified R8's diet texture had been downgraded from regular textured food to an altered regular mechanical textured diet. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 552	100% of compliance in achieved. The audit will be conducted monthly x□s 3 months. The audits will be brought forward to the QAPI committee for 3 month.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		6/3/24

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F 558	Continued From page 8 Based on observation, record review and interview it was determined that for two (R131 and R57) out of 40 initial pool residents screened the facility failed to ensure that the residents call bell was in reach and that the resident was capable of using it. Findings include: The facility policy on the resident call system last updated September 2022 indicated, "Each resident is provided with a means to call staff directly for assistance...The resident call system remains functional at all times. If the resident has a disabiity that prevents him/her from using the call system an alternative means of communication that is usable for the resident is provided and documented in the care plan." 1. Review of R131's clinical record revealed: 3/25/24 - R131 was admitted to the facility with multiple diagnoses including spinal injury. 3/25/24 9:52 PM - A nurse's note documented, R131 was, "Alert and oriented and able to make needs known a quadriplegic and requires maximum assistance of two...Resident a quadriplegic and unable to sign paperwork." 3/25/24 - The admission evaluation assessment documented R131 unable to use the call light/call bell. 4/1/24 - An admission MDS assessment documented R131 had impairments to all extremities and an active diagnosis of quadriplegia (paralysis of all four limbs). During the intial pool screening on 4/7/24 at 9:29 AM, R131 was observed with a standard push	F 558	A. R131 and F57 still reside in the facility. B. Any resident affected by a Quadriplegic dx has the potential to be affected by the deficient practice. C. A root cause analysis identified that the facility failed to provide an appropriate call bell system for the identified patients. All specialty equipment will be ordered by prior to admission. The Zephyr breath activated call bell was ordered on 3/27 and delivered on 4/6. D. An audit will be completed on all residents requiring a breath activated device and ensure it is within reach. E. An audit will be completed weekly x□s 4 weeks. The audit will be brought forward to QAPI for the next 3 months.	

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F 558	Continued From page 9 button call bell fastened to the fitted sheet, shoulder height, close to the side rail and a metal bell on the farthest end of the over bed table. R131 confirmed both bells were out of reach and that he was unable to use either call bell. R131 stated, "I talked to someone and every aide, I'm paralyzed they gave me this bell I'm unable to use either one. I can use a large round soft touch bell if placed by my chin or head. That's what I had at the last nursing home." R131 confirmed that staff checked on him regularly. During an interview on 4/7/24 at 12:30 PM, E28 (RN) unit manager was asked if there were any soft touch call bells in the facility. E28 was unsure and explained she would have maintenance look. E28 then accompanied the surveyor to R131's room, and confirmed the resident was unable to use the current call bells in the room. During an interview on 4/7/24 12:51 PM, E28 (RN) unit manager provided the surveyor with an invoice dated 3/27/24 for the order of a touch and breath call bell system. E28 was asked if leadership was aware that R131 was unable to use the call bell system currently in his room. E28 stated, "I don't think management knew but someone knew because we ordered it. I will have maintenance put it in." E28 could not confirm when the touch and breath call bell systems were delivered to the facility. 4/7/24 1:05 PM - E28 (RN) unit manager and E9 (ICP) were observed entering R131's room with call bell equipment. During an interview on 4/7/24 at 1:36 PM, R131 was able to return demonstrate ability to use breath call bell system, and confirmed	F 558		

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satisfaction.

During an interview on 4/10/24 at 11:07 AM, E1 (NHA) was unable to provide documentation regarding delivery of the breath call bell system. E1 stated, "We didn't sign for it but it was here on Sunday".

During an interview on 4/10/24 at 12:06 PM, E2 (DON) reported that if a resident was assessed as unable to use the standard push button call bell, "I would expect them to report that to their supervisor and then the supervisor get in contact with maintenance. Which they did and we didn't have a breath call bell and maintenance ordered it." E2 was unable to confirm the date of delivery of the breath call bell.

2. Review of R57's clinical record revealed:

10/11/22 - R57 was readmitted to the facility with diagnoses including but not limited to quadriplegia, spinal muscular atrophy, morbid obesity and tracheostomy.

1/18/24 - MDS quarterly documented R57 as totally dependent.

4/7/24 1:00 PM - An observation and interview with R57 revealed the sip and puff (type of call bell) was next to the bed in a position that R57 was unable to use.

4/7/24 1:44 PM - An observation of E37 (CNA) leaving the room with R57's lunch tray and the sip and puff was next to the bed in a position that R57 was unable to use.

