

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

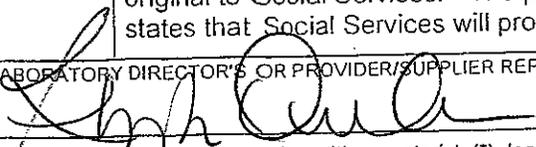
PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

LTC Residents Protection
OCT 06 2009
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from August 6, 2009 through August 14, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility and hospital documentation as indicated. The facility census the first day of the survey was 162. The survey sample totaled 25 residents, which included a review of 22 active records and three (3) closed records. Additionally, there were eight (8) sub-sampled residents.	F 000		10/17/09
F 166 SS=D	483.10(f)(2) GRIEVANCES 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 interviews and facility policy, it was determined that the facility failed to investigate grievances for two residents(R16 and SSR33) regarding missing items. Findings include: 1. During the group interview on 8/7/09, SSR33 stated that she had several articles of clothing missing from the laundry that were never found. SSR33 also stated that the facility did not respond to her complaints about the missing items. Facility policy titled, "Resident Missing Item" states, "All completed Missing Items forms will be forwarded to the Administrator....and forward the original to Social Services." The policy also states that Social Services will provide a copy of	F 166	F 166 Missing items for Resident SSR33 were logged by Social Services. Resident was informed of resolution. Missing item for Resident R16 was logged by Social Services. Resident was informed that missing items would be replaced. An incident report was also completed and reported to all the State authorities. Resident Concern policy and procedure and Incident Report policy and procedures were reviewed to insure that all reported concerns/complaints and incidents are addressed and residents are given information regarding resolutions to their concern, in a timely manner. The policies and procedures were updated to include updated information. All staff will be re-in serviced on both the Resident concern and incident policies and procedures by Staff Development. Audits will be conducted by Social Service to insure timely follow-up on resident concerns and incidents and that residents are informed of resolutions to their complaints / concerns and incidents Results of audits will be presented to the QA committee	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/6/09
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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 166

Continued From page 1

the form to all departments within 24 hours and record the items in the "Missing Item Log." It states, "Social Services or designee will contact the resident or family member within 10 days of the date the administrator signed the missing item report to inform them of the outcome of the search for the missing item."

During an interview with SSR33 on 8/13/09, she stated that she lost two dresses in the laundry about one year ago as well as a skirt and some blouses a few months ago. She stated that she recently lost a sweater. She stated that she reported these missing items to the previous administrator, who is no longer at the facility, however, no one responded to her complaint.

Review of the "Missing Item Log" lacked evidence of SSR33's missing items.

Review of SSR33's clothing inventory list lacked quantities of her clothing items. Interviews with E20 (Certified Nursing Aide) and E21(nurse) on 8/13/09 revealed that when a resident is admitted to the facility, the quantity of each clothing item should be recorded.

2. On 8/12/09 at 3:45 PM, an interview was conducted with R16, and E4 (Risk Manager). R16 reported his wallet and \$50.00 (different than reported in nurse's note) had been missing since 7/20/09. R16 stated he had reported this to E31 (CNA) and that E31 searched but was unable to recover the missing items. E4 stated that the procedure was for the staff to fill out a "Concern" form and give it to the Administrator and notify the other departments so that a thorough search could be conducted. An incident report should also be faxed to the state (DLTCRP).

F 166

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F 166	Continued From page 2 R16's nurse's note dated 7/20/09 and timed 10:30 PM stated, "... reported... has lost his wallet c (with) \$40.00 dollars in it.... This writer searched and was not found." Although E30 (nurse) documented the loss of the wallet and money in the nurse's note, she failed to complete a "Concern" form and failed to note it on the 24 hour report. She also failed to complete an incident report. On 8/12/09, a concern form entitled, "Resident/Family Missing Item(s) Form" was completed and an investigation initiated after the surveyor brought this matter to the facility's attention.	F 166		
F 174 SS=B	483.10(k) TELEPHONE 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 observations, staff interviews and an individual resident interview, it was determined that the facility failed to provide residents phone access in a private area where calls could be made without being overheard. Findings include: On 8/14/09 at 10:10 AM, SSR31 was observed asking staff to use a phone. E22 (CNA), brought the resident to the Hammond wing nurse's station to use the phone. While E22 was helping SSR31 dial the phone, the resident was interrupted three times by incoming calls before he was able to place the call. When asked if there was a private place for a resident to make a call, E22 stated that the nurse's station was the only place that	F 174	F 174 Facility purchased and installed cordless phones on Christiana, Hammond and Eastburn wing. Phones will be provided to residents in areas of resident preference. All staff will be in-serviced on phone availability by Staff Development. All residents will be informed of phone availability by Social Services. New residents will be informed at time of Admission. Social Service and Staff Development will conduct Periodic surveys of residents and staff to ensure residents and staff are aware of phone availability. Results of audits will be presented at the quarterly QA meeting.	10/17/09

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F 174	<p>Continued From page 3</p> <p>she knew for a resident to use the phone. E23 (Unit Clerk) agreed that the nurse's station was not a private place to make a phone call.</p> <p>In an interview with E12 (nurse), she stated that residents sometimes used phones in staff offices and that there was also a phone in the B-wing dining room that was available for resident use. Interview with Human Resource staff, E24 and E18 revealed that they were unsure of where residents could make private phone calls besides staff offices, but they would try to find out.</p> <p>During an interview with E14 (nurse) on 8/14/09, she stated that residents can make phone calls using the phone in the B-wing dining room or in the unit manager's office.</p> <p>Interview with SSR32, who was alert and oriented on 8/14/09, revealed that the only places that he knew that residents could make phone calls was the B-wing dining room or at nurses stations.</p> <p>During an interview with E25 (Corporate Nurse) and E26 (General Manager) on 8/14/09, they revealed a cell phone that was kept in the administrator's office which was for residents' use. They confirmed that facility staff were unaware of the existence of the cell phone and stated that they would make them aware of its availability to the residents.</p>	F 174		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>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</p>	F 225		

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F 225 Continued From page 4
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.

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:
Cross refer to F166, example #2.
Based on record review and interview, it was determined that for one (1) resident (R16) out of 25 sampled, the facility failed to immediately report and thoroughly investigate an allegation of misappropriation of property when the resident

F 225

F 225
Missing item for Resident R16 was logged by Social Services. Resident was informed that missing items would be replaced. An incident report was also completed and reported to all the State authorities.

Resident Concern policy and procedure and Incident Report policy and procedures were reviewed to insure that all reported concerns/complaints and incidents are addressed and residents are given information regarding resolutions to their concern, in a timely manner. The policies and procedures were updated to include updated information.

All staff will be re-in serviced on both the Resident concern and incident policies and procedures by Staff Development.

Audits will be conducted by Social Service to insure timely follow-up on resident concerns and incidents and that residents are informed of resolutions to their complaints / concerns and incidents

Results of audits will be presented to the QA committee

10/17/09

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F 225 Continued From page 5 reported his wallet and cash missing. Findings include:

An interview with R16 on 8/12/09 revealed that he had reported his wallet (change purse) with \$50.00 dollars in it, missing since June and that to his knowledge, it had never been found and no one ever got back to him. (R16's report differs from 7/20/09 nurse's note.)

A nurse's note dated 7/20/09, documented that R16 had reported a lost wallet with \$40.00 in it, missing from his pocket, where he always put it when he slept.

An interview with E4 (Risk Manager) on 8/12/09 revealed that no incident report had been completed and no investigation conducted. The interview confirmed that the facility failed to immediately report and thoroughly investigate R16's missing property until the surveyor brought this matter to the facility's attention.

F 241 483.15(a) DIGNITY SS=D

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 and interview, it was determined that the facility failed to ensure care was delivered in a manner that enhanced one resident's (SSR29) dignity. Findings include:
On 8/13/09 at 4:35 PM, SSR29 was observed seated on the toilet in the shower room. The

F 225

F 241

Residents SSR29 had no negative outcomes from the events noted. Social Services has interviewed resident and identified no ongoing concern within the deficiency.

