DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085034		C 04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HEALTHCARE & REHAB CTR	301 OCEAN VIEW BLVD LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from April 12, 2012 through April 25, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirty-five (135) residents. The survey sample totaled forty-nine (49) residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	**F 157** **It is the practice of this facility to immediately inform the resident; consult with the resident's physician and if known, notify the resident's legal representative when there is a change in physical, mental, or psychosocial status.** 1. Resident's R73 and R211 no longer reside at the facility. 2. Residents with changes in condition have the potential to be affected by this deficient practice. 3. (a) The Staff Developer will in-service Nursing Staff on the need to notify the physician with any change in a resident's condition. (b). Residents with changes in condition will be written on the 24 hour report sheet for review in clinical meeting. 7/10/12 4. The Director of Nursing and/or designee will perform random weekly audits of the resident's clinical record to evaluate whether the physician has been notified regarding the change in condition. The results of the audit will be forwarded to the QA & A committee for their review. The QA & A committee will determine the need for further action plans. 7/10/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
NHA	ADMINISTRATOR	5/21/12

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 157	Continued From page 1 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy and procedures it was determined that the facility failed to notify the physician of a change in condition for two (R73 and R211) out of 49 sampled residents and failed to notify the physician. Findings include: Review of the facility's policy and procedure for "Notification of Resident Change in Condition" revealed "3. Related to medical care, the charge nurse will notify the resident, the resident's physician and the legal representative when there is: b. significant change in condition (including medication & treatment orders)". Cross refer F309 #1 1. R73 was admitted to the facility on 1/20/12 with diagnoses, documented on the admission order sheet, that included hypercapnic (an increased amount of carbon dioxide in the blood. Taber's Cyclopedia) respiratory failure, hypomagnesemia, diabetes, Parkinson's disease, hyperlipidemia, iron deficiency, B-12 Deficiency, systemic hypertension, chronic pain, history of congestive heart failure, obesity, obstructive sleep apnea, depression, umbilical hernia, and chronic leg swelling.	F 157		

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F 157	Continued From page 2	F 157		
	Review of R73's nurses notes for 2/3/12 at 1:20 PM E16 (LPN) documented at 7:45 AM, R73 "unable to lift arms up to take own medication. Placed medication into resident's mouth and held drink for him". The chart lacked evidence that a thorough assessment was completed for this resident and lacked evidence of physician notification.			
	2. Cross refer F309#2 On 12/6/11 at 6:10 AM R211 had an unwitnessed fall that required neurological assessments to be completed.			
	R211's Neurological check sheet stated R211's motor strength for all his extremities were assessed as being normal until 12/6/11 at 7:10 AM. On 12/6/11 at 7:10 AM R211 was assessed that his bilateral extremities were "weak" (this was a documented decline from his earlier assessment). From 8:40 AM and throughout the rest of the completed assessments R211's motor strength in all his extremities were documented as "weak" (this is a continuous documented decline in his condition). There was no evidence that the physician was notified of R211's decline in motor strength.			
	An interveiw and review of the documentation was completed with E6 (RN) who confirmed there was no evidence that the physician was notified of R211's decline in motor strength.			
	The above findings were reveiwed with E2 (DON) and E3 (ADON) on 4/24/12 at 12:10 PM.			
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		

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F 166	Continued From page 3 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R256) out of 49 sampled residents the facility failed to make prompt efforts to resolve a resident's concern. Findings include: 1. During an interview on 4/13/12 at 10:54 AM and follow-up interview 4/19/12 at 12:30 PM R256 made the surveyor aware that he did not have his lower dentures and that they had been missing for a "few months". He further revealed that he had made staff aware. An interview on 4/20/12 at 10:33 AM with E9 (LPN), the nurse who usually cares for R256 on the day shift, revealed that she did not know anything about the resident having missing dentures. Review of the Admission Assessment dated 7/18/11 indicated he had full upper and lower dentures. A Readmission Assessment post hospitalization dated 11/2/11 indicated upper dentures but that lower dentures were "missing". An interview on 4/20/12 with E10 (social worker) and E8 (charge nurse) revealed that they were unaware of the missing dentures. E10 and E8 confirmed after review of the chart that the resident had full dentures when he was admitted	F 166	F 166 **It is the practice of this facility to resolve grievances the resident may have in prompt manner.** 1. Resident R256 no longer resides in the facility. 2. Residents that are readmitted to the center have the potential to be affected by this deficient practice 3. (a) The Staff Developer or designee will in-service Nursing Staff on the need to complete a facility concern form when a resident reports items missing following a readmission to the facility. (b). A concern form will be initiated when a Resident reports a missing item 7/10/12 4. Residents readmitted to the facility will have their Readmission Assessment audited weekly by the Unit Manager for any missing items that are indicated on the assessment to evaluate whether a Resident Concern log has been generated. The results of the audit will be forwarded to the QA & A committee for their review. The QA & A committee will determine the need for further action plans. 7/10/12	

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F 166	Continued From page 4 and now only had upper dentures. It was further revealed that staff should have identified that the resident was missing dentures and a consult for new dentures would be completed.	F 166		
F 174 SS=B	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that residents on the Henelopen wing had access to a telephone in a private area to prevent calls being overheard. Findings include: 1. During stage I of the survey interview screening questions resident(s) verbalized that there was no privacy when on the telephone. An interview on 4/20/12 with E7 (unit manager) revealed that there was a phone in the dayroom next to the nurses' station that the residents could use. Otherwise, the resident or their family could pay to have a personal phone in their room. It was further revealed that residents in the rehabilitation wing of the unit have phones in their rooms. Observations of the dayroom on 4/20 and 4/23/12 revealed a wall phone right next to the door at the entrance of the room. Residents were noted to be in the room at times to eat and socialize. Staff were noted to be in the room at times to work on	F 174	F 174 **It is the practice of this facility to provide reasonable access to the use of a telephone where calls can be made without being overheard.** 1. The facility will provide a portable phone for the resident's to utilize on the Henelopen wing. 6/1/12 2. All residents on the Henelopen wing who utilize the phone in the day room have the potential to be affected by this deficient practice 3. The residents on the Henelopen unit will be notified of the availability and operation of the portable phone system. 6/1/12 4. The Unit Manager and/or designee will randomly solicit the resident's to evaluate whether they feel they have privacy to make phone calls. The results of these solicitations will be forwarded to the QA & A committee. The committee will determine the need for further solicitations. 7/10/12	

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F 174	Continued From page 5 the computers and do charting. Interview with E1 (Administrator) on 3/25/12 confirmed that although this room could be a private place if no other residents or staff were using the room it did not provide residents private access to a telephone when other residents and staff were using the room.	F 174		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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F 225	Continued From page 6 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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, interview and review of the facility's policy and procedures it was determined that the facility failed to immediately report to the State Agency an allegation of neglect for one (R73) out of 49 sampled residents and failed to report an allegation of verbal abuse for one (R247) out of 49 sampled residents. In addition, the facility failed to conduct a thorough investigation for the above allegations. Findings include: The facility nursing policy, titled Incident Report revised Feb 2009, page 2, paragraph 1," Procedure for Alleged Abuse/Neglect: According to Federal Regulation, all resident incidents of Alleged Abuse, Neglect, Mistreatment, financial exploitation, misappropriate of resident property, and injury of unknown origin must be reported immediately (within 8 hours) to the Administrator of the facility, DON, State Survey and Certification Agency. A Final Report is to be completed and submitted to the Administrator, DON and the State Survey and Certification Agency within five (5) working days of the incident..." According to the facility's Investigation Protocol	F 225	F 225 **It is the practice of this facility to report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin in accordance with State Law through established procedures and to thoroughly investigate the alleged violations and report the findings in accordance with State Law.** 1. Residents R73 and R247 no longer reside at the facility. 2. All residents who have alleged violations involving abuse, neglect, mistreatment, financial exploitation, misappropriation of property and injury of unknown origin have the potential to be affected by this deficient practice. An incident occurrence report and an investigation was initiated for Resident 73 and Resident 247. 3. (a). The Staff Developer will in-service the nursing staff on the generation of an Incident report and thorough investigation with alleged violations of abuse, neglect, mistreatment, and injuries of unknown origin. (b). Incident Occurrences and investigations will be reviewed at the facility's morning meeting to evaluate compliance with proper reporting procedures. (c). The Assistant Director of Nursing will maintain a log of incident reports and will investigate allegations of neglect and report the findings in accordance with State Law. 7/10/12	