4/7/24 1:53 PM - During an observation and

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F 558	Continued From page 11 interview with E36 (Respiratory Therapist) it was confirmed that the resident did not have her sip and puff, but she would be able to call out for help. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 558		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582		6/3/24

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F 582	Continued From page 12 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R287) out of three residents reviewed for discharge the facility failed to provide R286 the Notice to Medicare Provider Non-Coverage (NOMIC) form before services were terminated. Findings include: R287's clinical record revealed: 3/20/24 R287 was discharged to home. 4/11/24 approximately 10:30 AM - During an interview, E1 (NHA) confirmed that the NOMIC form was not provided to R287. As part of R287's	F 582	A. R26 no longer resides in the facility. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to maintain the proper procedure for the NOMNC process. The NHA will conduct an audit of the past 10 discharges to ensure compliance with the NOMNC. An in-service will be conducted to ensure all interdisclinary team members understand the NOMNC process. D. The NHA will audit the NOMNC once a week x□s 4 weeks until 100%	

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F 582	Continued From page 13 resident rights, the NOMIC form notifies the beneficiary of his or her right to an expedited review of the service termination. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 582	compliance is achieved. The audit will be brought forward to QAPI for review for the next 3 months.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		6/3/24

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F 584	Continued From page 14 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (room 246) out of 59 rooms observed the facility failed to ensure cleanliness. Findings include: During daily observations of resident rooms the following was observed in room 246 : 4/7/24 10:53 AM - Three circular large brown stains on the fitted sheet of a occupied bed. A large circular dried pooling of the same brown liquid on the floor. 4/8/24 2:34 PM - The fitted was sheet clean. The large brown circular stain remained on floor also two pieces of balled paper napkins. 4/9/24 9:04 AM - A large brown circular stain remains on floor and the balled paper napkins were no longer present. During an interview on 4/9/24 at 9:40 AM, E10 (housekeeper) confirmed the stain on the floor of room 246. E10 stated, "There are three total housekeepers every day and a floor technician mainly to take care of the floors, trash, and	F 584	A. R40 remains in the facility. The brown stains on the bed and the floor were cleaned. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to provide appropriate daily cleaning services. E10 no longer works in the facility. The housekeeping staff will be inserviced on the Daily cleaning Procedures on or before 4/19/24. D. The housekeeping supervisor will conduct an audit of 12 rooms weekly x□s 4 weeks. The audits will be brought forward to QAPI until 100% compliance is achieved or the next 3 months.	

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F 584	Continued From page 15 common areas. Housekeepers sweep and mop everyday." During an observation on 4/9/24 at 1:56 PM, the large brown circular stain remained on the floor of room. During an observation on 4/11/24 at 10:00 AM, the stain was no longer present. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		6/3/24

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F 609	Continued From page 16 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R53) out of three residents reviewed for abuse the facility failed to recognize and immediately report an allegation of abuse. Findings include: The facility policy on Abuse, last updated April 2021 indicated that staff, "Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegations within timeframe's required by federal requirements." 3/25/24 - The facility reported an incident to the State Agency that alleged, "On 3/21/24 there was a disagreement between roommates and a room change was recommend by the on call nurse for that shift." 4/11/24 9:00 AM - Review of the facility incident report and investigations revealed a statement dated 3/12/24 written by E24 (LPN) that documented, "[R17] said he threw soda cans at [R53] and called him an asshole and a retard I heard [R53's] wife yelling but I am not sure what was said I heard both residents yelling at each other." Another statement dated 3/21/24 written by E25 (RN) documented, "[R17] agreed that he called his roommate a retard and initiated incident and he also accepted that he threw soda cans	F 609	A. R17 and R53 remain in the facility. The incident has been reported and an investigation was completed. R17 and R53 were separated immediately. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis identified that the nursing administration failed to report an allegation of abuse to the state agency in the appropriate time frame. Prior to room-mate pairing the facility will discuss any potential behavior issues before the move during morning clinical meeting. A review of what qualifies as a reportable will be inserviced with the DON, ADON and Unit managers. D. An audit of incident reports will be completed once a week x's 4 weeks and will be brought forward to QAPI for the next 3 months.	