The C.N.A was inserviced on residents the centers privacy and dignity Policy and procedure.

Rounds will be completed during each shift by Unit Managers & Supervisors to ensure respect of resident privacy as it relates to shutting doors and/or privacy curtains.

The facility reviewed its "DIGNITY" policy procedure no updates were necessary.

Staff Development will provide in-service education to all staff members regarding facility policies and procedures regarding resident rights / dignity requirements including, but not limited to, resident privacy related to the provision of care.

The inter-disciplinary team members will be assigned to complete a "DIGNITY" audit on a monthly base and will report those finding to the Administrator and Director of Nurses for monitoring. The findings will be reported to the monthly QA Committee

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F 241	Continued From page 6 shower room door was open and no curtain was pulled, allowing anyone passing full view of SSR29. While toileting SSR29, E34 (Certified Nurse Aide) failed to close the door to the shower room and only partially pulled the privacy curtain. During an interview, both E34 and E35 (nurse) acknowledged that SSR29 was left exposed in an undignified manner in view of anyone passing in the hall.	F 241		10/17/09
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide an ongoing program of activities designed to meet the needs of 1 resident (R22) out of 25 sampled in accordance with the residents' comprehensive assessments, interests, physical, mental and psychological well-being. Findings include: R22 was admitted to the facility on 3/12/08 with multiple diagnoses including Parkinson's disease and dementia. Review of R22's initial activities assessment, dated 3/17/08, revealed that his current interests included sports, music (old standards and opera), walking/wheeling outdoors, watching TV (news and game shows), talking/conversation and that he enjoyed travel. His activity care plan, last	F 248	F 248 Care plan for R22 was updated to include approach of 1:1 intervention in room with participation in out of room activity 2 times per week, a radio with CD player was placed in R22's room. Activity staff will offer to play music on a daily basis. The daily activity schedule will be verbally reviewed with R22 daily during morning distribution. Activity staff will invite and escort to any chosen activity. Activity director will conduct a daily communication meeting with activity staff to discuss declines in physical, cognitive or social aspects of resident care. All staff will be in-serviced on proper documentation of refusals and active participation vs. passive participation Activity Director will monitor participation logs weekly for missed or improper documentation. Activity Director will implement monthly QI study to track any residents with significant change in level of participation. Activities Director will ensure that residents are appropriately care planned and any interventions have been put in place and are effective. Results will be reported to the QA Committee.	

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F 248	<p>Continued From page 7</p> <p>updated on 7/11/09, identified the goal, "Resident will attend small group activities on unit such as Music with Gabe, Reminisce and food socials 2x per week x 90 days." Approaches included inviting, encouraging and assisting resident to activities.</p> <p>During a family interview with R22's Power of Attorney (POA) on 8/12/09, the POA stated that R22 was very friendly and sociable and that he enjoyed fishing, hunting, gardening and cooking. She stated that he did not participate in activities very much. During the interview, the resident stated that no one was available to escort him to activities. R22 stated that it took all of his energy going all the way down and back to the dining room twice a day for meals. The resident stated that he wanted to get back into physical therapy because he was bored sitting in his room all day.</p> <p>Observations of R22 during the survey from 8/12/09 through 8/14/09, revealed that he spent most of the time in his room alone. His room lacked a TV, radio or other leisure time materials. On 8/13/09 at 9:30 AM, R22 was observed sitting alone in his room at which time he stated that he was bored and was going back to bed.</p> <p>Review of R22's activity logs from 6/1/09 through 8/12/09 revealed that he attended at least two group activities per week from 6/1/09 through 7/4/09, however during the weeks of 7/5/09 through 7/11/09, 7/19/09 through 7/25/09 and from 8/1/09 through 8/12/09 he did not attend any group activities. Throughout the time period, it was documented that he participated daily in "friendly visits, watch TV/movie, listen to radio and socializing."</p>	F 248		

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F 248	Continued From page 8 During an interview with E6 (Activities Director) on 8/13/09, she stated the "friendly visits" meant the daily visit by activity staff to resident rooms to bring them the daily schedule. When asked why watching TV and radio was recorded for the resident when he had neither in his room, she stated that he sometimes went into the lounge to watch TV and that they had a radio in the dining room, however, the radio had been missing for the past month. Socializing meant that the resident spoke with other residents. The facility failed to provide an on-going program of activities to meet the interests of R22. As his interest in attending group activities declined, the facility failed to provide in-room activities to stimulate the resident resulting in his becoming increasingly bored and unmotivated.	F 248		
F 250 SS=D	Findings were reviewed with facility staff at the informational meeting on 8/14/09. 483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on closed clinical record review and interview, it was determined that the facility failed to ensure that one (1) resident (R23) out of 25 sampled was provided appropriate medically-related services to meet this resident's needs. The facility failed to ensure that R23, an alert and oriented resident, received the needed	F250	Resident R23 has been discharged from the center, the resident was not counseled Incident policy and procedure was reviewed and revised to insure that Social Service staff are given information regarding any incident resolutions. The policy was also updated to address and that residents will receive emotional support. Social Service staff are given information regarding the incident resolutions. The facility will review and revise its Incident/Accident Policies and Procedures to include new Incident/Accident reporting forms Audits will be conducted to insure follow-up on resident concerns, if reasonable. Residents will be informed of resolutions to their incident. Results of audits will be presented to the QA committee	10/17/09

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F 250	<p>Continued From page 9</p> <p>counseling services after she reported to the facility staff that a staff member "smacked" her on the face. Findings include:</p> <p>R23 was admitted to the facility on 11/27/08 with diagnoses that included dementia, diabetes mellitus, osteoporosis, coronary artery disease, deep vein thrombosis, and hypertension. R23 was also legally blind. According to R23's Minimum Data Set (MDS) assessment dated 12/2/08, her cognitive skills for daily decision-making were "modified independence-some difficulty in new situation only". She had no short or long-term memory problem. R23 was totally dependent of staff for all activities of daily living (ADLs).</p> <p>A nurse's noted dated 11/30/08 stated, "Pt. (patient) stated a staff member, who she could not identify, smacked her in the face." No red area or bruising noted". The facility's investigation of the incident revealed a written statement from E16(LPN) dated 11/30/08 and timed 12:15 PM stated, "...At lunch time pt. was wheeled back to B-wing lunch room. Pt. refused to eat lunch, stating, "After what happened, I'm not eating any of the food here.". When questioned about what had happened, pt. stated, "I got slapped...She slapped me in the face so hard my teeth rattled...The person who took me for a walk...".</p> <p>Review of R23's clinical record failed to indicate that the nursing staff or Social Worker provided emotional support and/or arranged to provide needed counseling services to meet this resident's needs at the time of the resident's allegation and prior to the facility's investigation of the incident. In an interview with E5 (Social Services Director) on 8/14/09, she acknowledged</p>	F 250		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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 250	Continued From page 10 that emotional support or counseling was not provided to meet R23's needs.	F 250		10/17/09
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to provide maintenance services necessary to maintain an orderly interior. Finding includes: Observations on 8/6/09 at 9:30 AM of resident room A15 revealed that the front door could not be closed completely. An interview on 8/12/09 at 11:15 AM with E8 (Director of Maintenance) confirmed the threshold was too high.	F 253	F253 Maintenance repaired Resident A15's door during survey. Entire facility will be assessed for Environmental issues cited as well to identify other areas deemed to be in disrepair. All identified items will be repaired or replaced as necessary. All staff will be in-serviced by Staff Development on identifying and reporting environmental issues. Policy and procedure for Environmental rounds was reviewed and no changes necessary Environmental rounds will be conducted monthly by the Director of Environmental Services. Results will be reported to the Administrator. Results of audits will be presented to the QA committee	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS 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.	F 279		