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F 225	Continued From page 7 revised date October 2009, page1, " Procedure: The facility will assure all alleged violations involving abuse, neglect, mistreatment, financial exploitation, misappropriation of resident property and injury of unknown origin per the Federal regulations will be reported immediately (within 8 hours) to the Administrator/Designee and State." Page 2, paragraph 2 "Documentation must provide evidence that alleged violations are thoroughly investigated (i.e., summary report, copies of record, summary witness statements, etc.)". 1. Cross refer F309 example #1 On 2/3/12 the nurses notes documented that R73 complained of not feeling well and he could not lift his arms. The nurse documented she put R73's medications in his mouth and held the drink for him. An interview with E16 (LPN) confirmed R73 was not feeling well but she neglected to assess him other than he could not lift his arms nor did she communicate this with E18 (CNA). An interview with E18 revealed that R73 told her he was not feeling well so she assisted him with his breakfast. E18 came back to R73's room to find him sitting on the side of the bed. R73 told E18 he needed to go to the bathroom. E18 assisted R73 as he ambulated using his walker to the bathroom. E18 left R73 in the bathroom to have a bowel movement. R73 called for E18 and stated that he was dizzy, short of breath and needed E18 to get a nurse. E18 neglected R73 by leaving him alone and unsupervised to find E16 who was in another resident's room. E18 neglected to return to R73 who was sitting on the	F 225	4. The Assistant Director of Nursing and or designee will audit weekly Incident Reports and Investigations to evaluate whether compliance with proper reporting procedures has occurred. Results of these audits will be forwarded to the QA & A committee. The QA & A committee will determine the need for further audits and or action plans.	7/10/12

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F 225	Continued From page 8 toilet unsupervised until E16 called for help. E16 found R73 had fallen off the toilet and he was alone, unsupervised, wedged between the sink and the commode. Review of this allegation of neglect with E3 (ADON) on 4/23/12 at 11:30 AM confirmed the facility failed to investigate this allegation of neglect and failed to notify the state agency. The finding were reviewed with E2 (DON) and E3 (ADON) on 4/24/12 at 1210 PM. 2. R247 an alert and oriented resident was admitted to the facility on 2/13/12 post hospitalization for repair of a right ankle fracture. Admitting diagnosis included history of epilepsy, seizures, hepatitis. The resident had a physician ' s order dated 2/13/12 for Levetiracetam 1,000 mg (milligram) comparable to Keppra 1,000 mg 1 tablet by mouth 2 times a day for seizures. According to the MAR (Medication Administration Record) for March 2012 the medication was scheduled to be given at 6:00 AM and 6:00 PM. R247 had care plan interventions dated 2/26/12 that included give seizure medication as ordered by doctor, monitor/document side effects and effectiveness. Care plan goal was that the resident will be free/remain free of seizure activity through review date. On 3/22/12 at approximately 7:30 AM R247 's son complained to E8 (nurse supervisor) that his mother told him that the nurse E28 (11-7 RN) gave his mother her seizure medication Keppra at 4:30 that morning and that the medication was due to be given at 6:00 AM. He stated that this is	F 225		

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F 225	Continued From page 9 the 4th time that he has had to explain this and that the physician sent a certified letter to the facility informing them that the seizure medication has to be given 12 hours apart. R247's son also told E8 that at 4:30 AM this morning E28 told his mother you either "take it (the medication) now or you won't take it at all", and that she would not be back to give it. The resident explained to E28 that is was too early for her to take the medicine that her neurologist told her it had to be given every 12 hours. An interview with E8, (RN supervisor) on 4/24/12 at approximately 1:30 PM confirmed that she did recall R247's son coming to the desk on 3/22/12 at approximately 7:30 AM to discuss the concern. E8 also confirmed that she completed a facility Resident Concern/Complement Form and that she also informed E1 (administrator) and E2 (director of nursing) of the concern that same morning. E8 stated that when there is a resident concern it is the practice to contact the ADON (assistant director of nursing) to determine how to proceed. E8 stated the next day, (3/23/12) she observed E3 (assistant director of nursing) speaking with R247's son. An interview with E3 was conducted on 4/24/12 at 12:56 PM. E3 was asked to review the Resident Concern/Complement Form. The form was dated 3/22/12. E3 stated that she recalled talking to R247's son for approximately 3 hours that day and thought the date was 3/23/12. E3 was then asked to review the time the incident was reported to the Division of Long Term Care Residents Protection. E3 confirmed that the report was submitted on 3/23/12 at 12:59 PM. When asked about the delay in reporting the	F 225		

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F 225	Continued From page 10 allegation of verbal abuse, E3 stated she thought everything happened the same day 3/23/12, meaning the incident, concern voiced to E8 and E3 and discussion with R247 's son. The actual date the allegation of verbal abuse was reported to facility staff was 3/22/12 approximately 7:30 AM which was confirmed during staff interview with E8 on 4/24/12. The incident documentation lacked evidence that the resident R247, and R247's son were interviewed as part of the facility's thorough investigation. Further, the facility failed to immediately (within 8 hours) report the allegation of verbal abuse to the state agency. The incident was not reported for 29 hours after the allegation of abuse was made.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility failed to ensure that the facility's policy and procedure for investigation, reporting and protection were implemented. The facility failed to identify an allegation of verbal abuse, and failed to protect the resident from the accused for the first 24 hours after becoming aware of the incident for one (R247) out of 49 sampled residents. Findings include: Cross-refer F225 Example 2	F 226		

