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

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STATE SURVEY REPORT

LTC Residents Protection
OCT 0 6 2009
Director's Office

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: May 12, 2009

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 on May 6, 2009 through May 12, 2009. The census on the first day of survey was fifty-four (54). The deficiencies contained in this report are based on record review, observation, staff interviews and review of other facility documentation as indicated. The survey sampled totaled nine (9) records, eight (8) active and one (1) closed record respectively.	
3205	**Nursing Home Regulations for Intermediate Care (effective prior to January 11, 2009)**	
3205.9.4	**Nursing Services**	
3205.9.4.1	**Individual nursing care plans shall be developed by nursing services as part of the total rehabilitation program with modification of the nursing as needed to meet the resident's daily needs. Nursing care plans are to be reviewed at least annually for adults and more frequently for children, in accordance with developmental changes.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that the facility failed to have a nursing care plan in place to address two resident's (R1, R6) health	

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	care needs out of nine sampled residents. Findings include: 1. R1 was admitted to the facility on 12/08/06 with multiple diagnoses. Subsequent to admission and to date, R1 was noted and documented by staff to have visual hallucinations. R1's condition was not addressed by a nursing care plan to provide interventions for ongoing hallucinations. 2. R6 was admitted to the facility for a brief thirty day stay on June 1, 2008. Subsequent to R6's admission until discharge on June 30, 2008, there was no nursing care plan in place to address her daily health care needs. The above findings were confirmed with the Director of Nursing, E2 on 05/12/09.	**3205.9.4.1** 1) R1 did have a care plan for hallucinations and was overlooked at time of survey. Please see Attachment #1 for the care plan. In the future, the DON will continue to monitor that care plans are done to address daily health care needs. 2) R6 was admitted as a respite resident and is no longer a resident. In the future we will no longer admit respite residents under a respite protocol. All respite admissions regardless of length of stay will follow the protocol for our regular admissions. This will include care plans, physician's orders, and H & P. The respite policy was removed from our P & P books. This will be monitored by the DON as she reviews all admission charts. All nurses were informed at the staff meeting on 9/14/09.
3205.9.5 **3205.9.5.1**	**Medications** **All medications administered to patients shall be ordered in writing, and signed by the attending physician.** **This requirement was not met as evidenced by:** Based on record review and interview, it was	

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	determined that the facility failed to have a physician's order on file to administer medication to one resident (R6) out of 9 sampled residents. Findings include: R6 was admitted to the facility on 06/01/08 for "respite care" according to the Nursing Home Administrator, E1 on 05/12/09. Review of the facility respite care protocol incorrectly stated this type of resident is scheduled to stay for less than one month and does not need to have admission physician's orders. Record review revealed R6's file lacked physician's medication orders to administer medications during her stay at the facility. During R6's stay at the facility, five (5) routine prescription medications, 174 doses, were administered on two work shifts from June 1, 2008 through June 29, 2008 by licensed professional nurses without written or signed orders by a licensed physician. On 06/29/08, R6 was discharged to home. State regulations do not provide any exceptions for medications to be administered without a physician's order.	**3205.9.5.1** R6 was admitted as a respite resident and is no longer a resident. In the future we will no longer admit respite residents under a respite protocol. All respite admissions regardless of length of stay will follow the protocol for our regular admissions. This will include care plans, physician's orders, and H & P. The respite policy was removed from our P & P books. This will be monitored by the DON as she reviews all admission charts. All nurses were informed at the staff meeting on 9/14/09.
3205.9.10	**Records and Reports**	
3205.9.10.1.2	**History and physical examination: Prepared by a physician within seven (7) days of the patient's**	

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	admission to the home. If the patient has been admitted to the home immediately after discharge from a hospital, the patient's summary and history which was prepared at the hospital and the patient's physical examination which was performed at the hospital, if performed within seven (7) days prior to admission to the home, may be substituted in lieu of the above records. Additionally, a record of an annual medical evaluation performed by a physician must be contained in each patient's file. **This requirement was not met as evidenced by:** Based on record review it was determined that the facility failed to have an admission medical examination on file for one resident (R6) out of nine sampled residents. Findings include: R6 was admitted to the facility on 06/01/08. Prior to admission, there was no medical evaluation performed or on file within the seven day time frame. According to documentation, R6 was not seen by a physician during her entire stay at the facility except during a brief visit to the emergency department at an acute care facility on 06/08/08. R6 was discharged to home twenty-eight days later on 06/29/08.	**3205.9.10.1.2** R6 was admitted as a respite resident and is no longer a resident. In the future we will no longer admit respite residents under a respite protocol. All respite admissions regardless of length of stay will follow the protocol for our regular admissions. This will include care plans, physician's orders, and H & P. The respite policy was removed from our P & P books. This will be monitored by the DON as she reviews all admission charts. All nurses were informed at the staff meeting on 9/14/09.