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F 609	Continued From page 17 against curtain which were lying on the floor between bed a and bed b." During an interview on 4/11/24 at 9:18 AM, E23 (RN supervisor) stated, "I was called that night by the nurse and asked to move the residents. They told me that they had gotten into an argument and they were yelling at each other. " E23 explained she was not aware that R17 threw the soda can at R53. During an interview on 4/11/24 9:25 AM, E2 (DON) confirmed that the resident to resident incident between R53 and R17 was not recognized as an allegation of abuse and therefore not immediately reported. E2 stated, "I was made aware the 22nd when I saw the statements, I verified it with the supervisor. It [soda-can] hit the curtain." E2 clarified that because the soda can didn't hit R53 that the incident was not recognized as allegation of abuse and not immediately reported. During an interview on 4/11/24 11:20 AM, R53 stated that R17, "Threw a soda can at me and my wife...He threatened me and called my Wife me an ass-hole got me and my Wife wet [with soda] so me and my wife screamed, the nurses came in and he got moved." These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		6/3/24

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F 641	Continued From page 18 resident's status. This REQUIREMENT is not met as evidenced by: Based on on record review and interview it was determined that for one (R42) out of five residents reviewed for medication review the facility failed to ensure accuracy of the MDS assessment. Findings include: Review of R42's clinical record revealed: 5/9/23 - R42 was admitted to the facility. 5/15/23 - An admission MDS assessment for R42 documented that the cognitive, behaviors, mood and pain level sections, were not assessed. During an interview on 4/9/24 at 1:22 PM, E15 (Director of Reimbursement Services) confirmed the finding. E15 stated, "it was missed, we didn't get to it. [R42] should've been interviewed." These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 641	A. R42 is still present in the facility. The MDS audits for the patient were reassessed and completed. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis identified that the MDS nurse failed to follow the procedure to appropriately complete the MDS assessment cognitive, behaviors, mood, and pain level. Education was provided to the staff related to MDS assessment for cognitive, behaviors, mood, and pain level through in-service education. D. The audit will be conducted on 10% of patients weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved or the next 3 months. A random audit will be completed by the Director of Clinical Reimbursement once a month, x's 3 months. These audits will be brought forward to QAPI for the next 3 months.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		6/3/24

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F 645	Continued From page 19 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645		

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F 645	Continued From page 20 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, and record review it has been determined that for one (R68) out of one resident reviewed for PASARR, the facility failed to ensure a referral for a new PASARR Level I and II screening occurred by or before the 60th day. R68 was remained in the facility beyond the authorization timeframe. Findings include: A facility policy and procedure titled, "Admission Criteria", documented... 1. "All new admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process." Review of R68's clinical record revealed: 7/26/23 - A review of R68's PASARR Level I	F 645	A. R68 remains in the facility and has a current PASSAR. B. All new and current residents will a mental Health diagnoses have the resident to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to follow the facility policy on Admission Criteria. The Admission Director, ADON, Social worker, and Social worker assistant all were trained on facility policy of Admission Criteria. Additional training was completed by Delaware Health and Ascend Administrative office on 4/24/24. IDT team to review during am clinical meeting to ensure all documentation is in the medical record. D. An audit will be done at the rate of 20% weekly until 100% compliance is	

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F 645	Continued From page 21 screen outcome revealed an approval period of 60 days for R68 a resident with a mental health disability in the nursing facility. 8/30/23 - R68 was admitted to the facility with diagnoses including but not limited to bipolar disorder, anxiety disorder and major depressive disorder. 11/6/23 - A review of R68's PASARR Level I screen outcome determination revealed R68 was referred for a PASARR Level II for a confirmed mental health disability. Additionally, R68's PASARR Level I screen was not done within the required authorization timeframe; by or before the 60th day. 11/13/23 - A review of R68's PASARR Level II determination revealed: short term approval without specialized services with an approval end date of 3/12/24. 4/9/24 1:41 PM - During an interview E15 (DRS) confirmed R68's PASARR Level I screen had not occurred by or before the 60th day. In addition, E15 confirmed R68's PASARR Level II's approval ended 3/12/24. 4/11/24 12:58 PM - During an interview E1 said, "[R68] was supposed to be discharged and had not been." The facility failed to coordinate the PASARR screening process for a resident with a mental health disability within the determined short term approval period as required. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA)	F 645	achieved. The audit will be presented to QAPI for review for the next 3 months.	