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

PRINTED: 09/09/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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F 279	Continued From page 11 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 clinical record review and staff interview it was determined that the facility failed to ensure that one (1) resident (R6) out of 25 sampled had a care plan which reflected the need to monitor for potential bleeding due to anticoagulant use. Findings include: R6 was admitted to the facility on 4/23/09 with diagnoses that included congestive heart failure and atrial fibrillation. Admission orders, dated 4/23/09 included administration of Coumadin (blood thinner, which has the potential to cause bleeding). Although the facility developed a plan of care for R6, they failed to include the potential for bleeding and the need for close monitoring due to anticoagulant therapy. During an interview with E11 (nurse) on 8/13/09 at 8:45 AM, E11 acknowledged the lack of a care plan for R6 for anticoagulant use and the potential for bleeding. F 280 SS=D CARE PLANS The resident has the right, unless adjudged	F 279	F279 The care plan for Resident R6 was reviewed by the Interdisciplinary care team with preventative measures identified/implemented and care plan updated. Pharmacy will provide a listing of all residents on anticoagulants. All residents assessed as having a potential for bleeding will have a care plan developed for potential for bleeding and preventative protocols initiated as necessary. The Policy/Procedure for identifying Residents with potential for bleeding was reviewed, revisions were not necessary. Pharmacy will provide a listing of all residents on Anticoagulant therapy on a monthly basis. Director of Nursing will review and ensure the Appropriate care pans and interventions are identified. Findings will be reported by the quarterly at the QA meeting.	10/17/09

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

PRINTED: 09/03/2009
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OMB NO. 0938-0391

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F 280

Continued From page 12

incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

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 care plan was revised by a team of qualified persons after each assessment for 2 (two) residents (R8 and R15) out of 25 sampled. Findings include:

Cross refer to F315

1. The facility initiated a care plan for R8 on 4/1/08 for "Alteration in Elimination R/T (related to) resident being incontinent. Resident is incontinent of bladder or bowel and has no memory recall and/or ability to retrain. Is continent of Bowel @ times". (The annual Minimum Data Set (MDS) assessment dated 03/02/2009, indicated that R8's cognitive skills for daily

F 280

F280

Resident R8 was reassessed; bowel and bladder retraining was Initiated. The care plan was updated to reflect changes.

All resident Bowel and Bladder assessments will be reviewed. For any resident with a score greater than 14, the Bowel and Bladder protocol will be initiated. Care plans will be updated as necessary.

Staff Development will in-service nursing staff on the Bowel and Bladder policy and procedure.

Unit Managers will review and ensure the appropriate care pans and interventions are identified.

Findings will be reported at the quarterly QA Meeting.

Resident R15's care plan was updated to reflect the need for 1:1

Any resident requiring 1:1 services will be reviewed at each change of shift. Inter-disciplinary team will review documentation daily for compliance with facility policy.

All nursing staff will be in-serviced by Staff Development on the 1:1 policy and procedure, the care planning policy and procedure as well as the policy for documenting doctor's orders.

Director of Nursing will review and ensure the appropriate care plans and interventions are identified.

Findings will be reported quarterly at the QA Committee. mittee.

10/17/09

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

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F 280	<p>Continued From page 13</p> <p>decision-making were "independent-decisions consistent/reasonable and that she had no long and short term memory loss"). The care plan included the interventions, "...Administer peri care after incontinency and apply protective barrier...Use pads or briefs." This care plan was reviewed monthly until 7/23/09.</p> <p>Review of R8's clinical record revealed that a "Bowel and Bladder Rehabilitation Assessment" was completed on 9/10/08 with a score of 20. According to this assessment sheet, "score of > (greater than) 14, Resident is Candidate". R8's care plan was reviewed monthly, however, the interventions were never revised to address that a bladder retraining program was attempted when it was identified that the resident was a potential candidate for retraining. This same bladder/bowel assessment sheet, had a notation at the bottom of the sheet dated 12/2/08, stated "Remains incontinent of BB (Bowel and Bladder)". Again, there was no evidence that bladder re-training was initiated.</p> <p>Interview with E17 (CNA) on 8/11/09 at approximately 10:25 AM revealed that "most of the time she (R8) would ask to use the commode for BM (bowel movement), with the use of a stand up lift but not as much for voiding. Sometimes she has control of bladder." During an interview with R8 on 8/14/09 at approximately 1:30 PM, she acknowledged that she could use the call bell to call for assistance to use the commode.</p> <p>2. R15 was readmitted to the facility on 8/4/09 post-hospitalization due to a viral syndrome. R15 had diagnoses including dementia with agitation and delusions, stroke, osteoarthritis and</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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F 280	Continued From page 14 osteoporosis. The 8/4/09 readmission physician's order sheet (POS) included 1:1 (one on one) supervision.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Cross refer F309, example #2 Based on record review, review of facility documents and interview, it was determined that the facility failed to provide one resident (R11) out of 25 sampled with services that met professional standards of quality. The resident was receiving medication for pain, however consistent monitoring for effectiveness was lacking. Findings include: R11 had physician's orders for oxycodone (Percocet), 7.5mg/325mg tablet every four hours as needed for pain. Review of R11's "Controlled Medication Utilization Record" for Percocet, dated 6/6/09 through 8/9/09 revealed that she generally received the medication once or twice per day and occasionally three times per day. During that period of time, R11 received 90 doses of Percocet, however, the effectiveness was only	F 281	F 281 Resident R11 was re-assessed and showed no sign of distress. The pharmacy will provide a listing of all residents on a pain management medication. Unit Managers will review all records to ensure compliance with facility policies. Staff Development will in-service all staff on the pain management policy and procedures as well as documentation. Unit Managers will audit the Pain Management Effectiveness form monthly and report the results to the DON and quarterly to the QA Committee.	10/17/09

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

PRINTED: 03/11/09
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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F 281	Continued From page 15 recorded 53 times. The facility policy for "Pain Assessment" was reviewed. It stated, "Do follow-up assessment within 2 hours after administration of medication." According to "Lexi-Comp's Drug Information Handbook for Nursing", 8th edition, under "Nursing Actions" for oxycodone, it stated, "...Monitor for effectiveness of pain relief ..." Interview with E9 (nurse manager) on 8/14/09 confirmed that the effectiveness of pain medication should be monitored and recorded within a couple of hours after administration.	F 281		
F 309 SS=E	483.25 QUALITY OF CARE 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, review of other facility documents and interviews, it was determined that the facility failed to ensure that four (4) residents (R11, R13, R14 and R20) out of 25 sampled, received the care and services necessary in accordance with the residents comprehensive assessments and plan of care. R11 and R14	F 309	<p>F309</p> <p>Resident R13, as of today, shows no signs of distress in regards to incident dated 6/21/09. The facility updated the "stash" room with emergency meds, to include a vial of each insulin.</p> <p>Residents with an order for insulin, when not available will be listed and the listing will be given to the DON, insulin will then be added to "stash". Any calls to the pharmacy going unanswered as to policy, the backup pharmacy will be called.</p> <p>A listing of residents on insulin medications will be generated and checked to ensure the medication is in the building.</p>	10/17/09

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

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F 309

Continued From page 16

were not closely monitored for the effectiveness of their pain management as per the plan of care nor was there any evidence that any action was taken to address R14's moderate to severe pain which was documented on the Medication Administration Record (MAR). R13 had a 190 blood sugar reading at 7:30 AM before breakfast. She failed to immediately receive her Humalog insulin coverage in accordance with the physician's order. As a result after 4 hours, R13's blood sugar reading went up to 490. R20's left heel was found with a dark red area. The facility failed to consistently off load R20's left heel per physician's orders. Findings include:

Cross refer F 425, F 514 #1

1. R13 had diagnoses that included IDDM (insulin dependent diabetes mellitus). According to R13's Minimum Data Set (MDS) assessment dated 5/14/09, her cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues/supervision required" and she had long and short term memory problems. R13 was totally dependent on staff for all activities of daily living (ADLs).