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F 226	Continued From page 11 On 3/22/12 at approximately 7:30 AM R247's son complained to E8 (nurse supervisor) that his mother told him that E28 (11-7 RN) gave his mother her seizure medication Keppra at 4:30 that morning and that the medication was due to be given at 6:00 AM. R247's son also told E8 that at 4:30 AM this morning (3/22/12) E28 told his mother you either "take it (the medication) now or you won't take it at all", and that she would not be back to give it. The resident explained to E28 that is was too early for her to take the medicine that her neurologist told her it had to be given every 12 hours. An interview with E3 (ADON) on 4/24/12 at 12:56 PM confirmed that the incident did occur but she was not sure if the incident was on 3/22/12 or 3/23/12. E3 reviewed the Resident Concern/Compliment Form completed by E8, dated 3/22/12. E3 did recall meeting with R247's son for approximately 3 hours and thought that was the same day of the incident. A review of the Resident Concern/Complement Form dated 3/22/12 revealed R247 's spouse and son were contacted on 3/23/12 and notified of follow-up. Review of the Incident Report for Web Intake, revealed that the incident of alleged abuse was submitted on 3/23/12 at 12:59 PM more than 29 hours after the facility staff was made aware of the allegation of verbal abuse. When asked if E28 was removed from caring for R247, E3 stated that the nurse E28 was suspended. A review of the staffing sheet for 3/22/12 for the 11-7 shift revealed that the accused E28 did work during the 24 hours following the allegation of verbal abuse and was	F 226	F226 **It is the practice of the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.** 1. Resident R247 no longer resides at the facility. 2. Any reported allegation of verbal abuse is subject to this deficient practice. 3. (a) The Assistant Director of Nursing has in-serviced all Nursing Administration, Dept Heads and Weekend Supervisors on the existing policy and procedure for proper reporting of allegation of verbal abuse. (b) The Staff Developer will in-service Nursing Staff on the existing policy and procedures for proper reporting of allegations of verbal abuse. 5/15/12 7/10/12 4. All incident reports and concern forms will be reviewed in morning meeting to evaluate timeliness in reporting alleged verbal abuse. Results of these audits will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 226	Continued From page 12 not removed from the care of the resident until after that date. On 3/28/12 the facility submitted a follow-up for the Incident Report for Web Intake substantiating the allegation of verbal abuse by E28. The facility failed to follow nursing policy, titled Incident Report revised date Feb 2009. page 2, paragraph 1, " Procedure for Alleged Abuse/Neglect: According to Federal Regulation, all resident incidents of Alleged Abuse, Neglect, Mistreatment, financial exploitation, misappropriate of resident property, and injury of unknown origin must be report immediately (within 8 hours) to the Administrator of the facility, DON, State Survey and Certification Agency ". Additionally, a review of the facility's Investigation Protocol dated October 2009 revealed the facility failed to follow Investigator Responsibilities paragraph 2 "Establish and enforce an environment of protection during and after investigation. As appropriate to incident, this may include suspending employee pending completion of investigation or temporarily assigning staff to another area. Review incident report for completeness. Provide feedback to staff when necessary. " The facility failed to follow the policy and procedure to thoroughly investigate the incident of alleged verbal abuse by E28 as the file lacked evidence of interview of R247, an alert and oriented resident and R247 's son who communicated the concern.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 13 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to provide care in a manner that promoted dining with dignity. Observations revealed a pattern of tray deliveries, setting up residents and feeding residents that failed to promote dignity. Findings include: 1. During lunch observation on 4/12/12 at 12:10 PM revealed R20 in her room eating lunch. Her roommate, R146, who needed assistance with eating, was in bed with no meal tray. At 12:16 PM the same observation was made. At 12:25 PM an aide entered the room with a tray for R146 and set her up to begin feeding her. E146 was required to watch her roommate eat lunch while she waited for someone to feed her. During lunch observation on 4/23/12 at 12:01 PM revealed R20, again in her room eating her lunch while her roommate, E146 was sitting in her wheelchair waiting for her food to be delivered and fed to her. E146 was required to watch her roommate eat her lunch while she waited for someone to deliver her food and feed her. Lunch was brought to E146 at 12:09 PM and the CNA began feeding her at 12:11 PM. An interview on 4/25/12 at 10:45 AM with E19 (aide) in the presence of E7 (unit manager) revealed that the aides pass out all the trays to	F 241	F 241 **It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.** 1. Resident R20 and resident R146 are now both served meal trays at the same time. While R20 is eating independently and, R146 is being assisted. 5/15/12 2. (a) Any roommates where one resident requires assistance while the other does not have the potential to be affected by this deficient practice. E19 was in-serviced on the proper techniques for promoting dining with dignity. (b) All residents who eat in the dining rooms have the potential to be effected by this deficient practice. 5/15/12 3. The Staff Developer and/or designee will in-service C.N.A.'s on the proper techniques to promote dining with dignity related to residents eating at the same time. The Staff Developer and/or designee will in-service C.N.A.'s on the proper use of gloves during meal service. 7/10/12 4. Nursing Administration will make random audits weekly of those roommates who eat together to evaluate that both are being served at the same time. Nursing Administration will also perform random audits weekly to evaluate that proper use of gloves during meal service. The results of these audits will be forwarded to the monthly QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans 7/10/12	

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F 241	Continued From page 14 residents who can feed themselves before they pass the trays to residents that need to be fed. E7 confirmed that in the future both residents would be served lunch at the same time. 2. During the lunch observation on 4/12/12 at approximately 11:46 AM in the main dining area E20 (aide) was observed wearing gloves while delivering food to residents, picking up food tickets and delivering drinks to residents. During the same lunch observation as above E21 (aide) were also observed wearing gloves while delivering food and drinks to residents and picking up the lunch tickets. Surveyor: Horsman, Cindy 3. During a lunch observation on 4/23/12 at approximately 11:35 AM in the Lewes activity room, revealed E 23 (CNA) was observed wearing gloves while delivering drinks to the residents. There was no indication for the use of gloves while delivering meals and setting up residents to eat their lunch. On 4/25/12 at 9:20 AM review of the observation was made withE14 (Food Service Director). Findings reviewed with E4 (COO RN), E1(administrator), E2 (DON) and E3 (ADON) on 4/25/12 at approximately 1:30 PM.	F 241		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the	F 244		

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F 244	Continued From page 15 grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of the resident council minutes, interview and the survey teams test tray analysis, it was determined that the facility failed to act upon the residents' grievances concerning the temperature and palatability of food in the facility. Findings include: Cross refer F364 Review of the last six months of the resident council minutes revealed there were consistent food complaints. On 4/13/12 an interview was completed with R16 and R12 that revealed residents in the facility continued to have complaints that the food was cold and did not taste good. On 4/19/12 test trays consisting of pureed, regular and mechanical soft foods were tested. The survey team found the food to be cold and not palatable. The facility failed to resolve the residents grievance concerning the temperature and palatability of the food.	F 244	F 244 **It is the practice of the facility to listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility** 1 (a). The cooking staff have been in-serviced to the proper techniques to prepare palatable pureed foods (b). The Dietary staff has been in-serviced on the proper temperatures of food delivery. 5/15/12 2 Residents on pureed diets are at risk for this deficient practice 3 (a). The Food Service Director will in-service the Cooking staff on the proper techniques to prepare palatable pureed foods (b). The Food Service Director will in-service the kitchen staff on the proper temperatures of food delivery. 7/10/12 4 (a). The Food Service Director weekly will test a "test tray" to evaluate the consistency of the pureed diet foods. (b). The Food Service Director weekly will test a "test tray" for the proper temperatures and palatability (c). The results of these audits will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246		

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F 246	Continued From page 16 preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview it was determined that the facility failed to provide one (R106) out of 49 sampled residents with the ability to make food preferences. Findings include: 1. R106 was admitted to the facility on 3/27/12. During an interview with the resident on 4/12/12 he stated that he had not been able to make meal choices but was aware that other residents were able to make meal selections. It was noted during the survey that some residents in the facility were provided with meal selection sheets. An interview on 4/23/12 with E11(unit clerk) revealed that residents who were able to make meal selections were provided with a selection sheet to fill out once a week. She further stated that this was for lunch and dinner as breakfast was a buffet on this unit. An interview on 4/24/12 with E12 (nurse) revealed that R106 should be getting a menu selection form. E12 called to the dietary department and was told that although they pass out the selection forms none had been returned by this resident. An interview with the resident again on 4/24/12 confirmed he still had not had a meal selection form since admission.	F 246	F 246 **It is the practice of the facility to provide the resident the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.** Resident R106 is now filling out the meal selection forms. 5/15/12 Residents who are admitted with the capability to make meal selections have the potential to be affected by this deficient practice. The Unit Manager and/or designee will interview new admissions with the capability to make meal selections to evaluate whether meal selection forms are being completed. 7/10/12 The results of these interviews will be reported to the QA & A committee. The committee will determine the need for further action plans. 7/10/12	