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F 645	Continued From page 22 and E2 (DON).	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized 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	F 656		6/3/24

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F 656	Continued From page 23 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R42) out of five residents reviewed for medication review the facility failed to develop a care plan to address the residents use of an anticoagulant. Findings include: Review of R42's clinical record revealed: 5/9/23 - R42 was admitted to the facility. 5/9/23 - A physicians order was written for R42 to receive an anticoagulant medication one tablet by mouth two times a day for blood clot prevention. 5/15/23 - An admission MDS assessment documented R42 received anticoagulant medication. 2/15/24 - A quarterly MDS assessment documented R42 received anticoagulant medication. Review of R42's care plans lacked evidence that care plan was created that addressed the residents use of an anticoagulant medication.	F 656	A. R42 is still present in the facility. A focus of risk for bleeding related to anticoagulant usage was added to the care plan. B. All residents on anticoagulant drugs have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to appropriately update the care plan to reflect the use of anticoagulant treatment. Education was provided to the staff related to the policy anticoagulants-clinical protocol and need to reference the interventions utilized for patients on anticoagulants in their care plan through in-service education. D. The audit will be conducted on 10% of patients weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved. The audits will be brought forward to QAPI for the next 3 months.	

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	085058	A. BUILDING _____ B. WING _____	C 04/11/2024

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F 656	Continued From page 24 During an interview on 4/9/24 at 1:25 PM E15 (Director of Reimbursement Services) confirmed the finding. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (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	F 657		6/3/24

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F 657	Continued From page 25 by: Based on record review and interview, it was determined that for four (R33, R45, R55, and R75) out of of twenty-three (23) sampled residents, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings included: 1. Review of R33's clinical record revealed: 7/31/20 - R33 was admitted to the facility. 4/9/24 - A review of quarterly care plan meetings for 12/13/23 and 3/6/24 lacked evidence of input from the Physician and the CNA. 2. Review of R45's clinical record revealed: 6/13/23 - R45 was admitted to the facility. 4/9/24 - A review of quarterly care plan meetings for 1/3/24 and 4/3/24 lacked evidence of input from the Physician and the CNA. 3. Review of R55's clinical record revealed: 8/24/22 - R55 was admitted to the facility. 4/9/24 - A review of quarterly care plan meeting for 12/20/23 lacked evidence of input from the Physician, nurse and the CNA. A review of the quarterly care plan meeting for 3/24/24 lacked evidence of input from the Physician and CNA. 4/10/24 9:25 AM - In an interview, E6 (CNA) stated that CNA's do not participate in care plan meetings, and they do not provide input. The "higher ups" meet with residents.	F 657	A. R33, R45, and R75 are no longer in the facility. R55 is still present in the facility. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to follow facility policy and procedures related to the policy care planning- interdisciplinary team. Education was provided to the staff related to the policy on care planning- interdisciplinary team through in-service education. The care conference was revised to include participation of the C.N.A and Attending Physician. (or all members of the IDT) D. The audit will be conducted on 20% of patient□s care plan meetings weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved. Results will be brought forward to QAPI for 3 months.	

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F 657	Continued From page 26 4/10/24 9:40 AM - In an interview, E7 (CNA) stated that when working on a different unit, she would ask to participate in resident care plan meetings. While not invited, E7 stated she would contribute. E7 stated she took it upon herself to participate in the other unit where E7 said she worked closely with the nurses. 4/10/24 1:02 PM - In an interview, E1 (NHA) stated that the medical provider participates by entering new orders. CNA's have contact with nurses all the time and provide input in this manner, but she acknowledged she has no way of proving CNA involvement. 4/10/24 2:07 PM - In an interview, E8 (CNA) stated that CNA's do not attend care plan meetings unless resident specifically requests that the CNA be present. CNA's are informed after the care plan meeting if there are changes. 4. Review of R75's clincal record revealed: 3/8/24 - R75 was admitted to the facility. 4/3/24 - A review of R75's care plan meeting lacked evidence of input from a CNA, dietary, activities, and the medical director. 4/10/24 1:02 PM - An interview with E1 (NHA) confirmed that the care plan meeting lacked evidence of the necessary members for input. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		6/3/24

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F 686	Continued From page 27 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for two (R24 and R57) out of four residents reviewed for position and mobility, the facility failed to turn and reposition the resident in accordance with professional standards of practice to prevent skin breakdown. Findings include: 1. Review of R24's clinical record revealed: 11/19/23 - R24 was readmitted to the facility with diagnoses including but not limited to hypoxic ischemic encephalopathy, anoxic brain damage and persistent vegetative state. 9/3/23 - An annual MDS assessment documented that R24 was totally dependent for turning and repositioning with two person physical assist. R24 had impairments on both sides for upper and lower extremities.	F 686	A. R24 and R57 are still present at the facility. B. All patients dependent on staff for turning and repositioning have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to follow physician orders to turn and reposition patients every two hours. Education was provided to the staff related to repositioning through in-service education. A Branden scale will be completed on all new admissions. D. The audit will be conducted on 10% of patients weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved. Results will be brought forward to the QAPI meeting for the next 3 months.	