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3201	**Delaware Regulations for Skilled and Intermediate Care Nursing Facilities (effective January 11, 2009)**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This regulation is not met as evidenced by:** Based on record review, interview, observation and facility documentation, it was determined that the facility failed to provide the care and services for the comfort, safety and general well-being and failed to meet the medical, nursing and psychosocial needs of five (5) residents (R9, R2, R1, R5 and R8) out of nine (9) residents sampled. The facility failed to assess R9 for pain while the facility documented behaviors and failed to determine the origin of the pain. The facility failed to seek medical intervention in a timely manner and also follow-up with intervention in a timely manner. The facility failed to identify the appropriate precautions for R2 who acquired a Clostridum Difficile (C. diff.) infection. Additionally, the facility failed to monitor reports received from the laboratory for physician ordered albumin level for R2. The facility failed to	

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	perform Abnormal Involuntary Movement Scale (AIMS) tests for three (3) residents (R1, R5, R8) who were receiving anti-psychotic medications and consequently failed to monitor these residents for side effects of the medicines. It was also determined that the facility failed to cover fluorescent light bulbs for the safety of the residents. Findings include: 1. R9 was admitted to the facility on 05/31/08 with diagnoses including Alzheimer's Dementia, Arthritis of the right knee and Fibromyalgia (a chronic condition characterized by widespread pain in your muscles, ligaments and tendons, as well as fatigue and multiple tender points). R9 was monitored for behavior even though there was no documentation of behaviors other than on the flow record that indicates persistent yelling and screaming. A review of the behavior monitoring flow record for February 2009 was unremarkable for behaviors. A care plan for chronic pain for arthritis was in place and updates every two months documented from 08/19/08 through 02/24/09 as no evidence of pain until 03/03/09. Beginning March 3, 2009, yelling and screaming behaviors began to surface. On 03/20/09 the physician was notified and a verbal telephone order was obtained for Tylenol 500 mg. every eight hours as needed for pain. Again, on 03/25/09 the physician was notified	**3201.6.1.1** 1) R9's pain is now controlled through several different interventions. R9 was assessed by the dentist on May 15th and the report indicated he did not feel pain was from the teeth/gums. R9 was assessed by physician on March 21st and May 19th. Pain in Dementia residents was reviewed at the in-service on September 14th with a hand out. There is also an in-service scheduled for October 12th on Pain by Compassionate Care Hospice. The DON will make rounds on a daily basis to assess residents for pain and effective interventions in a timely manner. Please see attachment #2 for a copy of the care plan for R9.

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	and a verbal telephone order was obtained for Tylenol with codeine every six hours as needed for pain. Beginning March 6, 2009 through March 31, 2009, Xanax 0.25 mg. as needed (PRN) was administered for increased anxiety seven times along with Tylenol 500mg. ten times, and Tylenol with codeine three times for increased rigidity. A review of the behavior monitoring flow record for April 2009 was remarkable for behaviors. Record review revealed numerous entries with an asterisk was documented to indicate displayed behaviors more than ten times on the day and evening shifts. Xanax 0.25mg. PRN was administered eight times for increased agitation, loud crying and yelling. In addition, Tylenol 500 mg. PRN twenty three times for general discomfort and Tylenol with codeine twenty times for comfort measures, crying loud and stating pain. On 04/28/09 documentation from care plan updates every two months indicated "has been hollering a lot if asked many times will say bones hurt." A review of the behavior monitoring flow record for May 2009 through exit date of May 12, 2009, was remarkable for escalating behaviors. On the evening shift an asterisk was documented every day indicating more than ten episodes of behavior of yelling and screaming and on the day shift respectively with two	

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	days exception. The following medications and number of administrations were employed to control behaviors and pain: Tylenol with codeine nine times, Vicodin 5mg./500mg. twenty-six times (05/05/09 – 05/12/09), Ativan 0.5 mg. ten times (05/08/09 to 05/12/09), Xanax 0.25 mg. (no diagnosis for the use indicated) six times and Tylenol 500 mg. five times. Roxanol 20 mg. (a morphine based narcotic and pain medication) was ordered PRN on 05/11/09 and had not been delivered to the facility at the time of exit on 05/12/09. R9 was also treated routinely with Tramadol HCL 100mg. until it's discontinuation on 03/25/09. R9 was placed on hospice care on May 1, 2009. Although escalating behaviors were being monitored, the administration of pain medications and their effectiveness were sporadic according to the medication administration records between March 2009 and May 2009. An interview with a medication nurse, E4 on 05/11/09 stated she thought that R9 was in pain and that it was radiating from the mouth. Nursing documentation stated on 05/06/09 that R9's 'teeth looks like rotting on bottom, yelling for three hours, given pain meds and Xanax.' 'Teeth rotting from the bottom up, hospice notified, dental consult ordered.' The dentist was called on 05/07/09 and a message was left on the	

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	answering machine. The surveyor inquired about the dental consult on 05/11/09 with the station nurse, E5. E5 stated the dental office had not called back and that she would leave another message. As of the exit date, the dental office had not responded. An interview on 05/12/09 at 12:00 PM with the Hospice Nurse stated there was pain involved and that they were now treating her with pain meds. The nurse stated that Roxanol had been ordered and the facility was awaiting the delivery of the medication. The Hospice Nurse could not determine the etiology of the pain. It could not be determined through clinical record review that R9 was ever examined by a physician subsequent to the onset of escalating behaviors beginning 03/03/09 through 05/12/09 indicating pain and discomfort. The extent of the physician's involvement with R9's care to address the behaviors and pain was via telephone through verbal pain medication orders. 2a. R2 was admitted to the facility on 04/23/07. According to staff and the clinical record, R2 was alert and oriented to person, place and time. Subsequent to several bouts of diarrhea, in February 2009, a stool sample was obtained on 02/28/09 and sent to the	2a) R2 is no longer confined to the room and an in-service was held on C-Diff. Please see attachment #3. It was reviewed that C-Diff is contact isolation only and residents do not need to be confined to their room. In the future the DON will monitor all residents on isolation for proper technique and protocol. When a resident is put on isolation, the DON will in-service the staff caring for the resident with a hand out on that particular type of organism and answer any questions they may have. The Department of Public Health will be contacted for any questions that are unknown or in questions.

