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

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STATE SURVEY REPORT

LTC Residents Protection
OCT 23 2009
Director's Office

NAME OF FACILITY: Foulk Manor South

DATE SURVEY COMPLETED: August 4, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning July 29, 2009 and ending August 4, 2009. The facility census on the entrance day of the survey was 42. The survey sample was composed of 6 residents. The survey process included observations, interviews and review of residents' clinical records, facility documents and facility policies and procedures.	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared solely as a matter of compliance with state law.
3201.6.0	**Services To Residents**	
3201.6.5	**Nursing Administration**	
3201.6.5.6	**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 a 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 is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to ensure that a care plan was reviewed and revised to	**3201.6.5.6** 1. Resident # 3 is no longer in the facility. 2. All current residents' care plans will be reviewed for the last 90 days to ensure they are current and address each resident's needs. 3. a. All current license staff will be provided in-service education on the care planning process and communication of changes in the resident's plan of care to ensure resident care needs are met and appropriate interventions are in place. b. A random audit of care plans will be conducted monthly on 10% of the facility's population by the DON/Nurse Designee to ensure care plans are current and meet each resident's needs. Findings will be reported to the NHA in the monthly QA meeting with corrective action as warranted. 4. Care plan completion and updating will be continuously monitored by the DON or designee. **Completion Date: November 23, 2009**

Provider's Signature [signature] Title Exec. Director Date 10/22/09

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	address pressure ulcers developed by one resident (#3) in the sample. Findings include: Clinical record review revealed that a care plan developed for Resident #3 on 7/28/08 failed to address excoriated and open areas of Resident #3's buttock and failed to include time frames for goals and specific interventions. Clinical record review also revealed that the facility reviewed the care plan on 9/18/08 but failed to revise it to address Stage 2 pressure ulcers of Resident #3's feet. These findings were reviewed with E1 (administrator), RN1 (DON) and RN2 (regional nurse) on 8/4/09.	
3201.10 3201.10.5	**Records and Reports** **Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow up action, including notification of the resident's representative or family, attending physician and licensing or law**	**3201.10.5** 1. Resident # 4 is no longer at the facility. 2. All residents have the potential to be affected by this cited practice. 3. a. All current license staff will be provided in-service education on the facility's policy and procedure on incident and accident reporting.

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	enforcement authorities, when appropriate. **This requirement is not met as evidenced by:** Based on clinical record review, review of a facility incident report and staff interview it was determined that the facility failed to notify a family representative of an incident that involved a resident (#4). Findings include: Review of the clinical record revealed a nurse's note dated 2/22/09 and timed 11:35 PM that included a description of the care and treatment delivered to Resident #4 following a fall in her room. The same nurse's note also stated "MD (and hospice) notified. Oncoming nurse made aware to notify POA (power of attorney) in AM on 2/23/09...". A nurse's note timed 10:00 AM on 2/23/09 revealed the "family very upset" when informed that an x-ray was ordered for complaints of left-side pain from a fall suffered by Resident #4 on 2/22/09. Review of the facility incident report dated 2/22/09 and timed 10:30 PM revealed the absence of any documentation to indicate that the "Responsible Party" was notified of Resident #4's fall on 2/22/09. These findings were reviewed with E1	b. It will be the responsibility of the Shift Supervisor to review each incident immediately after the incident occurrence to ensure timely notifications of appropriate responsible parties has been completed and documented in accordance with facility policy. c. An incident checklist will be utilized which will review and monitor completeness to ensure prompt notification of families. 4. a. All incidents will be reviewed in the daily stand up meeting by the DON/MOD/Designee to assure documentation has been completed. b. Findings will be reported to the NHA with immediate corrective action. **Completion Date: November 23, 2009**

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	(administrator), RN1 (DON) and RN2 (regional nurse) on 8/4/09. The facility policy "Incident/Accident Reporting Process" states "...3.0 Procedure...3. When the incident/accident involves a resident, the employee responding will...**Promptly notify** appropriate responsible party/family member by phone...".	
16 Del., C., Chapter 11, Subchapter II, §1121	**Patient's rights.** **It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which include but not be limited to the following:** **(1) Every patient or resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's**	**16 Del. C Chapter 11 Subchapter II, 1121** 1. Resident #3 is no longer at the facility. 2. All current residents with a pressure ulcer/wound will have their medical record audited to ensure accurate documentation and assessment of the pressure ulcer/wound has been completed. 3. a. All current license staff will be provided in-service education on the facility's wound care policy and procedures, proper wound documentation, staging of wounds with measurements and skin checks. b. All residents identified with a pressure ulcer/wound will be assessed weekly during wound rounds by the DON/Nurse Designee and a Nurse Practitioner certified in wound care, to ensure accurate staging and documentation of the identified pressure ulcer/wound has been completed.