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F 686	Continued From page 28 3/4/24 - A nursing Braden Scale documented R24 with a score of 10 (10 - 12 is considered high risk of skin breakdown). 3/14/24 - A care plan for R24 last included to turn and reposition at least every two hours while in bed. On the following dates and times, R24 was observed lying in bed on her back with the head of the bed upright at approximately a 45 - 60-degree angle while R24's wedges were observed in the room on a chair on 4/8/24: 8:22 AM, 9:35 AM, 10:38 AM, 11:40 AM, 12:15 PM and 2:01 PM. R24 was observed lying in bed on her back for four hours without any turning. 4/9/24 11:25 AM - During an interview, E8 (CNA) stated R24 sits up with a pillow under one of her shoulders. 4/9/14 11:45 AM - During an interview, E18 (CNA) stated R24 gets turned side to side every 2 hours using positioning wedges. The facility failed to ensure that R24 was turned and repositioned every two hours. 2. Review of R57's clinical record revealed: 10/11/22 - R57 was readmitted to the facility with diagnoses including but not limited to quadriplegia, spinal muscular atrophy, morbid obesity and tracheostomy. 7/13/23 - A quarterly MDS assessment documented that R57 was totally dependent for	F 686		

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F 686	Continued From page 29	F 686		

turning and repositioning with two person physical assist. R57 had impairments on both sides for upper and lower extremities.

12/1/23 - R57's care plan included to turn and reposition at least every two hours while in bed.

1/13/24 - A nursing Braden Scale documented R57 with a score of 11 (10 - 12 is considered high risk of skin breakdown).

1/18/24 - R57's quarterly MDS assessment documented that R57 had a documented BIMS score of 15, revealing an intact cognitive state and was dependent on staff to turn side to side.

On the following dates and times, R57 was observed lying in bed on her back with the head of the bed at approximately a 30-degree angle on 4/8/24: 8:20 AM, 9:37 AM, 10:41 AM, 11:50 AM and 12:16 PM.

R57 was observed lying in bed on her back for four hours without any turning.

4/9/24 11:25 AM - During an interview, E8 (CNA) stated R57 is turned to the left and right with pillows, one on each side.

4/9/14 11:45 AM - During an interview, E18 (CNA) stated that she has not seen R57 on her side, that she is always on her back. R57 has wedges for her legs, but she is always on her back.

4/10/24 12:49 PM - During an interview, R57 stated that the staff do not turn her from left to right, that she stays laying on her back.

The facility failed to ensure that R57 was turned

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F 686	Continued From page 30 and repositioned every two hours. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and review of facility documentation, it was determined that for one (R57) out of five residents reviewed for accidents, the facility failed to ensure residents were provided adequate supervision to prevent accidents resulting in harm. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 10/24/22. Findings include: Review of R57's clinical record revealed: 9/28/22 - R57 was admitted to the facility with diagnoses including but not limited to quadriplegia, spinal muscular atrophy, morbid obesity and tracheostomy. 9/28/22 - A care plan documented that R57 had a	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 31 potential for (actual falls) related to decreased mobility, poor safety awareness. 10/11/22 - R57 was readmitted to the facility. R57's fall risk evaluation was a score of 7, revealing a low fall risk. 10/17/22 - R57's admission MDS documented that R57 had a documented BIMS score of 15, revealing an intact cognitive state and was an extensive assist of two staff for transferring. R57 had impairments on both sides for upper and lower extremities. 10/19/22 11:10 AM - A facility incident report revealed that, "resident (R57) being transferred from shower stretcher to bed and slipped out of Hoyer lift." 10/19/22 11:50 AM - A facility progress note by E21 (former LPN) documented, "This nurse notified via phone by RT that resident had fallen from Hoyer lift to floor. Entered resident room to find her lying on the floor. 911 was initiated by RT. Supervisor notified. A&O x 4, c/o pain in back of head, denies blurred vision, denies LOC. Pressure applied to back of head r/t moderate bleeding. VSS, EMT and Paramedics arrived and took over care. Family (resident's mother) notified by phone." 10/19/22 1:00 PM - A physician note by E22 documented that, "Patient (R57) seen status post fall, patient had a fall and sustained a hematoma on the back of her head, with bleeding noted left-sided wound. Patient's neuro remained intact vital stable, patient reported 4 out of 10 pain in the back of her head. Patient was sent to ED for further evaluation and treatment."	F 689		