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	laboratory for analysis of C. diff. toxin (a bacterium that causes diarrhea). On 03/02/09, results proved positive for C. Diff. and contact isolation precautions were implemented for 18 days until 03/20/09 when a stool sample analysis proved negative and isolation precautions were discontinued. On 03/27/09, R2 again tested positive for C. Diff. and isolation precautions were implemented for 35 days until 05/11/09. During an interview with R2 on 05/11/09, it was revealed that facility staff told her she could not leave her room due to her condition with C. Diff. R2 also stated she had been confined to her room for the past five weeks and wanted to get out of the room. Interview with a staff nurse, E3 on 05/11/09 confirmed that the resident had not left the room since her lab report was positive for C. Diff on both occasions except for a fire alarm. A review of facility policy and procedures on Communicable Diseases stated C. Diff. as one of three most concerning diseases in the nursing home. Further, any resident who has a communicable disease (as C. Diff.) should be kept in their room away from community areas until symptoms have passed. Interview with The Department of Public Health on 05/11/09 revealed that a resident with C. Diff. should	

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	not be confined to their room and that C. Diff. is a contact isolation precaution only. Additionally, as long as proper hygiene is employed and proper hand washing technique is maintained, there should be no reason for isolating a resident. The facility failed to identify the appropriate method for caring for a contact isolation C. diff. bacterium resident resulting in inappropriately isolating this resident. 2b. R2 was admitted to the facility on 04/23/07 with diagnoses including congestive heart failure and pleural effusion. R2's clinical record revealed a physician's order dated 02/09/09 for labs including an albumin level to be drawn every year beginning the month of April 2009. A review of laboratory results indicated the ordered lab work was drawn on 04/02/09 however, the lab failed to run the albumin level. This finding was confirmed with the lab on 05/07/09. Interview with a staff nurse, E3 on 05/07/09 confirmed the labs drawn did not include albumin level results and that the facility failed to monitor the reports received from the lab for the albumin level. On 05/08/09, an albumin level was re-drawn on R2, however, the results were not available for review on 05/12/09. 3. R5 was admitted to the facility on 09/11/07 with a physician's order for the drug Risperdol 0.5 mg every day (an antipsychotic drug used to treat schizophrenia).	2b) R2 had an albumin level re-drawn on 5/8/09 and the results were received and faxed to the doctor on 5/11/09. In the future, when labs are drawn, a copy of the lab slip will be kept in the nursing office. As lab results come back on a daily basis, they will be compared to the copy and if anything is found missing, the DON or her designee will call the lab for the results. Therefore, if there has been an error by the lab, it will be found in a timely manner. This QA of lab results were reviewed with the nurses at the staff meeting on September 14th.

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	Facility policy and procedure stated an AIMS (Abnormal Involuntary Movement Scale) Test (designed to measure involuntary movements known as tardive dyskinesia a disorder that can develop as a side-effect of long term treatment with antipsychotic medication) should be done when the residents starts the drug, every six months and whenever there is a dose change. Since admission, the facility failed to complete any AIMS Tests on R5 to evaluate for side effects of the drug Risperdol and to determine if its use should be continued by a physician. 4. R8 was admitted to the facility on 04/04/09 with a physician's order for Seroquel 200mg twice a day (an antipsychotic drug used to treat bipolar disorder). Since admission there has been no AIMS performed on R8 as required by facility policy. The facility failed to evaluate for side effects and to determine if the drug should be continued. 5. R1 was admitted to the facility on 12/08/06 with a physician's order for Seroquel (an antipsychotic medication) and was currently taking 50mg. three times a day. Additionally, a physician's order dated 01/29/08 for an AIMS test was to be performed every six months. A review of the clinical record revealed the last AIMS was performed on 06/23/08 in violation of the	3) R5 had an AIMS test completed on 5/8/09 and has one scheduled every six months on the MAR and will also have one completed if there is a change in dose. The AIM's policy was reviewed with the nurses at the staff meeting on September 14th. Please see attachment #5. The DON will monitor those residents on psychotropic drugs for compliance with the AIM's test policy every 60 days. 4) R8 had an AIMS test completed on 5/14/09 and has one scheduled every six months on the MAR and will also have one completed if there is a change in dose. In the future any resident on Psychotropic drugs will have an AIMS test done when the resident starts the medication, every 6 months and when there is a change in dose. The AIM's policy was reviewed with the nurses at the staff meeting on September 14th. Please see attachment #5. The DON will monitor those residents on psychotropic drugs for compliance with the AIM's test policy every 60 days.

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	facility's policy. The facility failed to continually monitor R1 for side effects of the medication Seroquel as ordered by the attending physician. 6. One out of two fluorescent light fixtures in the hallway, outside of room #132, had no cover to protect the residents from falling glass in the event of bulb break. The fluorescent light fixture in the south side tub room of the old building had no cover to protect the residents from falling glass in the event of bulb break. This light was located directly over the tub.	5) R1 had an AIMS test completed on 5/06/09 and has one scheduled every six months on the MAR and will also have one completed if there is a change in dose. In the future any resident on Psychotropic drugs will have an AIMS test done when the resident starts the medication, every 6 months and when there is a change in dose. The AIM's policy was reviewed with the nurses at the staff meeting on September 14th. Please see attachment #5. The DON will monitor those residents on psychotropic drugs for compliance with the AIM's test policy every 60 days. 6) A cover has been placed over the fluorescent light fixture in the hallway, outside of room #132 and also over the light fixture located in the south side tub room of the old building. The administrative assistant will monitor that all exposed fluorescent light fixtures are covered in the future.
3201.6.5	**Nursing Administration**	
3201.6.5.3	**Within 14 days of admission, the facility shall make a comprehensive assessment of each resident's needs.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that the facility failed to assess two (2) residents (R7, R8) out of nine (9) sampled residents following admission to the facility. Findings include: 1. R7 was admitted to the facility on 03/08/09. Subsequent to admission, there was not a comprehensive assessment completed within 14 days	