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F 246	Continued From page 17 An interview on 4/24/12 at 1:45 PM with the E7 (unit manager) confirmed that R106 was not filling out a menu selection and stated she would ensure in the future that the resident would be assisted in completing the meal selection form.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	F 272 **It is the practice of the facility to conduct initial and periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity.** R 46's MDS was submitted 5/15/12 All Resident's having MDS's are at risk for this deficient practice (a). When the Social Service Director is absent from work, in her absence Section Q will be completed by the MDS Coordinator. 7/10/12 The MDS coordinator or designee will do random weekly audits to evaluate whether section Q has been completed. The results of these audits will be forwarded to the QA &A Committee. The QA &A committee will determine the need for further audits and or action plans. 7/10/12	

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F 272	Continued From page 18 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to comprehensively and accurately complete a resident assessment for one (R46) out of 49 sampled residents related to discharge planning. Findings include: R46 was admitted to the facility on 1/6/2012. Review of the initial Social Services Assessment dated 1/6/12 documented that a discharge plan for R46 included a potential for long term care or assisted living placement. Review of the initial Minimum Data Set (MDS) assessment dated 1/12/12 documented the resident was cognitively impaired for daily decision making and "Section Q-Participation in Assessment and Goal Setting" of the assessment was not comprehensively assessed with Sections Q300, Q400, and Q500 with no information. An interview with E22 (Registered Nurse Assessment Coordinator) on 4/24/12 at 1 PM revealed that Section Q of the MDS assessment was to be completed by the social service's staff and in her absence, she should have completed this section.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 19 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy and procedures it was determined that the facility failed to develop care plans for one (R47) out of 49 sampled residents. Findings include: The facility's policy and procedures titled "MDS/Care Plan Process" revealed "3. An interdisciplinary plan of care will be prepared for each resident within seven (7) days of completion of the MDS or at the latest, within twenty-one (21) days of admission or re-admission if significant change has occurred..."	F 279	F 279 **It is the practice of the facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.** 1. R 47 no longer resides at the facility 2. Resident's needing care plans for displays of agitation/anxiety and insomnia are at risk for this deficient practice. E 8 was in-serviced on the need to develop care plans for those residents displaying agitation/anxiety and insomnia 5/15/12 3. The Staff Developer and or designee will in-service nursing staff on the generation of care plans for those residents who display agitation/anxiety and or insomnia. 7/10/12 4. Random weekly audits will be done by the Unit Managers and or designee to evaluate whether care plans are developed on those residents who display agitation/anxiety and or insomnia. The results of the audit will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 279	Continued From page 20 On 2/21/12 R47 had a physician order for Lorazepam 0.5 mg one by mouth every 4 hours as needed for agitation and for Restoril 15 mg take one by mouth at bedtime for insomnia. Review of R47's Medication Administration Record revealed she was administered the Restoril on 4/10-4/14, and 4/18/12. R47 was also administer the Ativan on 4/12, 4/13, 4/14, and 4/15/12. Review of R47's care plans with E8 (RN) at 9:09 AM on 4/19/12 confirmed the facility failed to develop care plans for R47's displays of agitation/anxiety and insomnia.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure 2 (R73 and R211) out of 49 sampled residents were provided the necessary care and treatment in accordance with their comprehensive assessment and plan of care. R73 told the facility he could not lift his arms and was not feeling well. Additionally R73 required assistance with	F 309		

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F 309	Continued From page 21 breakfast and also complained to a staff member of shortness of breath and dizziness. The facility failed to ensure a thorough assessment was provided, failed to identify this change in condition and failed to communicate R73's complaints and change in condition to the physician. R73 was left unsupervised on the toilet and fell becoming wedged between the toilet and the sink. While being assessed post fall R73 went into respiratory failure CPR (Cardiopulmonary Resuscitation) started, 911 called and he was transported to the hospital. R211 had a fall and the facility failed to complete all his post fall neurological assessments even when they documented he had a decline in muscle strength. The facility also failed to follow the plan of care to monitor the vital signs every shift for forty-eight hours and to notify the physician with results. Findings include: 1. R73 was admitted to the facility on 1/20/12 with diagnoses, documented on his admission order sheet, that included hypercapnic (an increased amount of carbon dioxide in the blood. Taber's Cyclopedia) respiratory failure, hypomagnesemia, diabetes, Parkinson's disease, hyperlipidemia, iron deficiency, B-12 Deficiency, systemic hypertension, chronic pain, history of congestive heart failure, obesity, obstructive sleep apnea, depression, umbilical hernia, and chronic leg swelling. R73's admission assessment documented he was 5 foot 10 inches weighing 357 pounds. On 1/20/12 R73 signed the facility's advance directive sheet witnessed by the physician for "No code meaning a-do not use CPR or attempt resuscitation." The form stated "A DNR order has no effect prior to circulatory or respiratory	F 309	F 309 **It is the practice of the facility to provide the necessary care and services to each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.** 1. R 73 and R 211 no longer reside at the facility. 2. (a.) All Residents with changes in condition are at risk for this deficient practice. (b). A house wide sweep of requests for "do not resuscitate" was completed by Nursing Admin to evaluate whether those Resident's had a current written order. 4/19/12 3. (a). The Staff Developer or designee will in-service the nursing staff on the need to notify the MD with resident's changes in condition. (b). The staff developer or designee will in-service the nursing staff on the guidelines for neurological checks and to notify Physician if any changes in condition. (c). Resident's with changes in condition will be discussed in morning clinical meeting to evaluate whether MD notification is applicable. (d).Code status is reviewed on new admissions in morning meeting for appropriate documentation. 7/10/12 4. Results of these audits will be forwarded to the QA &A Committee for their review. The QA Committee will determine the need for further audits and or action plans. 7/10/12	

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F 309	Continued From page 22 failure. The resident will continue to be treated for his or her illness and made as comfortable as possible. On 1/23/12 R73 had a physician order for "DNR per code status sheet" that was signed by the physician on 1/23/12. Review of R73's care plans initiated 1/30/12 revealed R73 had care plans that included: 1.The Resident is at risk for falls related to potential for orthostatic hypotension, medications, and diagnoses with interventions that included: -Assist resident with transfers, toileting, and other ADLs as indicated for safety. -Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 2. ADL (activity of daily living) self care performance deficit r/t general weakness with interventions that included: -Set-up supplies and encourage resident to do as much of care as possible. -Provide supervision, cues and prompting as needed. Allow extra time to complete tasks. Monitor for fatigue and allow for rest periods as needed. 3. The resident has altered respiratory status related to history of OSA (Obstructive Sleep Apnea), CHF(Congestive Heart Failure), and COPD (Chronic Obstructive Pulmonary Disease) with interventions that included -Monitor for s/sx of respiratory distress... -Monitor/document/report abnormal breathing patterns to MD... Review of R73's nurses notes for 2/3/12 at 1:20	F 309		

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F 309	Continued From page 23 PM E16 (LPN) documented at 7:45 AM, R73 "unable to lift arms up to take own medication. Placed medication into resident's mouth and held drink for him". The chart lacked evidence that a thorough assessment was completed for this resident and lacked evidence of physician notification. During an interview with E16 on 4/20/12 at 2:30 PM, revealed she did not do an assessment on R73 when he stated he could not lift his arms and did not feel good. E16 continued to state she put the medications in R73's mouth and held the drink for him. E16 did not communicate with the CNA regarding R73's complaints. An interview with E18 (CNA), on 4/22/12 at 9:00 AM, revealed she went into R73's room and found him sitting on the side of the bed. R73 told her he was not feeling well but needed to go to the bathroom. E18 stated she knew he wasn't feeling well because she had to give him a little help with his breakfast. E18 stated she asked R73 if he wanted to use the wheelchair or walker. R73 said he wanted to use the walker so kept walking a few steps at a time and stopped and rested until he was in the bathroom. E18 stated R73 said he wanted privacy so he could have a bowel movement. E18 told him she would be in his room making his bed. When R73 was done or if he needed something he could just call as E18 was right outside the bathroom door. After a few minutes E18 stated she heard "Miss". E18 went into the bathroom and R73 told her he was dizzy and short of breath. Go get a nurse. E18 did not use the call bell she left R73 alone on the toilet and found E16 (LPN) in another resident's room and told her that R73 was dizzy and short of	F 309		