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	basic personal and property rights which include dignity and individuality. **This requirement is not met as evidenced by:** Based on clinical record review and staff interviews it was determined that the facility failed to ensure that one resident (#3) at risk for pressure ulcers received appropriate care. Findings include: The facility policy "Skin and Wound Management Program Guidelines for Care and Practice" states "3.0 Procedure:..3...Qualified staff will assess all residents weekly, from "head to toe" to identify any new pressure ulcers...Results of weekly assessments will be documented...in the resident's medical record. 4. When a pressure ulcer/wound is identified, the licensed nurse will document in the progress notes and complete an Initial Wound Assessment, to include size, stage, location, drainage, odor; obtain treatment order, initiate a care plan and notify the interdisciplinary wound committee. 5. The licensed nurse will communicate all identified pressure ulcers/wounds to the attending physician and family. The licensed nurse will document notifications in the medical record." Review of the clinical record revealed that Resident #3 was admitted to the long term care	4. a. The DON/Nurse Designee will track and trend causes of occurrences in pressure ulcer/wounds and report findings to the NHA. b. Weekly monitoring of the accuracy of staging and documentation of pressure ulcers/wounds will be done by the DON/Nurse Designee and findings will be reported in the monthly QA meeting with corrective action as warranted. **Completion Date: November 23, 2009**

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	facility on 7/25/2008 with diagnoses that included dementia, congestive heart failure (CHF), atrial fibrillation, coronary artery disease (CAD) and gait dysfunction. Further review of the clinical record revealed a facility form "Nursing Assessment" was completed 7/25/08 that indicated Resident #3 had short-term and long-term memory loss, severely impaired decision-making skills and was dependent for toileting, personal hygiene and bathing. Clinical record review also revealed that the physician admission orders for Resident #3 included an order for "...Treatment to (bilateral) buttocks...for excoriated and scattered open areas." Further review of the clinical record revealed that a nursing assessment and nursing note completed upon admission to the facility on 7/25/09 lacked adequate assessment of Resident #3's excoriated and open areas of the buttocks that placed him at risk for the development of pressure ulcers. Clinical record review revealed that affected sites referenced above were either briefly described or excluded from any documentation in the nurses' notes. Additionally the above referenced sites that were documented in the nurses' notes varied in stages of healing. After documentation of "buttocks wounds healing" on 8/1/08, a nurse's note dated 8/4/08 revealed that	

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	"open areas remain (bilateral) buttocks". Another nurse's note documented 8/19/08 stated "sacral wound reopened". However any documentation of a healed sacral wound was absent from the clinical record. A physician progress note dated 8/20/08 revealed that Resident #3 was diagnosed with "Stage 2 sacral and intragluteal decubitus ulcers" approximately 25 days after admission to the facility. A physician's progress note dated 9/9/08 revealed that Resident #3 had developed an unstageable sacral pressure ulcer with eschar to the center and multiple Stage 2 pressure ulcers of the buttocks in addition to facility acquired Stage 2 bilateral heel ulcers. The final physician note recorded prior to Resident #3's transfer to an acute care facility on 10/11/08 described his sacral pressure ulcer as unstageable and having a "necrotic/eschar wound bed. However weekly evaluations of the sacral and bilateral heel pressure ulcers documented 9/16/08 through 10/7/08 by licensed staff revealed the sacral ulcer was a stage 2. In an evaluation conducted on 10/7/09 of the right buttock it was staged as 2. Evaluations performed 9/23/08 through 10/7/08 assessed the left heel as stage 2 and unstageable. Evaluations of the right heel were absent despite documentation of the presence of a stage 2 pressure ulcer by the	

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	physician on 9/23/08. The facility failed to ensure that the care of Resident #3 included assessment of risk factors and the monitoring and documentation of actual pressure ulcers including accurate measurements for evaluation of deterioration or improvement of the ulcers. These findings were reviewed with E1 (administrator), RN1 (DON) and RN2 (regional nurse) on 8/4/09.	
16 Del., C., Chapter 11, Subchapter III, §1131	**Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **Definitions.** **When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.** **(3) "Neglect" shall mean:** **a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.** **This requirement is not met as evidenced by:**	**16 Del. C. Chapter 11 Subchapter III, 1131** 1. Resident #4 is no longer at the facility. 2. a. All residents have the potential to be affected by this cited practice. b. All current residents' personal monthly care records will be audited to ensure documentation of showers. 3. a. All direct care staff will be provided in-service education on documentation of showers on the monthly personal care records and resident rights. b. All residents' bath type will be noted under the bathing section on the monthly personal care record flow sheet. On the designated Shower day the direct care staff will enter a "S" if a shower was given, a "B" if bed bath was given, and an "R" for refusal.

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	Based on record reviews and staff interview it was determined that the facility failed to provide a scheduled bath for Resident (#4) in accordance with her care plan. Findings include: Review of Resident #4's clinical record revealed a progress note documented by D2 (nurse practitioner) on 12/26/08 that stated "...does not want to burden anyone, missed her shower-upset...". Further clinical record review revealed the absence of any documentation on the form, "Resident Monthly Personal Care Record", that indicated a shower was provided to Resident #4 during the night shift or the day shift on 12/26/08. Additionally documentation completed during the evening shift on 12/26/08 indicated that Resident #4 did not receive a shower. Review of the clinical record also revealed development of the care plan for the problem "Total assist with ADL care" and included the intervention "Provide showers/tub bath...". The facility failed to provide a shower for Resident #4 in accordance with her care plan. In an interview conducted with RN1 (DON) on 8/4/09 the bath schedule for Resident #4 was confirmed for Wednesdays and Saturdays on the night shift. The absence of a documented bath for	c. All refusals will be reported to the charge nurse and will be documented on the 24 hour nursing report. 4. Weekly monitoring of each resident's personal care record will be completed by the DON/Nurse Designee for the next 6 months and then a monthly random audit will be completed by the DON/Nurse Designee of the residents' monthly personal care records to ensure compliance. Findings will be reported to the NHA in the monthly QA meeting with corrective action as warranted. **Completion Date: November 23, 2009**

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	Resident #4 as scheduled on Wednesday, December 26, 2008 was also reviewed with RN1 during this same interview on 8/4/09. These findings were reviewed with E1, RN1 and RN2 on 8/4/09.	