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	to evaluate the care needs of the resident in order to develop an appropriate care plan. 2. R8 was admitted to the facility on 04/04/09. Subsequent to admission, there was not a comprehensive assessment completed within 14 days to evaluate the care needs of the resident in order to develop an appropriate care plan. The above findings were confirmed with the DON, E2 on 05/11/09 at 2:30 PM. Further, as of the exit date on 05/12/09, the DON confirmed a comprehensive assessment had not been developed by the facility to evaluate new admissions to the facility.	3201.6.5.3 1) A comprehensive assessment form has been developed and initiated for all residents and will be done within 14 days of admission and on a yearly basis. The DON will monitor that a comprehensive assessment is initiated on admission to help develop an appropriate care plan and completed within 14 days. Please see the attachment for a copy of the comprehensive assessment form developed for our facility. 2) A comprehensive assessment form has been developed and initiated for all residents and will be done within 14 days of admission and on a yearly basis. The DON will monitor that a comprehensive assessment is initiated on admission to help develop an appropriate care plan and completed within 14 days. Please see the attachment for a copy of the comprehensive assessment form developed for our facility
3201.6.5.5	**Based on the physician's admission orders and the admission information for each resident, an interim individual nursing care plan shall be developed within 24 hours of admission pending the completion of a comprehensive resident assessment.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that the facility failed to develop an interim	

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	care plan for one resident (R8) out of nine (9) sampled residents. Findings include: R8 was admitted to the facility on 04/04/09 as "respite care" according to the Director of Nursing (DON), E2 on 05/11/09. A review of the clinical record revealed an interim care plan was not developed within the required 24 hours subsequent to admission. The care plan was not developed until 04/14/09.	**3201.6.5.5** An interim plan of care will be initiated within 24 hours of a resident's admission, regardless of the length of stay. The DON will monitor that all admissions have an interim plan of care initiated within 24 hours of admission.
3201.6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.** **This requirement was not met as evidenced by:** **Cross refer 6.1.1 Example #1** Based on record, observation and interview, it was determined that the facility failed to review and revise the assessment and care plan during a significant change for one resident (R9) out of nine (9) sampled residents. Findings include:	

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	R9 was admitted to the facility on 05/31/08 with diagnoses including Alzheimer's Dementia, Arthritis of the right knee and Fibromyalgia. A care plan for chronic pain for arthritis was in place. R9 was monitored monthly for behaviors including yelling/screaming (Code #14) on the monthly behavior monitoring flow sheets. There was no documentation of behaviors between 08/19/08 through 02/24/09 (according to care plan documentation updates every two months) and no evidence of pain. On 04/28/09 progress notes documented on the care plan stated "has been hollering a lot if asked many times will say bones hurt." R9 was place on hospice care on May 1, 2009. Behaviors escalated from March 3, 2009 through May 12, 2009 and were identified as pain by a staff medication nurse, E4, station nurse, E5 and a Hospice nurse. Staff could not determine the source of pain although there was speculation by the mentioned nursing staff that decayed teeth could be the possible cause of the pain. During the timeframe from March 3, 2009 through May 12, 2009, there was no re-assessment or revision in the plan of care to actively address this significant change in both physical and mental condition that was	**3201.6.5.7** R9's change in status was assessed and the care plan was updated. Please see attachment for a copy of the care plan. Her plan of care addresses pain control methods that are working to keep her pain free. The DON will monitor that an assessment and care plan will be reviewed/revised as needed for significant changes in physical and mental conditions and will be done at least quarterly.

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	identified as pain by staff and hospice care even though R9 was receiving pain and anxiety medications. Additionally, a revised assessment of R9 would have led the facility to examine and investigate the origin of R9's behavior and pain.	
3201.6.5.8	**The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.**	
3201.6.5.8.2	**The facility shall follow a comprehensive, systematic process of evaluation and care planning to ameliorate medical and psychosocial indicators prior to restraint use.**	
3201.6.5.8.3	**The resident's care plan shall document the facility's use of interventions, such as modifying the resident's environment to increase safety, and use of assistive devices to enhance monitoring in order to avoid the use of restraints.**	
3201.6.5.8.4	**Should such interventions and assistive devices fail to provide for the resident's safety, a physician's written order permitting the use of restraints shall be required and shall specify the type of restraint ordered.**	

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3201.6.5.8.5 3201.6.5.8.6	**The facility shall be accountable for the safe and effective implementation of the physician's order permitting the use of restraints.** **When the use of restraints had been implemented, the facility shall initiate a systemic process, on an ongoing basis, documented in the care plan, in an effort to employ the least restrictive restraint.** **These requirements were not met as evidenced by:** Based on record review and facility documentation, it was determined that the facility failed to have a medical symptom in the clinical record for the use of a restraint and failed to include other interventions prior to the use of the restraint for three (3) residents (R3, R5, R8) out of nine sampled residents. Findings include: 1. R3 was admitted to the facility on 06/08/08 with multiple diagnoses including Alzheimer's Dementia and was dependent upon staff for all activities of daily living (ADL). Review of R3's clinical record revealed a physician's order dated 08/11/08 for a lap buddy when in the wheelchair to prevent falling forward. R3 was observed in a wheelchair on 05/12/09 with the lap buddy in place. R3 was asked if he could remove the restraint and there was no response. It was determined that R3 could not remove or release the lap	**3201.6.5.8** 1) R5 is no longer a resident in the facility. Lap buddies will only be used after all alternative methods have been implemented and found to be ineffective. This was reviewed with the staff at the meeting on Sept. 14th to assess residents for chair/position of comfort, toileting, activities and pain assessment. The use of lap buddies will be used in rare occasions when all other sources have been exhausted and the use will be properly documented and care planned. The DON and Administrative Assistant will monitor that the protocol is followed.