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F 309	Continued From page 24 breath. E18 stated after leaving E16 she was stopped in the hallway talking. The nurses notes, dated 2/3/12, continued to document that at 9:45 AM a CNA approached E16 stating that the resident was on the commode and had complained of shortness of breath. E16 entered the room a few minutes later to find R73 had fallen off the toilet and was on his side wedged against toilet and sink. Review of the nurses notes for 2/3/12 (late entry 2/7/12) at 1:00 PM revealed E12 (LPN) documented she was called to R73's room to check R73 on the floor by the aid. R73 was on the floor wedged between the toilet and sink. He denied hitting his head. R73 requested to help him up off the floor. Stated he was not hurt just help me up. We were unable to get him out where he was wedged. He was too heavy. Additional help was called. R73's skin was cool and clammy and diaphoretic. R73 stated "just pull my arm" R73 was pulled to a sitting position but couldn't straighten legs due to position of door jam. Laid him back down again and tried to reposition sat him back up to sitting position but unable to move much. R73 was laid back down on his side. R73 continued to be diaphoretic. Additional people arrived to help move R73. A sheet was placed under him to attempt to slide him. He started breathing heavier and became anxious then lethargic but aroused easily answered appropriately when questioned. E15 (MD) arrived to assess and help. The blood sugar was taken and was 116. R73's blood pressure was taken and the physician requested to give the glucagon. R73 became less responsive. E15 (MD) requested 911 be called.	F 309		

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F 309	Continued From page 25 R73 breathing became more labored and MD requested suction machine off cart. While getting machine E12 heard a code being called came back to room observed CPR being initiated. Soon after E12 observed 911 team arriving. The nurses notes, dated 2/3/12, continued to document R73 was showing signs of respiratory distress, with an oxygen saturation of 84%. E16 sent the aide to get oxygen. E17 asked about R73's code status, E16 stated she was unsure and went to check the chart. E15 (MD) was at the nurse's station, E16 asked E15 to evaluate R73. E15 requested a blood sugar check that was 116. 911 was called at approximately 10:00 AM. The facility called a "Code Blue" and started CPR. On 4/20/12 at 2:30 PM, interview with E16 (LPN) confirmed she was finishing up a dressing and went to the bathroom where she found R73 on the bathroom floor alone with no clothes on laying on his side wedged between the toilet and the sink. E16 went to the door and called for help. The nurses notes, dated 2/3/12, documented that E16 immediately recruited E17 (LPN) to assist as well as the assistance of two of the aides. On 4/22/12 at 9:00 AM, interview with E18 (CNA) revealed that E18 heard E16 yell from R73's room that R73 was on the floor. E18 stated she went in to help as R73 had fallen off the toilet and was wedged between the sink and the toilet. (The area between the toilet and sink measured 18 inches). E15 (MD) documented on 2/3/12 in R73 's chart	F 309		

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F 309	Continued From page 26 that he was informed that another physician's resident had fallen off the toilet. E15 went to evaluate R73 who was in distress and complaining of shortness of breath. His vital signs were 200/100, heart rate of 109 and respirations of 30. R73 then began thrashing about, accu check was performed and blood sugar was 116 glucagon times one was given. R73 became slightly less responsive to voice and stimulus and eventually started frothing at the mouth and respirations ceased. R73 was placed on his side and throat cleared. R73 took a deep breath and eyes rolled back in his head secondary to acute... and sudden unresponsiveness. No chart was available to determine code status. CPR was started and oxygen via Ambu bag provided. Eventually after approximately 15 minutes 911 arrived. CPR in progress/maintained without heart rate or pulse. Rechecked accu check and blood sugar was 123 after glucagon . Pt placed on board for transfer when EMT arrived patient transferred to (name of hospital) emergency department. Pt was still without heart rate and respirations and CPR continued. Pt was unresponsive for a total 20 to 25 minutes. EMT was informed upon their arrival of down time. The ER was called and made aware of code status. On 4/20/12 at 11:20 AM, E15 (MD) was interviewed who stated the staff stated they could not find R73's chart. He thought he was assessing a resident for a fall. While he was talking to and assessing the resident, the resident went into respiratory failure. This resident was not his patient he was the patient of another physician. When he asked the staff about the resident he was told the resident (R73) was	F 309		

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F 309	Continued From page 27 diabetic and had circulatory problems. E15 continued to state he was not sure if R73 was in a chronic or acute state. Due to R73's fall he was treated as being in an acute state that would require CPR. On 4/25/12 at approximately 9:10 AM a second interview was conducted with E15 (MD) that revealed R73 was alert and calm laying on the floor in a supine position with one leg bent when he entered the bathroom.E15 stated R73 was not diaphoretic when he first walked in. E15 asked R73 what happened. R73 could not tell E15 how or why he fell off the toilet and he was not sure if he hit is head. When E15 asked the staff about R73 the staff told E15 that R73 had vascular disease and was diabetic. E 15 continued to state that R73 became short of breath and diaphoretic. Then E15 turned R73 on his side. E15 checked R73's blood sugar and it was 116. E15 gave R73 glucagon because he was afraid his blood sugar would drop. Due to R73 becoming short of breath oxygen via a mask was started and 911 was called. R73's eyes rolled back in his head. R73 was on a sheet and we pulled it forward so people could get around him. I could get to his head. He brought up some froth so we cleared it and used Ambu bag and did chest compressions. Cross refer to F385 2. R211 was admitted to the facility on 11/14/11 for rehabilitation with diagnoses that included atrial fibrillation, coronary artery disease, history of Coronary Artery Bypass Graft, dyslipidemia,	F 309		

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F 309	Continued From page 28 chronic obstructive pulmonary disease, permanent pacemaker placement mild aortic mitral and tricuspid insufficient, gastroesophageal reflux disease, obstructive sleep apnea, venous insufficiency, anemia acute renal failure and weakness. The MDS assessment dated 11/21/11 documented R211 was cognitively intact (BIMS score 15) and required assistance with bed mobility, transfers and walking with one person to assist. Review of R211's code status revealed an Advanced Directive form dated 11/14/11 was signed by his responsible party and was signed by the nurse practitioner on 11/15/11. However, the nurse practitioner nor the physician wrote a DNR order for R211. The physician order sheet dated 11/29/11 for the period of 12/1/11-12/31/11 documented R211 was a full code. R211's medication administration record also documented he was a full code. On 11/14/11 a fall risk assessment was completed on R211. His assessment score was "15" indicating he was a high risk for falls. Review of R211's care plans revealed he had a care plan for ...at risk for falls related to decreased mobility, impaired bed mobility, potential for orthostatic hypotension, medications and diagnosis with interventions put in place. Review of R211's nurses notes dated 12/6/11 at 6:10 AM revealed R211 was found sitting on the floor by the CNA. R211 stated he slipped off of the bed and no injury was noted. R211 stated he	F 309		