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F 689	Continued From page 32 10/19/22 untimed - A facility investigation report revealed a written statement by E26 (Former CNA) that documented, " ... I (E26) always look for help when their [sic] isn't any, I try. I got her (R57) in the air and tried transferring her feet to the bed. While turning her (R57) feet, she started to slip. I yelled help twice grabbing her feet to try to keep her in the air. By the time help came in ... she (R57) was on the floor ...". 10/19/22 untimed - A facility investigation report revealed a written statement by E27 (RT) had documented that E27 had returned to the nurse's station after a break and saw the curtains closed for R57's room. R57 returned to her room from the shower room and stuck her head through the curtain and asked E26 if she needed any help. E26 replied that she did not need any help. E27 replied that she would be sitting at the nurse's station. A few minutes later E26 and R57 screamed for help. E27 ran into the room and R57 was on the floor. 10/23/22 11:56 AM - A skin evaluation note by E21 documented, " ... Skin is warm dry and intact with exception of laceration with 4 staples to back left side of head related to previous fall ...". 11/8/22 - E26 was terminated from the facility. The Facility's 5 day follow up summary documented the root cause of the incident was that the lift was not completed by two employees; the outcome of the investigation was that 1. Staff member failed to ask for help with transfer 2. Sling was placed improperly; the system changes that were put in place were in-servicing and competencies on Hoyer lift for the nursing staff.	F 689		

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F 689	Continued From page 33 4/10/24 12:02 PM - An interview with R57 revealed that on 10/19/22 E26 was bringing her back to her room after getting a shower. E26 began to use the Hoyer lift to move her back to bed. R57 stated she asked E26 if the Hoyer lift was for a 2 person assist and that E26 stated there was no staff to help. R57 recalled being raised up in the air and then sliding out of the sling headfirst when she then hit her head and blacked out. 4/11/24 8:51 AM - An interview with E20 (former DON 2) revealed that E26 attempted to put R57 back to bed by herself resulting in the fall. E20 stated that she interviewed E26 who stated that she knew she should not have tried to use the Hoyer lift by herself. 4/11/24 11:16 AM - An interview with E1 (NHA) revealed that E26 was suspended pending an investigation and they did not return when she was terminated on 11/8/22. The facility audited the evaluations on the Hoyer lift for the residents. The facility had in-service training and physical return demonstrations with signatures for the trainings that began 10/19/22 and completed 10/24/22. The facility's in-service training documentation included: Mechanical lift use policy, How to use a Mechanical lift Caregiving series education, Safe Lifting and Movement of Residents policy, a Video on the use of a Mechanical lift and a Patient Lifts Safety Guide. Based on the review of the facility's thorough investigation, documented response, completion of in-service training and audits, staff interviews and no further incidents related to injuries using a Hoyer lift, R57's accident was determined to be	F 689		

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F 689	Continued From page 34 past non-compliance harm. The plan of correction was initiated on 10/19/22 and completed on 10/24/22. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 and E2 (DON).	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		6/3/24

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F 690	Continued From page 35 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R75) out of one resident reviewed for incontinence, the facility failed to respond to or provide services to restore bladder continence. Findings include: A facility policy titled, "Urinary Continence and Incontinence assessment and management" revised August 2022 stated "the staff will appropriately screen for, and manage individuals with urinary incontinence." ... "The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible." Review of R75's clinical record revealed: 3/8/24 - R75 was admitted to the facility. 3/8/24 4:39 PM - A admission bowel and bladder continence evaluation documented R75 was incontinent. 3/12/24 11:31 AM - Review of R75's bowel and bladder program evaluation revealed R75 was a candidate for scheduled prompted voiding. 3/14/24 10:02 AM - An admission MDS revealed that R75 is frequently incontinent and a toileting program was not attempted.	F 690	A. R75 is still present at the facility. B. All incontinent patients at the facility have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to appropriately provide services to restore continence for patients. Education was provided to the staff on urinary continence and incontinence □ assessment and management through in-service education. D. The audit will be conducted on 10% of residents weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved. These audits will be brought though QAPI for the next 3 months.	