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	buddy independently. R3's clinical record did not indicate the use of a restraint other that to prevent him from falling forward. No other interventions, such as a seating evaluation, were attempted to avoid the use of the restraint according to the current care plan. 2. R5 was admitted to the facility on 09/11/07 with diagnoses including Dementia and was dependent upon staff for all ADL's. R5 was observed during the survey process with a lap buddy in place. R5 was asked if she could remove the restraint and was unable to do so independently. Certified Nursing Assistant flow sheets indicated the lab buddy was used for safety. Record review revealed there was no medical symptom to warrant the use of the lap buddy. Further, the current physician's order sheet (POS) dated May 2009 did not have a physician's order for the use of the restraint. No other interventions were attempted to avoid the use of the restraint according to the current care plan. 3. R8 was admitted to the facility on 04/04/09 with multiple diagnoses including Alzheimer's Dementia. R8 was observed during the survey process to have side rails up on both sides of the bed. Record review revealed there was no medical symptom to warrant the use of side rails. Further, the current POS dated 04/11/09 did not have a physician's order for the use of	2) R5 is longer using a lap buddy. Other methods have been implemented that have been working. R5 is able to rest comfortably in a chair with the use of a tabs monitor to alert staff if resident tries to get up. R5 is also monitored for pain if resident becomes restless. Lap buddies will only be used after all alternative methods have been implemented and found to be ineffective. This was reviewed with the staff at the meeting on Sept. 14th to assess residents for chair/position of comfort, toileting, activities and pain assessment. The use of lap buddies will be used in rare occasions when all other sources have been exhausted and the use will be properly documented and care planned. The DON and Administrative Assistant will monitor that the protocol is followed.

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	the restraint. There was neither an evaluation prior to the use of the restraint nor other interventions attempted to avoid the use of the restraint according to the current care plan. A review of facility policy and procedures on protective devices dated 08/29/00 stated the objective was to provide safety for the resident and prevent him from injuring himself or others. Further, there must be a physician's order. Identifiers of restraints included side rails and wheelchairs with lap buddies.	3) R8 was assessed and it was determined that the resident did not need side rails. Side rails are no longer used for R8. Use of side rails were addressed at the staff meeting on September 14th. In place of side rails we will use alternative methods such as low beds, tabs monitors, alarm pads, care planning the resident to find if there are reasons the resident may be attempting to get out of bed. The DON or administration must approve any use of side rails and order will be obtained for the chart. The DON and Administrative Assistant
3201.6.8.2 3201.6.8.2.2	**Menus** **Menus showing food actually served each day shall be kept on file for at least 3 months. When changes in the menu are necessary, substitutions of similar nutritive value shall be provided.** **This regulation is not met as evidenced by:** Based on staff interview, it was determined that the facility failed to retain 3 months of menus and/or substitutions on file. Findings include: 1. Interview of the dietary manager, E8, and administrative assistant, E9, indicated that no filed menu data sheets were available for the review period.	**3201.6.8.2** 1) The facility will keep on file menus showing food actually served each day and any substitutions of similar nutritive value that were served in a 3 month period. A form has been developed for staff to keep an accurate record of foods served and the Dietary Manager will monitor weekly that records are being kept daily. Please see attachment #6.

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3201.6.10 3201.6.10.2	**Pharmacy Services** **For a resident admitted or readmitted from the hospital with orders for nine or more medications (excluding over-the-counter medications), the facility shall complete an on-site or off-site pharmacy review within 10 days of admission or readmission.** **This requirement was not met as evidenced by:** Based on record review it was determined that the facility failed to have a pharmacy review following one admission and two readmissions to the facility for three (3) residents (R8, R2, R5) out of nine (9) sampled residents. Findings include: 1. Record review revealed that R8 was admitted to the facility on 04/04/09 with thirteen (13) prescription medications. According to the clinical record a medication regimen review was not completed by the pharmacist until 04/21/09, seventeen (17) days later. 2. Record review revealed that R2 was admitted to an acute care facility on 01/31/09 for pneumonia, pleural effusion and urinary tract infection. R2 was readmitted to the facility on 02/09/09 with twelve (12) prescription medications. According to the clinical record a	**3201.6.10** 1) In the future, a medication regimen review will be completed within 10 days on all admissions and re-admission to the facility with orders for nine or more medications and faxed to the pharmacy for review. The DON will review all charts on admissions and re-admissions to ensure that the MRR is being completed. The Pharmacy Consultant will monitor for compliance during his monthly reviews and QA will review at the quarterly meetings to ensure compliance. 2) In the future, a medication regimen review will be completed within 10 days on all admissions and re-admission to the facility with orders for nine or more medications and faxed to the pharmacy for review. The DON will review all charts on admissions and re-admissions to ensure that the MRR is being completed. The Pharmacy Consultant will monitor for compliance during his monthly reviews and QA will review at the quarterly meetings to ensure compliance.