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F 309	Continued From page 29 did not hit his head. The physician and family were notified. The facility Fall (post) guide policy stated under procedures "4.neurological checks will be initiated... - in the event of an un-witnessed fall". The facility's Neurological checks sheet stated to complete "Neuro checks as follows: every 30 minutes for 1 hour, then every hour for 4 hours then every 8 hours for 9 shifts". The assessment included assessing vital signs, verbal response, eyes open, pupils and motor strength. On 12/6/11 at 1:35 PM R211 had a physician order stating to "monitor vital signs every shift times 48 hours and notify physician with results". R211's Neurological check sheet revealed R211's motor strength for all his extremities were assessed as being normal until 12/6/11 at 7:10 AM. On 12/6/11 at 7:10 AM R211 was assessed that his bilateral extremities were "weak" (this was a documented decline from his earlier assessment). From 8:40 AM and throughout the rest of the completed assessments R211's motor strength in all his extremities were documented as "weak" (this is a continuous documented decline in his condition). There was no evidence that the physician was notified of R211's decline in motor strength. On 12/6/11 at 7:40 PM the neurological assessment sheet was blank, there was no evidence that R211 had a neurological assessment completed even though a decline in motor strength was documented. Review of the facility's "Vital Sign Flow Record Post Fall" sheet revealed staff documented	F 309		

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F 309	Continued From page 30 R211's vital signs and that R211 did not have any mental status changes or change in alertness. However, the 12/7/11 at 6:10 AM assessment was left blank. There was no evidence that R211 was assessed at 12/7/11 at 6:10 AM. Review of R211's nurses notes dated 12/7/11 at 9:10 AM revealed "Called to unit at 8:55 AM to pronounce R211. R211 was without apical pulse or respirations for three minutes. Pronounced at 9:05 AM presumed time of death 8:55 AM on 12/7/11". No code was called and CPR was not started. On 4/20/12 at 9:45 AM an interview with E29 (LPN) revealed that R211 had wounds. The wound team was in R211's room and he was alert. Later, after wound rounds, someone came and told E29 that R211 was unresponsive. E29 called E6(RN) to assess and pronounce R211. E29 confirmed he should have written a note on his findings but failed to do so. Review of R211's code status on the chart with E29 revealed that he always looked for the advance directive in the chart. E29 continued to state that in the rehabilation unit it is not uncommon for the wrong code status to be documented in the chart so he goes straight to the advance directive to find a resident's code status. An interview on 4/20/12 at 8:20 AM with E6 (RN) revealed that the resident did "not have an apical pulse but did have a pulse in his arm because the pace maker kept working." E6 continued to state that he was called to R211's room twice because they did not have an RN on their unit. E6 also confirmed that R211's neurological assessments should have been completed as indicated and	F 309		

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F 309	Continued From page 31 that the nurse should have notified the physician concerning the decline in R211's motor strength. Review of the survey findings were presented and reveiwed with E2 (DON) and E3 (ADON) at 12:10 PM on 4/24/12.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain an environment that was free from accidents by cleaning the carpet, leaving it wet without a dry pathway for residents use. Findings include: On 4/19/12 the Sussex unit hallway carpet was observed being cleaned by E25 (Floor tech). He was observed using the carpet cleaner cleaning the entire carpet, without leaving a dry pathway, in front of residents' rooms with resident in and out of their room ambulating and wheeling their wheelchairs on the wet carpet. Surveyor slipped twice going from the wet soapy carpet to the vinyl floor. Surveyor spoke with E25 who stated he had to do the hallway all at once because the machine moved back and forth. (from wall to wall)	F 323	**F 323** **It is the practice of the facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** 1. Signage was posted on the Sussex unit to alert personnel of the wet carpeting. 4/20/12 2. The Housekeeping Director in-serviced E 25 on the proper technique for carpet cleaning. 4/20/12 3. The Housekeeping Director or designee will in-service housekeeping staff on the proper technique for carpet cleaning. (b). The Housekeeping Director will do random environmental rounds to evaluate proper technique for carpet cleaning. 4. The results of the random rounds will be reported to the QA & A committee. The committee will determine the need for further action plans.	

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F 323	Continued From page 32 On 4/20/12 at 10:45 AM E25 was observed using the carpet cleaner cleaning the same hallway again not marking off half of the hallway in order to leave a dry path. Surveyor spoke with E26 (corp nurse) and E2 (DON) who also observed the carpet and E25's technique for cleaning. E26 and E2 confirmed the wet carpet was an accident hazard. E25 should have cleaned one half of the carpet at a time leaving a dry path to prevent residents from slipping on the floor after ambulating on the carpet. At 10:55 AM on 4/20/12 E27 (restorative aid) told surveyors to be careful as the carpet was wet and you may slip when you walk on the hallway with soap on shoes. E27 also told the resident she was ambulating to stop and not to walk any further as the carpet was wet and she might slip.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

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F 329	Continued From page 33 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy and procedure, it was determined that for three (R155, R30, and R132) out of 49 residents sampled, the facility failed to ensure that the resident's drug regimen was free from unnecessary drugs and was adequately monitored. The facility failed to ensure HgbA1C (Hemoglobin A1C-blood test used as a standard tool to determine blood sugar control for patients with diabetes) was drawn and monitored for R155 who had a diagnosis of diabetes mellitus. In addition, the facility failed complete AIMS (Abnormal Involuntary Movement Scale) assessments on R30 and R132 who were administered anti-psychotic medications. Findings include: 1. Review of the facility's nursing policy and procedure titled "Laboratory and Radiological Services" documented under "Procedure: 2. Write out required lab slips with complete information including ICD-9 code and place in Lab Book. Include labs to be drawn every month, every 3 months, and every 6 months." Review of R155's January 2012 Physician Order Sheet (POS) documented an order for HgbA1C every 3 months scheduled for January, April, July,	F 329	F 329 **It is the practice of the facility that each resident's drug regimen is free from unnecessary drugs.** 1. (a). R 155's HgbA1C was discontinued per Physician's orders. (b). AIMS test was completed on R 30. (c) AIMS test was completed on R 132. 5/15/12 2. (a). All Residents receiving laboratory services are at risk for this deficient practice. (b).All Residents on anti-psychotics are at risk for this deficient practice 3. The Staff Developer or designee will in-service nursing staff on the completion of laboratory slips during monthly recapitulation. AIMS testing will be done on admission and biannually. 7/10/12 4. (a.)The Unit Managers and or designee will audit laboratory orders monthly to evaluate whether they have been drawn per physician's orders. (b). The Unit Managers and or designee will audit Residents on anti-psychotics to evaluate whether AIMS tests have been completed. (c). Results of these audits will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 329	Continued From page 34 and October. Record review revealed that the most recent HgbA1C was completed on 10/21/10. An interview with E5 (Unit Manager) on 4/18/12 at approximately 2:45 PM revealed that at the time of the monthly recapitulation of the POS, the staff nurse performing this task was required to complete the laboratory slip and place this in the "Lab Book" as well as documenting this on the resident's Treatment Administration Record (TAR). E5 confirmed that the staff nurse who conducted the monthly recapitulation failed to complete the laboratory slip and failed to document this on the January 2012 TAR, thus, the HgbA1C in January 2012 was not completed. 2. Review of facility's nursing policy titled "AIMS Testing" indicated that the AIMS Abnormal Involuntary Movement Scale) assessment would be conducted when a resident is initially place on an anti-psychotic drug and assessment will be done every 6 months thereafter to monitor for Tardive Dyskinesia (disorder that involves involuntary movements). Review of R30's April 2012 POS revealed R30 was ordered Seroquel (anti-psychotic medication) and in addition, AIMS test was to be completed every six months (August and February). Review of the April 2012 Medication Administration Record (MAR) documented that R30 was administered the above medication as ordered. Record review revealed an AIMS assessment was completed on 8/25/11, however, no additional assessments were conducted. An interview with E5 on 4/25/12 at approximately 1 PM revealed that the facility did not have a system to ensure that the AIMS assessment was completed as required in the facility's policy, thus, no additional assessments were conducted.	F 329		