The facility initiated a care plan dated 5/14/09 for "uncontrolled blood sugar R/T (related to) IDDM". Interventions included "insulin cov. (coverage) as ordered".

R13 was receiving Lantus insulin 14 units (long acting insulin) at HS (bedtime) per physician's orders, dated 6/18/09.

A physician's telephone verbal order dated 6/20/09 and timed 2400 (midnight) stated, "Administer Humalog AC (before meals) & HS (at

F 309

A listing of all residents with a delay in receiving medications will be given to the Unit Manager on a daily basis. 10/17/09

An audit will be conducted by the Unit Managers on a monthly basis for all residents on insulin medications to ensure medications are in the building. Audit results will be presented at quarterly QA meeting.

Resident R11 was re-assessed and showed no sign of distress.

The pharmacy will provide a listing of all residents on a pain management medication. Unit Managers will review all records to ensure compliance with facility policies.

Staff Development will in-service all staff on the pain management policy and procedures as well as documentation.

Unit Managers will audit the Pain Management Effectiveness form monthly and report the results to the DON and quarterly to the QA Committee.

Resident R14's care plan has been updated.

A listing of all residents with a diagnosis of Pain will be provided to the appropriate Unit Manager.

All identified residents with a diagnosis of Pain will have their care plan reviewed and a check for the pain management sheet will be conducted. All clinical information will be added/updated if missing.

Random audits will be conducted for residents with diagnoses of pain by DON/designee monthly.

Results of audits will be reviewed at the quarterly QA meeting

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

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OMB NO. 0938-0391

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F 309	<p>Continued From page 17</p> <p>bedtime) sq (subcutaneous) Insulin Sliding Scale (dosing of insulin is based on blood glucose value).</p> <p>According to the facility's policy entitled, "1.0 Providing Pharmacy Products and Services...4. If orders for medications are received from the prescriber when the Pharmacy is closed, Facility staff should take the following steps: 4.1 Facility staff should remind the prescriber that the Pharmacy is closed and that a delay in medication therapy can be prevented by using a drug that is included in the Facility's interim/stat/emergency drug supply..."</p> <p>There was lack of documentation in the nurse's note that E29 (11-7 AM shift RN, who received the 6/20/09 order at 2400) reminded the prescriber that the Pharmacy was closed and that there might be a delay in insulin therapy and if they could use a drug that was included in the facility's emergency drug supply.</p> <p>Subsequently, a nurse's note dated 6/21/09 stated, "BS (blood sugar) @ 0730 (7:30 AM) was 190 - unable to cover with Humulin (physician's order was written for Humulog) Ins. (insulin) not available. (Name of physician's) office aware. Pharmacy called x 3 with no call back until 11:15. Drs. office called again for BS of 490. Changed order from Humulin (should have stated Humulog) Insulin to Novolin R. Covered at this time with Nov. (Novolin) R. V/S (vital signs) stable...no s/s (signs/symptoms) of any discomfort."</p> <p>On 8/11/09 in an interview with E4 (Risk Manager), it was revealed that she was not aware of the pharmacy occurrence. E4 immediately</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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F 309	<p>Continued From page 18 initiated an investigation. Inservices for the nursing staff on "Medications" were also held on 8/11/09.</p> <p>Review of the facility's results of the investigation, dated 8/12/09, revealed and acknowledged that E27 (LPN) and E28 (RN) were aware that the insulin coverage needed to be given immediately. However, the prescribed Humulog insulin was not available in the facility medication "stash" box and the pharmacy did not answer in a timely manner. In addition, although E27 called and made the "physician's office aware", E27 and/or E28 failed to immediately inform the physician and ask if they wanted a substitute medication (insulin) given. According to R13's "Meal Intake Record" she had consumed 75% of her breakfast, along with 360 ccs of fluid. Approximately four (4) hours later (11:15 AM) and without any insulin coverage, R13's blood sugar went up to 490. At this time, E28 "instructed" E27 to "again contact the PCP (Primary Care Physician)" and asked that the "order be changed to Novolin regular" which was in the facility's emergency drug supply.</p> <p>A physician's order received on 6/21/09 and timed 11:30 AM stated, "D/C (discontinue) Humulog Insulin, Give Reg. Ins. (Novolin Regular) with same coverage scale AC & HS".</p> <p>Review of the facility's list of medications available in their Interim Box (stash) on 8/12/09 revealed that Novolin R insulin was included in the list of available drugs.</p> <p>In an interview with E4 (Risk Manager) on 8/14/09 at 5:30 PM, she acknowledged that E27 and E28 should have immediately informed the physician if he wanted a substitute medication that was in the</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2009
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--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 19</p> <p>facility's interim box and not waited 4 hours and placed R13 at risk for not having insulin coverage.</p> <p>2. R11 was admitted to the facility on 7/3/07 with multiple diagnoses including severe Chronic Obstructive Pulmonary Disease (COPD), pulmonary hypertension, congestive heart failure, severe osteoarthritis and depression.</p> <p>R11's Physician's Order Sheet (POS) dated 7/6/09, indicated orders for a Fentanyl patch, 50mcg every 3 days for pain. She also had orders for oxycodone (Percocet) 7.5mg/325mg tablet every four hours as needed for pain. Additionally, she had standing orders for Tylenol, 650mg every four hours as needed for pain.</p> <p>Review of R11's "Pain Assessment" sheet, dated 7/13/09, revealed that the resident had chronic back pain and recommended Percocet as needed every four hours for pain.</p> <p>During an interview with R11 on 8/7/09 she stated that the pain medications that she was receiving were not helping very much to relieve her pain. She stated that she often asked for medication (Percocet) and was sometimes told that it was too soon since her last dose.</p> <p>The facility policy for "Pain Assessment" was reviewed. Listed under "Steps", it stated to, "Do follow-up assessment within 2 hours after administration of medication."</p> <p>R11's care plan, last updated on 6/17/09 identified the problem, "P/F (potential for) Alteration in comfort R/T (related to) pain. Under the approaches it listed, "Assess/tx(treatment) doc (document) sx (signs) of pain and doc</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 20 effectiveness of interventions."</p> <p>Review of R11's "Controlled Medication Utilization Record" for oxycodone (Percocet), dated 6/6/09 through 8/9/09 revealed that she generally received the medication once or twice per day and occasionally three time per day. During that period of time, R11 received 90 doses of Percocet, however, the effectiveness was only recorded 53 times.</p> <p>During an interview with E29 (nurse) on 8/10/09, she stated that R11 often asked for pain medication and that she gave her Percocet most of the time. She stated that the resident had just asked for Tylenol, however, when the MAR was reviewed, there was no evidence that the Tylenol was given that day. When E29 was asked where she documented the administration of the medication, she stated that she was planning to record it under standing orders. Review of R11's MAR's for 6/09, 7/09 and 8/09 lacked evidence that Tylenol was given during that time period.</p> <p>Interview with E9 (nurse manager) on 8/14/09 confirmed that the effectiveness of pain medication should be monitored and recorded within a couple of hours after administration:</p> <p>Even though the facility's policy and standards of practice indicate the need for monitoring the effectiveness of pain management interventions, the facility failed to adequately assess R11's pain after the administration of medications as per her plan of care.</p> <p>3. R14 was admitted to the facility in 10/07 with multiple diagnoses including diabetes, past cerebral vascular accident (CVA) with right sided</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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
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F 309	<p>Continued From page 21</p> <p>paralysis, COPD, pulmonary edema, peripheral vascular disease (PVD) and bipolar disorder.</p> <p>Review of R14's "Pain Assessment" sheet, dated 7/17/09, revealed that she had lower leg pain due to her PVD. The recommendation was for Vicodin 5/500mg daily. R14's care plan, last updated on 3/16/09, identified the problem, P/F Alteration in comfort R/T pain and included the approach, "Observe and document for effectiveness of medication."</p> <p>R14's MAR, dated 7/09, indicated that she received Vicodin 5/500mg daily for chronic pain. Included was a pain monitoring sheet which documented presence, location and intensity of pain three times per day. On 7/21/09, severe leg pain was documented and on 7/22/09 and 7/24/09, moderate leg pain was recorded. There was no evidence in the clinical record that any action was taken in regard to R14's reports of moderate-severe leg pain.</p> <p>4. R20 was originally admitted to the facility on 11/8/02 and had diagnoses which included peripheral vascular disease, diabetes mellitus and cerebrovascular accident (stroke) with left sided hemiplegia (paralysis on one side of the body). The annual Minimum Data Set (MDS) assessment, dated 7/6/09 identified this resident's cognitive skills for daily decision making as independent, with no short or long term memory problems. This same MDS revealed that R20 did not ambulate and required extensive assistance of two (2) staff for bed mobility.</p> <p>A nurse's note, dated 8/5/09 and timed 2:30 PM</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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
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F 309 Continued From page 22
stated that a dark red area was found on R20's left heel. A physician's order, dated 8/5/09 stated, "...upload (left) heel (every) shift - float (left) heel while in bed."