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	medication regimen review was not completed by the pharmacist until 02/27/09, eighteen (18) days later. 3. Record review revealed that R5 was admitted to an acute care facility on 01/21/09 for complaints of chest pain. R5 was readmitted to the facility on 01/23/09 with thirteen (13) prescription medications. According to the clinical record a medication regimen review was not completed by the pharmacist until 02/27/09, thirty-five (35) days later.	3) In the future, a medication regimen review will be completed within 10 days on all admissions and re-admission to the facility with orders for nine or more medications and faxed to the pharmacy for review. The DON will review all charts on admissions and re-admissions to ensure that the MRR is being completed. The Pharmacy Consultant will monitor for compliance during his monthly reviews and QA will review at the quarterly meetings to ensure compliance.
3201.6.11	**Medications**	
3201.6.11.1	**Medication Administration**	
3201.6.11.1.1	**All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that the facility failed to administer	

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	medication as ordered by the physician for one resident (R1) and failed to have a physician's order upon admission for one (R8) out of nine (9) sampled residents. Findings include: 1. R1 was admitted to the facility on 12/08/06 with multiple diagnoses including anemia. Record review revealed a physician's order for Procrit 1ml (10,000 units) subcutaneously every week. A review of the medication administration record (MAR) indicated on 03/05/09 weekly scheduled Procrit was not given until 03/06/09, 04/13/09 dose was given on 04/15/09, 04/29/09 was given on 05/01/09. An interview on 05/07/09 with staff nurse, E3 stated prior to receiving the medication Procrit, hemoglobin and hematocrit lab work must be drawn and faxed to the pharmacy. E3 further stated this was not being done in a timely manner and lab work should have been drawn earlier to prevent the delay in receiving the medication as ordered by the physician. 2. R8 was admitted to the facility on 04/04/09 without a physician's order to administer medications. Record review revealed a physician's order was not obtained until 04/11/09 for thirteen prescription medications. R8 was briefly admitted to an acute care facility on 04/06/09 through 04/09/09 for weakness, headache	**3201.6.11** 1) R1 is now receiving his Procrit as scheduled. Hemoglobin and Hematocrit lab work is now scheduled on the MAR and the lab calendar to be given the day after the resident receives the injection. It is also indicated on the MAR to check on the availability of the Procrit the A.M. (24 hours) prior to when it is due to be given. The lab results are normally received within 24 hours. Once the nurse receives the lab work, it is then faxed to the pharmacy in order to receive the Procrit in time for the scheduled dose. The DON monitors all labs to be sure they are faxed to the pharmacy.

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	and tightness in the chest. Medication Administration Records (MAR) revealed the following medications Seroquel, Keflex, Lexapro, Actos, Aricept, Lisinopril, Namenda, Simvastatin and Albuterol (nebulizer) were administered by licensed professional nurses between 04/04/09 through 04/06/09 and 04/09/09 through 04/11/09 without written or signed orders by a licensed physician.	2) R8 was admitted as a respite admission for a short term stay and then was admitted. We no longer have a separate protocol for respite admissions. All residents who are admitted to our facility regardless of length of stay will follow the protocol for admissions. The facility will obtain physician orders for all residents regardless of length of stay. The DON will review the charts of new admissions to insure that physician orders are written and signed by the physician.
3201.6.12	**Communicable Diseases**	
3201.6.12.2	**Specific Requirements for Tuberculosis**	
3201.6.12.2.3	**All facilities shall have on file results of tuberculin tests performed on all newly admitted residents and newly hired employees, and annually thereafter on all employees. A tuberculin test as specified, done within the twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement. This regulation is not met as evidenced by:** Based on record review and staff interview, it was	

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	determined that the facility failed to perform annual, employee tuberculin tests and failed to test one (1) newly admitted resident (R3) out of nine (9) sampled residents. Findings include: 1. Employee #E6 had no record of a current tuberculin test being performed with in the last year. 2. R3 was admitted to the facility on 06/08/08. Record review revealed the tuberculin test (Mantoux) had not been performed on R3 upon admission. MAR's for April 2009 reflected the initial 1st and 2nd step tuberculin test was not performed until 04/24/09 and 04/30/09 respectively. This finding was confirmed with the DON, E2 on 05/11/09 at 2:30 PM.	**3201.6.12** 1) E6 was an active an employee but had been removed from the schedule prior to the survey because the facility had not obtained a copy of a current PPD. The employee did not work again until a copy of the PPD was obtained. Please see attachment #8 for a copy of the PPD for E6 that was done in October 2008. The facility will continue their policy of removing staff from the schedule when a PPD is past due. Once a current PPD is available, the staff will resume their schedule.
3201.6.12.2.6	**Persons who do not have a significant reaction to the initial tuberculin test shall be retested within 7-21 days to identify those who demonstrate delayed reactions. Initial tests done within one year of a previous test need not be repeated in 7-21 days.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that the facility failed to retest (1) one resident (R5) for tuberculosis out of nine (9) sampled residents. Findings include: R5 was admitted to the facility on 09/11/07. Record	2) Each resident's chart will be reviewed within 7 days of admission by the DON and at that time the chart will be reviewed for PPD compliance. PPD's will be scheduled for the first full day after admission to the facility. The DON will also review the chart at the end of each month for compliance. This was addressed with the nurses at the staff meeting on September 14th. PPD's are currently in compliance.