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F 329	Continued From page 35 3. R132 was admitted to the facility on 8/30/11 from another nursing home and was on Risperdal (anti-psychotic medication) at the time of admission. Review of R132's April 2012 POS revealed R132 continued on the Risperdal and review of the April 2012 MAR documented that R132 was administered the above medication as ordered. Record review revealed a lack of evidence of an AIMS assessment when R132 was admitted to the facility. Additional record review revealed that an AIMS assessment was completed on 3/12/12. An interview with E6 (Unit Manager) on 4/20/12 at approximately 3 PM confirmed the findings. Repeat deficiency from annual survey ending 12/10/2010.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations made on test trays on 04-19-12, it was determined that the facility failed to provide food that was palatable. Findings include: 1. A test tray was taken on the Sussex unit on 04/19/12 at 12:23PM. The pureed pork and pureed green beans were bland. Very little flavor remained with the food once the thickening agent	F 364	F 364 **It is the practice of the facility that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and that the food is palatable, attractive, and at the proper temperature.** 1. (a). The cooking staff has been in-serviced to the proper techniques to prepare palatable pureed foods (b). The Dietary staff has been in-serviced on the proper temperatures of food delivery. 5/15/12 2. Residents on pureed diets are at risk for this deficient practice	

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F 364	Continued From page 36 was added. Interview with E14, the food services director, on 04/23/12, indicated that the procedure for making the pureed diet food was for liquid to be added to the ground food with the appropriate amount of thickener, then to puree it. E14 also indicated that the cooking staff may not have added enough quantity of the original food product to account for the final volume of the pureed food item. 2. A test tray was taken on the Henlopen unit on 04/19/12 at 12:14PM. The temperature of the mashed sweet potatoe was 117.5 degrees Fahrenheit (F), the meat (pork) was 115.2F meat, and the green beans were 114.3F. These hot food temperatures were perceived as cold to the surveyor when tasted. The meat was tough to chew. The food was not palatable.	F 364	3. (a). The Food Service Director will in-service the Cooking staff on the proper techniques to prepare palatable pureed foods (b). The Food Service Director will in-service the kitchen staff on the proper temperatures of food delivery. 7/10/12 4. (a). The Food Service Director weekly will test a "test tray" to evaluate the consistency of the pureed diet foods. (b). The Food Service Director weekly will test a "test tray" for the proper temperatures and palatability (c). The results of these audits will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the kitchen and meal observations it was determined that the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Findings	F 371	7/10/12	

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F 371	Continued From page 37 include: 1. A bucket of water and soap was located inside of the two section vegetable sink. E14 (Food Service Director) immediately removed the bucket from the sink and placed this on the floor. 2. A container of "Ham Salad" with an expiration date of "4/10" was observed in the walk in refrigerator. E14 immediately discarded this item. 3. The following ready-to use status cookware with wetness and with dried food debris was observed on the food contact surface: Five half pans, six large loaf pans, 11 large pans, and two sheet pans. 4.A large box containing corn flakes directly on the floor in the storage location. 5. Following opened items were observed with no open date: - Large container of "Old Bay Crab Cake Classic" seasoning. - Two bags of imitation bacon bits with no seal. - Large container of corn syrup. - Bag of mini oreo cookies. - Half gallon orange juice. 6. The microwave oven had spills and spatters on the interior surfaces. 7. A washcloth on the power breaker. 8. Debris on top of "Hersey Ice Cream" freezer. 9. The internal thermometer for the Lewes unit	F 371 F 371 **It is the practice of the facility to (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions** 1. (a). The bucket of water located inside of the vegetable sink was removed by E 14. (b). The Ham Salad was immediately discarded by E 14. (c). The ready-to-use status cookware were washed. (d). The large box of corn flakes found on the floor in the storage location was removed from the floor. (e). The container of old bay seasoning, the two bags of imitation bacon bits, the large container of corn syrup, the bag of mini oreo cookies and the half gallon of orange juice were discarded. (f). The microwave oven was cleaned. (g). The washcloth on the power breaker was removed. (h). The top of the "Hersey Ice Cream" freezer was cleaned (i). The nourishments in the Lewes refrigerator were discarded. (j). The Food Service Director has in-serviced E-30 on wearing a hair net when plating food in dining room. (k). E 30 has been in-serviced on infection control issues related to gloving (l). The Food Service Director has in-serviced E 23 and E 31 on wearing a hair net when plating food. (m). The Food Service Director has in-serviced E 24 on infection control issues related to glove use.		4/13/12

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F 371	Continued From page 38 nourishment refrigerator indicated a temperature of 20 degrees Fahrenheit (F). The liquid drinks in the refrigerator were not frozen. The surveyor, minimum recording, thermometer indicated the lowest temperature, after an hour of recording for this unit, was 42.8F. This was below the required 41F for cold food storage. The facility failed to maintain the snack/nourishment refrigerator so as to prevent the potential for food-borne illness 10. On 4/23/12 a lunch observation was made in the dining areas of the Lewes wing (secured unit). On the Lewes wing dining room on 4/23/12 E30 (CNA) was observed plating food for residents in this dining room without wearing a hair net. At 11:05 AM on 4/23/12 E30 was observed plating food, checking diet sheets and then using her contaminated gloves to reach in a bag of rolls to give R116 a roll. On 4/23/12 during the lunch observation in the activity room E23 (CNA) and E31 (CNA) were observed plating food without a hair net. On 4/25/12 at 9:20 AM R14 (Food Service Director) was notified of the surveyor findings. 11. Observation on 4/23/12 11:55 AM in the main dining room (MDR) revealed that E24 (aide) was wearing gloves to serve food and handle meal tickets then without washing her hands held R46's bread while she buttered it with contaminated gloves. This aide continued to collect tickets and serve trays. E24 then brought bread to four residents at another table again handling the bread of R216 with her contaminated gloved hands.	F 371	2. The Food Service Director will in-service the Dietary Staff on the proper storage, preparation, and the distribution/serving of food under sanitary conditions. 7/10/12 3. The Food Service Director or designee will perform weekly audits to evaluate whether food is stored, prepared, distributed and served under sanitary conditions. 7/10/12 4. Results of this audit will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 371	Continued From page 39 On 4/25/12 at 1:30 PM the above findings were reviewed with E1 (administrator), E2 (DON), E3 (ADON) and E4 (COO RN).	F 371		
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the physician failed to write an order for the code status for one (R211) out of 49 sampled residents. Findings include: Review of R211's code status revealed an Advance Directive form dated 11/14/11 was signed by his responsible party and was signed by the nurse practitioner on 11/15/11 indicating he was a DNR. However, the nurse practitioner/ physician failed to write a DNR order for R211 for the staff to follow. The physician order sheet dated 11/29/11 for the period of 12/1/11-12/31/11 documented R211 was a full code. R211's medication administration record also documented he was a full code. Review of R211's chart with E2 (DON) and E3	F 385	F 385 **It is the practice of the facility to ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.** 1. R 211's do not resuscitate order was written onto the Physician Order Sheet 4/19/12 2. A house wide sweep was completed to evaluate whether Resident's that requested to be a "DNR" has an order for a do not resuscitate on their Physician Order Sheet. 4/19/12 3. (a). New Admissions will be reviewed in clinical meeting for DNR orders. The Nursing Administration staff or designee will weekly audit the Resident's who are DNR's to evaluate whether an order has been written by the MD/NP to support this code status. 4/19/12 4. Results of this audit will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 385	Continued From page 40 (ADON) on 4/24/12 at 1210 PM confirmed the physician or the nurse practitioner should have written an order for R211's code status for the staff to follow.	F 385		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the pharmacist reported any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon for three (R155, R30, and R132) out of 49 sampled residents. The licensed pharmacist failed to identify and report an irregularity when R155's routine HgbA1C (Hemoglobin A1C-blood test used as a standard tool to determine blood sugar control for patients with diabetes) was not completed as ordered. The facility failed to act upon the irregularities identified by the licensed pharmacist when two residents (R30, R132) receiving anti-psychotic medication required the AIMS assessments to be completed. Findings include:	F 428		