Four (4) observations on 8/12/09 and 8/13/09 revealed that R20's heels were in direct contact with the mattress while in bed. The facility failed to consistently off load R20's left heel per physician's orders.

On 8/13/09 at 2:00 PM during an interview with E15 (CNA), she stated that she was not aware that R20's left heel was to be offloaded while in bed. E15 stated that she usually places a pillow under R20's legs but that she had applied lotion to R20's ankles and that the resident had refused placement of the pillow. During an interview with E14 (nurse) on 8/13/09 at 2:30 PM when asked how CNA's are informed of residents' care needs, such as offloading, E14 stated that it should be told to them verbally and also updated on the "Nurse Aide's Information Sheet." Review of R20's "Nurse Aide's Information Sheet" lacked information pertaining to the offloading of the left heel while in bed.

F 309

F 312 SS=D 483.25(a)(3) ACTIVITIES OF DAILY LIVING

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview, it was determined that the facility failed

F 312

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

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707	
(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 312	<p>Continued From page 23</p> <p>to ensure that 2 residents (R22 and R24) out of 25 sampled received the necessary services to maintain good grooming and personal hygiene. R22's fingernails were long and jagged and were not trimmed properly. R24 failed to receive showers twice a week in accordance with this resident's plan of bath care. Additionally, R24's scheduled hair care visits with the beautician was not monitored and therefore, was not met for a month. Findings include:</p> <p>1. Review of R24's closed records revealed that she had diagnoses that included DJD (Degenerative Joint Disease), ambulation dysfunction, dementia, and CHF (congestive heart failure). According to this resident's Minimum Data Set (MDS) assessment dated 12/22/08, her cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues/supervision required." R24 was totally dependent on staff for her personal hygiene/bathing and needed extensive assistance with activities of daily living (ADLs).</p> <p>The facility initiated a care plan dated 1/17/08, last reviewed on 1/16/09 on "Unable to do own ADLs without assistance secondary to dementia, DJD". The interventions included "Provide assistance with hygiene and grooming".</p> <p>According to R24's CNA ADL Flow Record, R24 was to receive showers twice a week on Tuesdays and Fridays on the 3-11 PM shift. Review of this resident's ADL Flow Record revealed that she did not receive her showers 6 out of 8 times in the month of December, 2008. R24 also did not receive showers 3 out of 8 times in the month of January, 2009. In an interview</p>	F 312	<p>F312</p> <p>R24 was discharged from facility.</p> <p>Resident R22 fingernails have since been trimmed and filed.</p> <p>All residents will be assessed for long/jagged fingernails and have them trimmed and filed as necessary. Residents requesting nail care will be addressed immediately.</p> <p>Staff Development will serviced Nursing Assistants on resident ADL and their ADL care as well as addressing residents needs when requested</p> <p>Unit Managers will audit resident nail care and immediately</p> <p>Correct any concerns on a weekly basis.</p> <p>Audit results will be reviewed at quarterly QA meeting.</p>	10/17/09

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

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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
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F 312

Continued From page 24
with E32 (CNA- Team Leader) on 8/13/09, E32 stated that she was not aware that R24 was not getting her showers as care planned. In addition, she stated that R24 went to the beautician for hair care but these appointments are not recorded on the ADL flow sheet. The beautician had the record.

R24's record of hair care from the beauty shop was provided by E33 (Business Office Manager) on 8/13/09. The record revealed that this resident was receiving hair care from the beautician mostly 2x a month starting from 1/23/08, with the last appointment on 11/24/08. The record indicated that R24 did not have beauty shop hair care from 11/25/08 through 1/6/09.

A nurse's note dated 1/6/09 stated, "Residents (family member) called complaining of resident's hair not done at beauty shop. (Family member) made aware of change of beautician...message have being (sic) left for beautician to care for residents hair ASAP". In an interview with E11 (LPN-C Wing Unit Manager) on 8/14/09 at 11:00 AM, she acknowledged that there was a change of beautician in the facility, however, she stated that the facility always had a beautician at all times. In a telephone interview with E11 and E33 on 9/1/09 revealed that they did not know the reason why R24 did not receive hair care from 11/25/08 through 1/6/09 (6 weeks). The facility failed to follow through with R24's hair care with the beautician.

R24 had beauty shop hair care done on 1/7/09 as per family's request.

2. R22 had multiple diagnoses including

F 312

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

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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
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F 312 Continued From page 25
Parkinson's disease and dementia.

Review of R22's care plan last updated on 7/11/09, revealed the problem area, "Unable to do own ADL's (activities of daily living) without assistance secondary to Parkinson's disease." Approaches included, "Provide assistance with hygiene and grooming."

During an interview with R22 and his family member on 8/12/09, he stated that he asked his CNA (Certified Nurse Aide) to trim his fingernails on the previous day. The CNA told the resident that "he would see about it." Observations of R22's fingernails revealed that they were long and jagged.

On 8/13/09 at 9:15 AM, E9 (Unit Manager) was shown R22's fingernails and confirmed that they needed to be trimmed. She stated that the CNA's trim the residents' nails and that she would make sure that R22's nails were done that day. At 3:20 PM, R22 was observed in his room. He stated that someone trimmed his fingernails that day, however, observations revealed that some of them were still long and jagged. E9 was shown R22's fingernails and confirmed that they were not trimmed properly, then proceeded to trim them herself.