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	review revealed the 1st step tuberculin test was performed on 09/12/07. The results were not recorded. A 2nd step tuberculin retest was not performed within the 7-10 as required, provided the 1st step was negative. There was no further evidence within the clinical record that the tuberculin testing had been repeated on R5 since 09/12/07.	**3201.6.12.2.6** R5 received a 1st step tuberculin test on 5/13/09 and a 2nd step was done on 5/26/09. Both results were recorded on R5's chart. In the future, a 2 step tuberculin test will be done for residents who do not have a significant reaction to the first test and who have not had a tuberculin test within the past year. The second one will be done within 7 – 21 days of the initial test and will be scheduled on the MAR at the time when the first PPD is recorded. The DON will review the charts of new admissions at the end of the month to ensure that PPD's are being scheduled and results are being recorded.
3201.6.12.4.1	**All employees shall receive education and training on standard precautions, use of personal protective equipment, the importance of hand hygiene, the facility's infection control policies and reporting of exposures to blood or other potentially infectious materials.** **This regulation is not met as evidenced by:** Based on record review and administrative staff, E2 and E9, interview, it was determined that the facility failed to train new staff for infection control policies and procedures. Findings include: 1. Interview with the administrative staff, E2 and E9, revealed that the last infection control training took place in May of 2007. Based on the hire date, 27 out of 77 employees were hired after the training took place and had no current infection control training.	**3201.6.12.4.1** An infection control was completed by all staff on C-Diff and hand washing in May 2009. An updated schedule of all mandatory in-services was completed by the nursing office. A policy was created to mandate that in-services must be attended or done via reading/quizzes. If the in-service is not attended or completed, those staff will be removed from the schedule until it has been completed. A list of staff completing the in-services will be kept in the nursing office and monitored by the DON or her designee.

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3201.6.13	**Infection Control**	
3201.6.13.1.6	**The infection control committee shall establish the infection control training of staff and volunteers, and disseminate current information on health practices.** **This regulation is not met as evidenced by:** Based on record review and administrative staff interview, it was determined that the facility failed to ensure the education of infection control policies and procedures. Findings include: 1. The last infection control training took place in May of 2007. Based on the hire date, 27 out of 77 employees were hired after the training took place and had no current infection control training.	3201.6.13.1.6 An infection control was completed by all staff on C-Diff and hand washing in May 2009. An updated schedule of all mandatory in-services was completed by the nursing office. A policy was created to mandate that in-services must be attended or done via reading/quizzes. If the in-service is not attended or completed, those staff will be removed from the schedule until it has been completed. A list of staff completing the in-services will be kept in the nursing office and monitored by the DON or her designee.
3201.7.3	**Facility Systems Requirements**	
3201.7.3.1.3	**Hot water accessible to residents shall not exceed 110° F.** **This regulation is not met as evidenced by:** Based on hot water temperature readings taken in the resident rooms and bathing rooms, it was determined that the facility failed to provide hot water that did not exceed 110°F. Findings include:	

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	1. On 05/06/09, the hot water in the hand washing sink in room #120 was 116°F. A follow-up reading was taken in this room on 05/08/09 and found to be 117.9°F. 2. On 05/06/09, the hot water in the hand washing sink in room #119 was 112.2°F. 3. On 05/06/09, the hot water in the hand washing sink in the toilet room across from room #131 was 113.9°F. A follow-up reading was taken in the toilet room on the opposite wing of the old building on 05/08/09 and found to be 123.9°F.	**3201.7.3.1.3** The thermostats have been adjusted to meet the requirement that hot water does not exceed 110 degrees. The plumbing contractor, Schrock's Plumbing, has also been contacted to take a look at installing a more sensitive thermostat to help us stay in compliance. We anticipate having this corrected within 30 days. The administrative assistant will monitor that the problem is corrected in the time allotted and will monitor the temperature readings periodically to ensure compliance.
3201.7.4.3.1	**Bathroom walls and floors shall be impervious to water. Bathrooms shall have at least one window or mechanical ventilation.** **This regulation is not met as evidenced by:** Based on observation of the toilet room in the hallway near room #123, it was determined that the facility failed to provide a window or mechanical ventilation for the room. Findings include: 1. There was no mechanical ventilation or window provided to this toilet room	**3201.7.4.3.1** A contractor has been contacted to install a mechanical ventilation in the toilet room near room #123. We anticipate to have this completed within 30 days. The administrative assistant will monitor that the work is completed.
3201.7.5	**Kitchen and Food Storage Areas**	
3201.7.5.1	**Facilities shall comply with the Delaware Food**	

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	Code. **3-303.12 Storage or Display of food in Contact with Water or Ice.** **(A) Packaged food may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water.** **This regulation is not met as evidenced by:** **Based on observation of the tray preparation area in the kitchen, it was determined that the facility failed to keep Mighty Shake cartons away from contact with standing water from melted ice. Findings include:** **1. On 05/06/09, the ice pan that contained juices and shakes had no mechanism for draining away standing water.** **4-302.12 Food Temperature Measuring Devices.** **Food temperature measuring devices shall be provided and readily accessible for use in ensuring attainment and maintenance of food temperatures**	**3201.7.5** Grates were purchased that fit in the bottom of the bins and are effective in draining water away from the milk and shake cartons. The dietary staff was instructed on how to use at the dietary staff meeting on 5/19/09 and a handout provided to illustrate. Please see attachment #9.