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F 428	Continued From page 41 1. Cross refer F329, example 1. Review of R155's January 2012 Physician Order Sheet (POS) documented an order for HgbA1C every 3 months scheduled for January, April, July, and October due to diagnosis of diabetes mellitus. Record review revealed that the most recent HgbA1C was completed on 10/21/10. Review of the monthly Medication Regime Review (MRR) from January 2012 through March 2012 lacked evidence that the licensed pharmacist (E13) identified the irregularity and reported the lack of HgbA1C monitoring. An interview with E13 on 4/26/12 at approximately 9:30 AM confirmed that the above findings. 2. Cross refer F329, example 2. Review of R30's April 2012 POS revealed R30 was ordered Seroquel (anti-psychotic medication) and review of the April 2012 Medication Administration Record (MAR) documented that R30 was administered the above medication as ordered. Record review revealed an AIMS assessment was completed on 8/25/11, however, no additional assessments were conducted. Review of the monthly MRR dated 1/18/12 documented "Please provide AIMS assessment for monitoring possible adverse effects of medication", however, record review lacked evidence of a follow-up by the facility. An interview with E5 on 4/25/12 at approximately 1 PM confirmed that no additional AIMS assessment was completed since 8/25/11. 3. Cross refer F329, example 3. R132 was admitted to the facility on 8/30/11 from	F 428 428	**It is the practice of the facility that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The Pharmacist reports any irregularities to the attending Physician, and the Director of Nursing, and these reports are acted upon.** 1. R 155's order for the every three month HgbAIC was discontinued by the Physician. The AIMS test was completed for R 30 and R 132. 5/15/12 2. Residents requiring HgbA1C's are at risk for this deficient practice. Residents on anti-psychotic medications are at risk for this deficient practice. 3. (a). Medication Regime Reviews are completed monthly by a licensed pharmacist. (b). New admission's physician order sheets are faxed to the pharmacy for their medication regime review. (c). For those Residents on an anti-psychotic, an AIMS monitoring will be done on admission and bi-annually. 7/10/12 4. A random monthly audit will be done by the Unit Managers or designee to evaluate whether medication regime review recommendations have been completed. A random monthly audit will be done by the Unit Managers or designee to evaluate timeliness of AIMS monitoring. Results of these audits will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 428	Continued From page 42	F 428		
	another nursing home and was on Risperdal (anti-psychotic medication) at the time of admission. Review of R132's April 2012 POS revealed R132 continued on the Risperdal and review of the April 2012 MAR documented that R132 was administered the above medication as ordered. Record review revealed lacked evidence of an AIMS assessment when R132 was admitted to the facility. Additional record review revealed that an AIMS assessment was completed on 3/12/12. Review of the monthly MRR dated 9/16/2011 and 11/15/2011 "Resident receives antipsychotic med Risperdal. Please provide AIMS assessment for monitoring possible adverse effects of medication", however, record review lacked evidence of a follow-up by the facility. An interview with E6 (Registered Nurse, Unit Manager) on 4/25/12 at approximately 1 PM confirmed that the only AIMS assessment completed was on 3/12/12, thus, there was no evidence of an initial AIMS assessment when the resident was admitted to the facility on 8/30/11. Repeat deficiency from annual survey ending 12/10/2010.			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on review of the Henlopen unit shower room on 4-23-12, it was determined that the	F 463	F 463 **It is the practice of the facility to equip to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.** 1. The call bell in the third shower stall from the entrance on the left side (on Henlopen) is functioning. 4/25/12 2. An environmental observation was completed to evaluate functionality of call bells. 4/25/12 3. The Maintenance Director will perform weekly environmental rounds to evaluate the functionality of call bells. 7/10/12 4. Results of these environmental rounds will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 463	Continued From page 43 facility failed to maintain a properly function call system in the common shower room. Findings include: 1. The call bell in the third shower stall from the entrance, on the left side, did not activate a light outside the room or a light on the call panel at the nurse station, however, the audible alarm did sound. All other call bell units functioned properly.	F 463		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R92) out of 49 sampled residents, the facility failed to ensure laboratory services ordered to assess a resident's health status were obtained. Findings include: Review of R92's January 2012 Physician Order Sheet (POS) documented an order for urinalysis (UA) every six months scheduled for January and July. Record review revealed that the most recent UA was completed in July 2011. An interview with E5 (Licensed Practical Nurse, Unit Manager) on 4/25/12 at approximately 1 PM revealed that at the time of the monthly recapitulation of the POS, the staff nurse performing this task was required to complete the laboratory slip and place this in the "Lab Book" as well as documenting this on the resident's	F 502	F 502 **It is the practice of the facility to provide or obtain laboratory services to meet the needs of the residents.** 1. An order was obtained by the Physician to discontinue R 92's every six month urinalysis. 5/15/12 2. Residents receiving laboratory services are at risk for this deficient practice. 3. The Staff Developer or designee will in-service Nursing Staff on the completion of laboratory slips and placement of the order in the "Lab Book." 7/10/12 4. The Unit Managers or designees will audit Residents with bi-annual urinalysis orders to evaluate whether they have been placed on the POS's, written on the treatment record and they have been obtained. The results of this audit will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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F 502	Continued From page 44 Treatment Administration Record (TAR). E5 confirmed that the staff nurse who conducted the monthly recapitulation failed to complete the laboratory slip and failed to document this on the January 2012 TAR, thus, the UA in January 2012 was not completed.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to maintain records that were accurately documented for one (R106) out of 49 sampled residents. Findings include: 1. R106 was admitted on 3/27/12. A new wound alert form was intiated on 4/1/12 for a 1 cm round area that was found on the right upper ear. A Wound Evaluation Form was initiated on 4/4/12	F 514	F 514 It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1. R 106's wound on right upper ear has healed. 5/15/12 2. Wound alerts were compared with weekly wound trackers to evaluate whether documentation matched. 3. Wound Care Nurse Practitioner will be in-serviced on principles and guidelines of documentation related to origin of pressure wounds. 7/10/12 4. The Assistant Director of Nursing or designee will audit weekly the documentation from the Wound Consultant's notes to evaluate proper origin of the wound. The results of the audit will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 7/10/12	

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HARBOR HEALTHCARE & REHAB CTR	301 OCEAN VIEW BLVD LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 45 by the wound care consultant indicated that the wound was first identified on 4/1/12 and was acquired in the community not the facility. An interview on 4/23/12 E17 (nurse) revealed the nurse's note indicated the wound was acquired at the facility. All the above findings were reviewed with E1 (administrator), E2 (DON), E3 (ADON) and E4 (COO RN) on 4/25/12.	F 514		

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: April 25, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey and complaint visit was conducted at this facility from April 12, 2012 through April 25, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred thirty-five (135) residents. The survey sample totaled forty-nine (49) residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	**Cross refer to the CMS 2567-L Survey Report date completed 4/25/2012**
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report dated 4/25/12, F157, F166,	**F157, F166, F174, F225, F226, F241, F244, F246, F272 F279, F309, F323, F329, F364, F371, F385, F428, F463, F502 and F514**

DSM NAA ADMINISTRATOR 5/21/12

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	F174, F225, F226, F241, F244, F246, F272, F279, F309, F323, F329, F364,F371, F385, F428, F463, F502 and F514.	