F 312

F 315
SS=D 483.25(d) URINARY INCONTINENCE

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract

F 315

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

PRINTED: 03/02/09
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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
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F 315	<p>Continued From page 26</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedures and interview, it was determined that the facility failed to ensure that 1 (one) resident (R8) out of 25 sampled, who was incontinent of bladder received appropriate services to restore or improve normal bladder function to the extent possible. The facility failed to re-assess R8's continence status, failed to follow facility policy and procedure to ensure that appropriate bladder interventions were developed, implemented and monitored for this alert and oriented resident. Findings include:</p> <p>R8 was admitted to the facility with diagnoses that included cerebral vascular accident (CVA), degenerative joint disease, dementia, hypertension and depression. Originally, a previous quarterly MDS assessment dated 1/8/08 indicated that R8 was "frequently incontinent of bladder - but some control present" and was coded 3. According to R8's annual Minimum Data Set (MDS) assessment dated 03/02/09, her cognitive skills for daily decision-making were "independent-decisions consistent/reasonable". R8 had no long or short term memory loss. R8 was totally dependent on staff for transfer, toilet use and personal hygiene. R8 was assessed as incontinent of bladder-"had inadequate control of bladder, multiple daily episodes" (coded 4) and no scheduled toileting program was in place. R8 was also coded as 3 on bowel (frequently incontinent of bowel 2-3 times a week).</p>	F 315	<p>F315</p> <p>F315</p> <p>Resident R8 was reassessed; bowel and bladder retraining was Initiated. The care plan was updated to reflect changes.</p> <p>All resident Bowel and Bladder assessments will be reviewed. For any resident with a score greater than 14, the Bowel and Bladder protocol will be initiated. Care plans will be updated as necessary.</p> <p>Staff Development will in-service nursing staff on the Bowel and Bladder policy and procedure.</p> <p>Unit Managers will review and ensure the appropriate care pans and interventions are identified.</p> <p>Findings will be reported at the quarterly QA Meeting.</p>	10/17/09
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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
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F 315	<p>Continued From page 27</p> <p>R8's last "Bowel and Bladder Rehabilitation Assessment" was done on 9/10/08 and had a score of 20 that indicated "Resident was a candidate" for bladder training. Despite the results of the assessment, there was no evidence that any bladder retraining such as a toileting program, was completed. During an interview with E17 (CNA) on 8/11/09, she stated that the resident's current transfer status was via stand-up lift and she used a commode.</p> <p>Subsequently, a written statement at the bottom of the 9/10/08 "Bowel and Bladder Rehabilitation Assessment", sheet stated that R8 "Remains incontinent of B/B (Bowel/Bladder)" and dated 12/2/08. However, review of R8's clinical record lacked evidence of a completed re-assessment and record of a voiding diary or toileting program to support the result of this assessment. Additionally, on 5/12/09 and 7/23/09 the facility again identified R8 as "always incontinent of bladder and bowel". However, there was a lack of documentation that this resident was evaluated via a voiding diary and/or toileting program as per facility policy to support that this resident was always incontinent of bladder and bowel.</p> <p>During an interview with E17 (CNA) on 8/11/09 at 10:25 AM she stated, R8 would ask for assistance to use the commode for bowel movements but not as much for voiding. E17 stated that R8 sometimes had control of her bladder.</p> <p>In an interview with R8 on 8/14/09 at 1:30 PM, she stated that she would call for assistance to use the commode. She knew when she had to use the commode to void. The staff used the standup lift for her transfer to the commode.</p>	F 315	<p>Residents with an order for insulin, when not available will be listed and the listing will be given to the DON, insulin will then be added to "stash". Any calls to the pharmacy going unanswered as to policy, the backup pharmacy will be called</p> <p>A listing of residents on insulin medications will be generated and checked to ensure the medication is in the building.</p> <p>A listing of all residents with a delay in receiving medications will be given to the Unit Manager on a daily basis.</p> <p>An audit will be conducted by the Unit Managers on a monthly basis for all residents on insulin medications to ensure medications are in the building. Audit results will be presented at quarterly QA meeting.</p>	10/17/09
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2009
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/14/2009
NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707		
(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 315	Continued From page 28 The facility originally initiated a care plan on 4/1/08 on "Alteration in Elimination RT resident being incontinent. Resident is incontinent of bladder or bowel and has no memory recall (which is in conflict with MDS of 3/09) and/or ability to retrain. Is continent of bowel at times". The intervention "Toilet at regular intervals if resident is able" was crossed out and dated 4/1/08. Although this care plan was reviewed monthly with the last review date on 7/23/09, the current intervention to "Use pads or briefs" was never revised. There was no evidence that any attempts were made to manage the incontinence and improve bladder function. There was no toileting plan in place. The CNA's continued to document in the CNA Flow Sheets for 9/08, 12/08, 3/09, 5/09 and 8/09 that R8 was incontinent of bladder at all times. In an interview with E12 (LPN-Unit Manager) on 8/10/09, she acknowledged that there was no current bladder assessment for R8. She stated that a 3-day "Voiding/Bowel Diary" would be initiated to determine this resident's continency. A "Voiding/Bowel Diary" was initiated on 8/11/09. On 8/14/09, review of the 3 day Voiding/BM (toileting program) diary for 8/11/09, 8/12/09 and 8/13/09 revealed that out of 39 scheduled toileting, R8 was only toileted 11 times. In an interview with E18 (RN) and E19 (LPN), they both stated that they were not aware that this Voiding/BM diary was initiated for R8. Additionally, on 8/14/09 at 5:30 PM, E12 acknowledged that some of the staff did not know how to use the 3 day Voiding/Bowel diary.	F 315			

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

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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 315	Continued From page 29	F 315		
F 323 SS=D	<p>The facility failed to ensure that R8 received appropriate services to restore or improve her normal bladder function to the extent possible.</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, interview and review of other facility documents, it was determined that the facility failed to ensure that two (2) residents (R21 and R15) out of 25 sampled residents received proper care with the use of an assistive device and/or adequate supervision to prevent accidents. The facility failed to follow R21's plan of care to adequately supervise and handhold R21 when ambulating her which resulted in a fall with multiple injuries, including a laceration above her left eye that required four (4) sutures and a hematoma above the left ear. R15 sustained a laceration, requiring steri-strips to the bridge of her nose when she fell while reaching for her walker which was left out of her reach. Findings include:</p> <p>1. R21 had diagnoses that included left hip fracture, alzheimer's, dementia, depression, osteoporosis, ambulatory dysfunction, and a right total knee replacement with a history of falls. According to R21's annual Minimum Data Set</p>	F 323		

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

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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F 323	<p>Continued From page 30</p> <p>(MDS) assessment dated 3/25/09, this resident's cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues/supervision required." R21 had both long and short term memory problems. R21 was listed as having an unsteady gait.</p> <p>Review of R21's clinical record revealed a nurse's note dated 5/28/09 and timed 7-3 (shift) which stated, "...CNA (Certified Nurse Aide), (E37), was ambulating c (with) resident down the hall when she fell forward @ 0910 (at 9:10 AM), the CNA tried to catch her and was able to grab her sweater and break her fall, laceration observed over L (left) eye, c/o (complains of) pain in L shoulder, VS (Vital Signs) (blood pressure, pulse, respirations and temperature) = 130/80-80-18-97.5, neuro check done, ice applied... resident transported to (name) hospital..." A nurse's note dated 5/28/09 and timed 3:30 PM stated, "Resident returned from ER (Emergency Room) via w/c (wheelchair) ... alert & oriented X 1 (times one) (self) c L arm in sling and bandaid over L eyebrow. L eyebrow c 4 sutures intact, some redness at incision line, redness noted on top L eyelid. VS 102/60-88-18-98. L arm warm to touch (positive) pulses, c/o discomfort/pain when arm moved. Dtr (Daughter) states X-rays of L arm/shoulder done @ ER (negative) for fx (fracture). Addendum 2 cm nodule (?hematoma) noted above residents L ear on head, denies pain when touched..."</p> <p>A nurse's note dated 5/29/09 (untimed) under the "Safety" section of the chart summarized the same events as above except added, "...Resident needs supervision c (with) ambulation. No devices. Had shoes on. Floor was dry. Fell by doorway to courtyard. No railing to hold onto. P.T.</p>	F 323	<p>F323 F323</p> <p>Resident R21 had his transfer status updated. Resident R21 had refusal of care reviewed by the Unit Manager/Supervisor. The Plan of Care was updated as appropriate.</p> <p>All residents requiring transfer with physical assist will have their transfer status reviewed and care plans will be updated by the MDS Coordinator/Unit Manager..</p> <p>The facility policies and procedures for transfers and resident refusal of care was reviewed and no revision were necessary.</p> <p>All nursing staff will be re-in serviced by Staff Development on proper transfer techniques and documentation requirements when residents refuse care.</p> <p>Unit Managers/Supervisors will be made aware of any residents refusal of care. They will perform random audits of the documentation and the residents Plan of Care to ensure proper documentation. Results of the audits will be reported to the DON and monthly to the QI Committee.</p>	10/17/09
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707		
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F 323	<p>Continued From page 31</p> <p>(Physical Therapy screen." On 6/3/09, "Fall Committee Mtg (Meeting) held. All interventions reviewed."</p> <p>Review of R21's care plan dated 9/8/08, and last updated on 6/18/09, titled Potential for falls R/T (related to) cognitive deficit, hx (history of) falls, ... refuses to ask for assist, ...refuses to use walker, vision deficit", listed under approaches, "...Staff to amb (ambulate) c resident hold hand if agreeable or use rail..."</p> <p>Review of R21's 5/09 ADL (Activities of Daily Living) Flow Record documented R21's "Locomotion in Hall" as "Limited Assistance - some physical help provided - 1 person assist". It listed the intervention "Handheld asst (assist) at all times if refused write it". There were no refusals documented in May 2009.</p> <p>The 5/28/09 Incident Report and facility's investigation were reviewed (including witness statements). The 5 day Follow-up described the incident as "Witnessed fall with injury: C.N.A. was walking with (name- R21) and another resident... when (R21) fell.... Resident sustained a laceration above left eye and complained of pain in left arm.. Sent to E.R. for eval. CTT scan of head and x-ray of left arm were negative... Resident to walk with supervision and handhold. Disciplined and inserviced C.N.A. P.T. screen."</p> <p>During an interview on 8/14/09 at 11 AM, the Risk Manager, E4, stated that the facility's video tape revealed that E37 had been walking, holding the hand of her assigned resident (SSR30), while R21 was walking in front of them. R21 was assigned to another CNA, E38. E37, who was helping E38, was unfamiliar with R21 and the</p>	F 323			