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	as specified under Chapter 3. **This regulation is not met as evidenced by:** Based on observation of three, reach-in freezer units in the dietary area, it was determined that the facility failed to have a temperature monitoring devices in all units. Findings include: 1. The three, storage / receiving area, reach-in freezer units of the dietary area had no internal thermometers for indicating the internal temperature of the units.	**4-302.12** Thermometers were purchased and placed in the three freezer units. The dietary manager will check weekly to ensure the thermometers are in place and will report to the administrative assistant for replacements.
3201.8.0	**Emergency Preparedness**	
3201.8.1	**Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.** **NFPA 101 Life Safety Code** **Section 7-6 Fire Detection, Alarm, and Communication Systems.** **7-6.2 Signal Initiation** **7-6.2.8 Complete Smoke Detection Systems.**	

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	Where a complete smoke detection system is required by another section of this Code, automatic detection of smoke in accordance with NFPA 72, National Fire Alarm Code, shall be provided in all occupiable areas, common areas, and work spaces in those environments suitable for proper smoke detector operation. **This regulation is not met as evidenced by:** Based on observation of room #120, it was determined that the residents' room was missing a smoke detector. Findings include: 1. The receptacle in the ceiling designated for the smoke detector was vacant. No other smoke signaling device was observed in the room.	**3201.8.1** We have contacted Homeland Security and Fire Protection, the agency that is contracted to provide our fire alarm testing. They are scheduled to come within the next 30 days to correct the problem with the smoke detector. The administrative assistant will monitor that the problem is corrected in the time allotted.
16 Del. C., Chapter 11, Subchapter II §1121	**Patient's Rights (24)** **Every patient and resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food and deprivation of sleep.** **This requirement was not met as evidenced by:**	

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	Based on record review and interview, it was determined that the facility involuntarily secluded one resident (R2) out of nine (9) sampled residents. Findings include: Cross refer 6.1.1 Example #2. R2 was admitted to the facility on 04/23/07. According to staff and the clinical record, R2's cognition was intact. On 03/02/09 R2 tested positive for the bacterium Clostridium difficile (C. Diff., a bacterium that causes diarrhea)) and was isolated from other residents and secluded to her room for eighteen (18) days until 03/20/09. On 03/27/09, R2 again tested positive for C. Diff. and was placed in isolation and seclusion a second time from other residents for thirty-five (35) days. R2 stated on 05/08/09 she had not been out of her room for the last five (5) weeks and was eager to leave her room. A review of facility policy and procedures identified C. Diff. as a communicable disease and incorrectly stated any resident that has a communicable disease should be kept in their room away from community areas until symptoms have passed.	**16 Del. C.,** **Patient's Rights (24)** 2a) R2 is no longer confined to the room and an in-service was held on C-Diff. Please see attachment #3. It was reviewed that C-Diff is contact isolation only. In the future the DON will monitor all residents on isolation for proper technique and protocol. When a resident is put on isolation, the DON will in-service the staff caring for the resident with a hand out on that particular type of organism and answer any questions they may have. The Department of Public Health will be contacted for any questions that are unknown or in questions.

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	According to the Department of Public Health on 05/11/09, C. diff. is a contact isolation precaution only and does not warrant the seclusion of residents. The facility failed to properly identify the appropriate method for caring for a contact isolation C. Diff. bacterium resident, resulting in involuntary seclusion of R2 for a total of fifty-three (53) days.	
16 Del. C., Chapter 11, Subchapter III, §1131	**Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients (9)a** **"Neglect" shall mean lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.** **This requirement was not met as evidenced by:** Cross refer 3201.6.1.1 Example #1 Based on observation record review and interview, it was determined that the facility neglected to address the physical needs of one resident (R9) out of nine (9) sampled residents. Findings include: R9 was admitted to the facility on 05/31/08 with the known painful diagnosis of Fibromyalgia and arthritis of the right knee. During the period of time beginning	

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	03/03/09 until the survey exit date of 05/12/09, record review revealed R9 displayed behaviors including yelling aloud, screaming and crying according to clinical record documentation. Observations were made of R9 during the survey process and reflected the same. The physician was notified by staff and telephone orders were obtained on 03/20/09, 03/25/09, 05/04/09, 05/05/09, 05/08/09 and 05/11/09 for medication to address pain and behaviors. In addition, on 5/06/09 there was a physicians order for a dental consult as a result of staff discovering lower decaying teeth that possibly contributed to the source of R9's pain. As of 05/12/09, R9 had not received the dental consult even though a message was left for the dentist on 05/07/09. R9 was treated with a combination of pain and anxiety medications from March –May 2009 including: Xanax, Tylenol 500 mg., Tylenol with Codeine, Vicodin, and Ativan. A recent order on 05/11/09 included the drug Roxanol. There was no documentation within the clinical record that the attending physician examined the resident on or subsequent to the onset of behaviors or at anytime of prescribing the pain/anxiety medications. Further, there were no nursing assessments performed during this time frame from 03/09 – 05/09 in attempt to determine the actual source	**16 Del. C.,** **Neglect** 1) R9's change in status was assessed and the care plan was updated. Please see the attachment for a copy of her care plan. Her plan of care addresses pain control methods through several different interventions that are working to keep her pain free. R9 was assessed by the dentist on May 15th and the report indicated he did not feel pain was from the teeth/gums. R9 was assessed by the physician on March 21st and May 19th. Please see attachment #2. Pain in dementia residents was reviewed at the in-service on September 14th with a hand out. There is also an in-service scheduled for October 12th on Pain by Compassionate Care Hospice. The DON will make rounds on a daily basis to assess residents for pain and effective interventions in a timely manner. The DON will monitor that an assessment and care plan will be reviewed/revised as needed for significant changes in physical and mental conditions and will be done at least quarterly.

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	of pain and properly care plan for R9. R9 was never sent out of the facility for a diagnostic evaluation to locate the source of the pain. Interviews with one medication nurse E4, a staff nurse, E5 and the Hospice nurse confirmed R9 was in pain however, the source of the pain was speculative. The facility neglected R9 by failing to attend to her physical needs by lack of assessments, diagnostic evaluations and physician examinations, both medical and dental, to determine and address the cause of pain R9 was experiencing.	