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	085058	A. BUILDING _____ B. WING _____	C 04/11/2024

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F 690	Continued From page 36 4/9/24 10:37 AM - - During an observation R75 stated, "I need to use the bathroom." FM1 (Spouse) put the call bell on for assistance. E33 (CNA) entered the room at 10:50 AM. 4/9/24 11:00 AM - An observation of E33 providing care confirmed that R75 was incontinent and that E33 did not offer or assist R75 with the urinal. 4/9/24 12:00 PM - A review of the CNA task flow sheet revealed that E33 documented "not applicable" for "bed pan and urinal use" for R75. 4/9/24 2:46 PM- During an interview FM1 revealed, staff did not assist R75 with toileting when the call light was on. FM1 also said, [R75] was continent of bowel and bladder when E31 (COTA) from therapy assisted him with toileting. 4/10/24 8:52 AM - An interview with E32 (COTA) revealed R75 could voice when he has the urge to use the bathroom and had initiated the use of the bed pan and urinal for R75. 4/10/24 10:50 AM - An interview with E33 (CNA) and E34 (CNA) revealed R75 was not able to sustain continence. E33 and E34 confirmed when assigned to R75 the urinal or bed pan had not been offered to promote continence. 4/10/24 11:46 AM - During an interview E28 (RN) confirmed the admitting nurse does the bowel and bladder evaluation. E28 revealed R75 is more alert at this time, and his care plan should have been updated with this change. 4/11/24 8:15 AM - During an interview E31	F 690		

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F 690	Continued From page 37 (COTA) stated, "[R75] is able to verbalize the need to use the toilet." E31 revealed that R75 is encouraged to the use the bedpan and urinal during therapy. E31 said, "I do not think that direct care staff is following the recommendation." 4/11/24 8:30 AM - - During an interview E29 (Rehab. Director) stated, "I spoke with nursing on 4/10/24 and requested staff use the bedpan and urinal for [R75]." 4/11/24 11:11 AM - An interview with E30 (RN UM) confirmed that upon admission all residents are placed on a every two hour continence check to verify continence and that is considered the facilities "toileting program." 4/11/24 11:54 AM - A review of the CNA task flow sheet for R75 lacked evidence of a every two hour continence check on admission. The facility failed to provide care and services that promoted maintaining and/or restoring continence. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		6/3/24

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F 695	Continued From page 38 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R3 and R66) out of two residents reviewed for respiratory care,the facility failed to provide respiratory care consistent with professional standards of practice. For R3, the facility failed to ensure the canister and tubing for suctioning had been changed. For R66, the facility failed to ensure the oxygen tubing and humidifier bottle were labeled. Findings include: 1. 3/11/24 - R66 was admitted to the facility. 3/17/24 - An admission MDS documented R66 was cognitively intact and had diagnoses that included Chronic obstructive pulmonary disorder (COPD) and hypoxic respiratory failure unspecified. A facility policy titled "Oxygen Administration" revised October 2010 included "Oxygen tubing will be changed and dated weekly, refillable humidifiers will be dated and changed weekly, disposable humidifiers will be dated and discarded when empty." 3/12/24 - A physician order included 4L via nasal cannula to maintain oxygen saturation greater than 92%. 3/11/24 - 4/10/24 - Review of EMAR's lacked evidence that the oxygen tubing and the humidifier bottle were changed weekly. 4/7/24 and 4/8/24 - Several random observations	F 695	A. R66 and R3 are still present in the facility. All respiratory supplies including tubing and canisters were replaced, labeled, and dated appropriately. B. All residents with oxygen therapy needs have the potential to be affected by this deficient practice. Director of Respiratory will review and, if necessary, update the standard policy on disposable supplies concerning the routine changing and labeling of such items. C. A root cause analysis identified that the facility failed to follow physician orders and facility policy related to the labeling and changing of respiratory supplies. Respiratory and/or designee will provide training/ in-service for respiratory therapists and nurses on the updated policy regarding the routine replacement and labeling procedures for disposable supplies. Ensure competency assessments are completed on or by 4/25/24. D. Random audits will be conducted weekly on four patients to monitor compliance. Audits will be conducted at the rate of 4 residents weekly until 100% compliance is achieved for three consecutive audits. The audit will continue monthly for three months until 100% compliance is achieved and brought forward to QAPI.	

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F 695	Continued From page 39 revealed that the oxygen tubing and humidifier bottle was not labeled and dated. 4/8/24 9:20 AM - During an interview E11 (RN) confirmed that R66's oxygen tubing and humidifier bottle were not dated. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON). 2. Review of R3's clinical record revealed: 8/25/22 - R3 was admitted to the facility with diagnoses including but not limited to acute respiratory failure, difficulty swallowing and hypertension. 11/28/23 5:20 PM - A physician's order documented... "1. Tracheostomy care change oxygen tubing, canister and humidifier bottle one time a day every Monday and as needed." 4/7/24 10:08 AM - R3 was observed sitting in the wheelchair in her room, further observations revealed that R8's tracheal suction machine equipment had not been changed, the suction canister had thick secretions and had a date of 1/26/24 and tubing for the suction equipment was not dated. 4/8/24 12:34 PM - Day 2 observations revealed R3's tracheal suction machine equipment had not been changed and the canister contained the same thick secretions as observed and dated 1/26/24. 4/9/24 12:59 PM - During an interview and observation E13 (LPN) confirmed R3's suction	F 695		