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

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F 323	<p>Continued From page 32 resident's care plan.</p> <p>Review of E38's Clinical Performance Advisement, dated 6/5/09 stated, "... (R21) 5/28 0910 fell... CNA that was walking her to TV lounge was not assigned to her & did not know her & that she needed supervision with hand hold. As team captain & assigned CNA you need to give report to CNAs that float to your unit on how to transfer residents." In addition, the Unit Manager, E36, was also referred for safety. Her clinical performance advisement, dated 6/5/09 stated, "... (R21) 5/28 0910 fell... CNA ... not assigned... did not know her. You walked passed her in hallway. As UM (Unit Manager) you need to check CNAs that float to your wing know how to transfer residents." E36 and E37 were not interviewed as they no longer work for the facility.</p> <p>During the 8/14/09 interview, E4 acknowledged that the facility staff had failed to ensure R21's plan of care was followed when ambulating this resident which resulted in a fall with multiple injuries.</p> <p>2. R15 was admitted to the facility on 5/20/08 with diagnoses including dementia with agitation and delusions, stroke, osteoarthritis and osteoporosis. The annual Minimum Data Set (MDS) assessment, dated 4/23/09, identified that R15 required supervision when walking in her room and in the corridor.</p> <p>The physician's order sheet (POS), dated 6/1/09, included provide 1:1 supervision, use of walker, non skid socks on at bedtime, offer recliner chair in resident's room to sleep and keep bathroom light on at all times. The fall care plan, revised 5/14/09, had a plan of action that reflected the physician's orders.</p>	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 33 On 6/10/09, R15 sustained an avoidable fall with injury when her walker was moved away from her to eat lunch. When lunch was finished, the walker was not returned. In an interview on 8/13/09, E4 (nurse), Risk Management stated, "the walker was a few steps away from the recliner, further into the room". Per the Incident Report, dated 6/10/09, R15 stated, "I was trying to get my walker & fell & cracked my head". Additionally, the Incident Report noted that R15 had a cut across the bridge of her nose requiring steri-strips and had swelling at the right eyebrow to which ice was applied. The 5 day follow up Incident Report noted, "Unwitnessed fall with injury... staff inserviced to keep walker in reach. Staff are doing 30 minute intervals of one on one supervision around the clock. PT (physical therapy) Screen ..." Also, on 8/13/09 E4, stated that E9, the Unit Manager, advised her that the assignment sheets for one on one supervision were discarded.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility failed to provide adequate supervision and have the walker within reach to prevent R15's fall on 6/10/09. On 8/13/09, in an interview with E4, she acknowledged this finding. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		

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

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F 425	<p>Continued From page 34</p> <p>acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Cross-refer to F309 example #1 Based on record review and interview, it was determined that the facility failed to ensure that pharmaceutical services provided medications in a timely manner for 1 (one) resident (R13) out of 25 sampled. Findings include:</p> <p>The facility's policy entitled "Providing Pharmacy Products and Services" was reviewed.</p> <p>R13 had a physician's order dated 6/20/09 and timed 2400 for, "Administer Humalog AC & HS sq Insulin sliding scale." A nurse's note dated 6/21/09 stated, "BS (blood sugar) @ 0730 (7:30 AM) was 190 - unable to cover with Humulin (sic) Ins. (insulin) not available. Pharmacy called x 3 with no call back until 11:15." At that time R13's blood sugar reading was 440 for not having received the insulin coverage at 7:30 AM when her blood sugar reading was 190. The pharmacy failed to respond to the facility's call to dispense the Humalog Insulin to meet R13's needs.</p> <p>In an interview with E4 (Risk Manager) on 8/14/09 at approximately 5:10 PM, she acknowledged that</p>	F 425	<p>F425</p> <p>Resident R13, as of today, shows no signs of distress in regards to incident dated 6/21/09. The facility updated the "stash" room with emergency meds, to include a vial of each insulin.</p> <p>Residents with an order for insulin, when not available will be listed and the listing will be given to the DON, insulin will then be added to "stash". Any calls to the pharmacy going unanswered as to policy, the backup pharmacy will be called</p> <p>A listing of residents on insulin medications will be generated and checked to ensure the medication is in the building.</p> <p>A listing of all residents with a delay in receiving medications will be given to the Unit Manager on a daily basis.</p> <p>An audit will be conducted by the Unit Managers on a monthly basis for all residents on insulin medications to ensure medications are in the building. Audit results will be presented at quarterly QA meeting.</p>	10/17/09
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 35 the pharmacy called the Emergency Pharmacist who did not immediately respond. It took 4 hours for the Pharmacist to respond.	F 425		
F 497 SS=D	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation and staff interview, it was determined that the facility failed to insure that one (1) of nine (9) sampled certified nurse aides received their mandatory annual performance review. Findings include: E19 was hired 2/7/08. Review of the personnel file revealed the absence of a performance review. An interview on 8/13/09 at 9:10 AM with E18 (Human Relations Assistant) confirmed this finding.	F 497 F497 F497	Employee E19's annual review has been completed. An audit of all employee records will be completed to ensure all other employees have mandatory evaluations completed. A report will be generated by the Corporate Human Resources Department at the beginning of each month that will inform The Human Resources Assistant of all reviews due that month. This report will be reviewed at month end to ensure all reviews were completed. Any reviews not completed will be carried over to the next month until completed. Staff Development will in-service all staff on the monthly reports and tracking of reports. The Human Resources Director will audit the report on a monthly basis and report the findings quarterly at the QA meeting.	10/17/09
F 508 SS=D	483.75(k)(1) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES	F 508		

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

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F 508	<p>Continued From page 36</p> <p>The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of facility policy, it was determined that the facility failed to provide radiology services in a timely manner for one (1) resident (R9) out of 25 sampled. Findings include:</p> <p>R9's nurse's note, dated 4/26/09 and timed 1700 (5:00 PM) stated that the resident claimed to have fallen and was complaining of left hip pain. This same nurse's note stated that at 5:30 PM an order was obtained for a left hip X-ray to rule out fracture.</p> <p>A nurse's note, dated 4/27/09 and timed 1340 (1:40 PM) stated, "...Spoke to (name) at (radiology services provider) 'Very sorry on the wait will send someone out to take Xray' awaiting Xray tech." A second nurse's note on 4/27/09 timed at 1730 (5:30 PM) stated, "...report received. Xray negative for fracture..."</p> <p>The left hip X-ray was not completed until sometime after 1:40 PM on 4/27/09, over 20 hours after it was ordered. The results of the X-ray were not obtained until 5:30 PM on 4/27/09, 24 hours after the X-ray was ordered. The facility failed to ensure that radiology services were provided in a timely manner for R9.</p> <p>During an interview with E10 (nurse) and E14</p>	F 508	<p>F508</p> <p>Resident R9 is not at risk for distress from incident dated 4/26/09. Radiology was notified of delay in care and was informed of the deficient practice:</p> <p>Any residents with a STAT order for Radiology will be documented and reported to the Director of Nursing.</p> <p>Any residents with a STAT order of Radiology with a delay will be sent to the Hospital for X-ray within a reasonable time frame, not to excide 3 hours.</p> <p>Audits of residents with a STAT order will be completed on a monthly basis by the DON at QA meeting.</p>	10/17/09