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F 695	Continued From page 40 machine equipment had not been changed and the suction canister contained secretions and was dated 1/26/24. E13 stated, "I'm not sure why it has not been changed, but I will change it." The facility failed to provide R3 with respiratory care as required by a physicians order in changing tracheostomy care equipment routinely and as needed. These findings were reviewed at the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 695		
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 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.	F 756		6/3/24

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F 756	Continued From page 41 (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 for one (R42) out of five residents reviewed for medication review the facility failed to ensure pharmacist recommendations were reviewed by the attending physician. Findings include: The facility policy for MRR's last updated May 2019, indicated "The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. " 2/5/224 11:47 - A Pharmacist Consultant Note documented, "Medication Regimen Reviewed: Recommendations Made." Review of R42's 2/5/24 MRR revealed a lack of physician response to the recommendations to evaluate and consider discontinuing use of vitamin c and to consider switching timeframe of laxative.	F 756	A. R42 is still present in the facility. Pharmacy recommendation for R42 was reviewed to ensure signatures were in place. B. All residents have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to follow the policy on Medication Recommendation Review. Education was provided to the staff and physician on Medication Recommendation Review through in-service education. D. The audit will be conducted on 10% of patients weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved. Audits will be brought forward to QAPI for the next 3 months.	

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F 756	Continued From page 42 During an interview on 4/10/24 at 1:07 PM, E1 (NHA) confirmed the facility was unable to locate a physician response to the February 2024 MRR. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		6/3/24

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F 758	Continued From page 43 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R42) out of five residents reviewed for medication review the facility failed to complete AIMS testing every six months for a resident on antipsychotic medications. Findings include: The facility policy on psychotropic medication use, last updated July 2022 indicated, "Psychotropic medication is any medication that affects brain activity associated with mental processes and behaviors. Psychotropic medications are monitored with AIMS testing as required." Review of R42's clinical record revealed: 7/18/23 - A physicians order was written for R42	F 758	A. R42 is still present in the facility. An AIMS evaluation was conducted on this patient. B. All residents on antipsychotic medication have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to follow guidelines on the appropriate frequency of AIMS testing. Education was provided to the staff related to antipsychotic medication use through in-service education. D. The audit will be conducted on 10% of patients weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved. Audits will be brought forward to QAPI for the next 3	

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F 758	Continued From page 44 to receive an antipsychotic medication daily. 7/18/23 - R42 received an AIMS test assesment for side effects related to antipsychotic medication use. 7/2023 - A care plan for use of antipsychotic medications included the intervention for - AIMS testing per facility protocol. 4/10/24 - Review of R42's clinical revealed AIMS testing had not been completed for R42 in nine months. During an interview on 4/11/24 at 8:30 AM, E3 (ADON) confirmed the findings. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).	F 758	months.	
F 812 SS=E	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 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.	F 812		6/3/24

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F 812	Continued From page 45 §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 observation it was determined that the facility failed to ensure that all nourishment refrigerators were maintained in a sanitary condition and food is stored safely to prevent food-borne illness. Findings include: 1. 4/7/24 8:45 AM -The following was observed in the Reserve Unit nourishment refridgerator: -Boost dated 10/17/23. -Sandwich in green and white wrapper dated 2/21. -Brown paper bag unmarked. -Partially eaten pretzel salad undated. -Cheese doodles opened unlabeled. -Salad dressing dated 9/8/23. 4/7/24 9:47 AM - The above was confirmed and removed from the refridgerator by E38 (Supervisor). 2. 4/8/24 - The nourishment refrigerated adjacent to the small dining room in the Riverside unit had a large semi-dried spill of orange liquid on the middle and bottom shelves of the door, and the full-sized refrigerator located in that same dining room contained an undated unlabeled small plastic food storage bowl of leftover food. These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 and E2 (DON).	F 812	A. Two of five refrigerators had unlabeled or out dated food items in them. B. All residents at the facility with the capability to eat food by mouth have the potential to be affected by this deficient practice. C. A root cause analysis identified that the facility failed to appropriately label and store food brought the patients from outside visitors. Education was provided to the staffs on foods brought in by family/visitors through in-service education. D. The audit will be conducted on all refrigerators weekly for three weeks until 100% compliance is achieved and monthly for three months until 100% compliance is achieved. Audits will be brought forward to QAPI for the next 3 months.	