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

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F 508	Continued From page 37 (nurse) on 8/12/09, they acknowledged that the X-ray should have been completed within four hours after being ordered. They also both acknowledged that the X-ray would have been ordered "stat" (Immediately/as soon as possible) since it was ordered to rule out a hip fracture. The facility policy entitled "X-RAY" stated, "...If a physician requests a "stat" order, it is to be understood that the x-ray company is allotted a four hour response time..."	F 508		10/17/09
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS 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 ensure that clinical records on 4 residents (R13, R23, R24 and R22) out of 25 sampled, were maintained in accordance with accepted professional standards of practice that are complete and accurately documented. Findings include: Cross refer to F309 example #1 1a. There was lack of documentation in R13's clinical record from E29 (RN who received the	F514	Residents R13, R23, R24 and R22 clinical records have been corrected. Resident R13, as of today, shows no signs of distress in regards to incident dated 6/21/09. The facility updated the "stash" room with emergency meds, to include a vial of each insulin. Residents with an order for insulin, when not available will be listed and the listing will be given to the DON, insulin will then be added to "stash". Any calls to the pharmacy going unanswered as to policy, the backup pharmacy will be called A listing of residents on insulin medications will be generated and checked to ensure the medication is in the building. A listing of all residents with a delay in receiving medications will be given to the Unit Manager on a daily basis. An audit will be conducted by the Unit Managers on a monthly basis for all residents on insulin medications to ensure medications are in the building. Audit results will be presented at quarterly QA meeting. Resident R23 shows no distress at this time in regards to the 12/08 Incident. Random audits of the MAR will be conducted monthly by the Unit Manager/Nursing Administration to determine accuracy of Information obtained in the Clinical record.	

All audit results will be reviewed for accuracy and reported at QA Meeting

Resident R24 was discharged from the center.

Residents with un-witnessed falls will be listed daily by the Risk Manager

All staff will be in-serviced on the falls policy and procedure by

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 514	<p>Continued From page 38</p> <p>physician's telephone verbal order) on 6/20/09 at 12:00 AM reminding the prescriber that the Pharmacy was closed and that there might be a delay in insulin therapy, and if they can use a drug that is included in the facility's interim drug supply as per facility policy entitled "Providing Pharmacy Products and Services".</p> <p>Cross-refer to F309 example #1</p> <p>1b. E27 (nurse) signed off in the MAR (Medication Administration Record) that Humulog insulin was administered at 7:30 AM but did not circle the signature to indicate that it was not administered because it was not available. E27 called the physician's office that R13's Humulog insulin coverage was not available but did not document sufficient information in the nurse's notes to identify the time and the name of the physician she spoke to. In addition, she failed to document if she informed the physician that the previously prescribed insulin (Humulog) was not available and would want to change the order to an insulin available in the facility's emergency drug supply for R13, whose blood sugar reading was up to 190 and needed the insulin coverage. E27 incorrectly documented in R13's nurse's note the drug's name as Humulin insulin instead of Humulog as prescribed. E27 lacked documentation of the results of R13's monitoring between the four hours that this resident was without insulin coverage. E27 failed to document that the supervisor was notified of the pharmacy occurrence.</p> <p>1c. According to E4 (Risk Manager) E27 (nurse) and/or E28 (nursing supervisor) failed to document a Pharmacy occurrence, when the Pharmacist failed to respond to the facility's call for R13's insulin to be delivered.</p>	F 514 F514	<p>Staff Development</p> <p>Residents with unwitnessed falls will be reviewed with the Inter-disciplinary team within 24 hours, all incidents will be re-Reviewed the following week at the Falls Committee meeting to Ensure incident is complete.</p> <p>Random audits will be conducted by DON/Designee to ensure Incidents are completed. Results of the audits will be reviewed at The quarterly QA meeting.</p> <p>Care plan for R22 was updated to include approach of 1:1 intervention in room with participation in out of room activity 2 times per week, a radio with CD player was placed in R22's room.</p> <p>Activity staff will offer to play music on a daily basis. The daily activity schedule will be verbally reviewed with R22 daily during morning distribution. Activity staff will invite and escort to any chosen activity.</p> <p>Activity director will conduct a daily communication meeting with activity staff to discuss declines in physical, cognitive or social aspects of resident care.</p> <p>All staff will be in-serviced on proper documentation of refusals and active participation vs. passive participation</p> <p>Activity Director will monitor participation logs weekly for missed or improper documentation. Activity Director will implement monthly QI study to track any residents with significant change in level of participation. Activities Director will ensure that residents are appropriately care planned and any interventions have been put in place and are effective.</p>	10/17/09
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Results will be reported to the QA Committee.

All licensed staff will be in-serviced on accuracy of documentation

Random audits will be conducted monthly by the Unit Manager/Nursing Administration to determine accuracy of Information obtained in the Clinical record.

All audits will be reviewed for accuracy and reported at QA meeting

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

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F 514	<p>Continued From page 39</p> <p>2. R23's 12/08 MAR (Medication Administration Record) revealed the following medications were not signed off as administered on 12/1/08: "Novolin NPH 12 u sq q AM" and "ASA EC 81 mg. 1 tablet p.o." Additionally, on 12/3/08 the prescribed cranberry capsule 2 tabs p.o. TID was not signed off at 21:00 (9:00 PM). A physician's order dated 12/2/08 for "500 mg. of Tylenol q HS (bedtime) was administered at bedtime on 12/3/08 but was not administered at bedtime on 12/2/08. There was no documentation in the clinical record as to why the medication was not administered on 12/2/08.</p> <p>3. R24's clinical record revealed that on 11/20/08, this resident had an unwitnessed fall from a recliner. A late entry note was written on 11/24/08 at 1700 that identified a potential injury incurred by R24 and was discovered and reported by a family member on 11/21/08 that the family believed was related to the resident's 11/20/08 fall. This information was vital to the facility's investigation of the incident. In an interview with E4 (Risk Manager) on 8/13/09, she acknowledged that the documentation was not complete and it should have been documented in a timely manner.</p> <p>Cross refer to F248</p> <p>4. R22's Activity log for 7/09 and 8/09 indicated that he listened to the radio every day during both months, however this resident did not have a radio in his room. When questioned about this issue on 8/13/09, E6 (Activities Director) stated that they play the radio in the main dining room during meals. Since no radio was observed in the</p>	F 514		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2009
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NAME OF PROVIDER OR SUPPLIER REGAL HEIGHTS HEALTHCARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 LANCASTER PIKE HOCKESSIN, DE 19707
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(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
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F 514	<p>Continued From page 40</p> <p>dining room during the survey period (8/6/09 - 8/14/09), E6 was asked about this documentation. She stated that their radio had been missing for about the past month and that staff "may just fill it in out of habit."</p> <p>The facility inaccurately documented in R22's Activity log that he listened to the radio when in fact there was no radio for him to listen to for approximately one month.</p>	F.514		
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STATE SURVEY REPORT

LTC Residents Page 1 of 9
OCT 06 2009
Director's Office

DATE SURVEY COMPLETED: August 14, 2009

NAME OF FACILITY: Regal Heights

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

SECTION **STATEMENT OF DEFICIENCIES Specific Deficiencies**

The State Report incorporates by reference and also cites the findings specified in the Federal Report.

An unannounced annual and complaint survey was conducted at this facility from August 6, 2009 through August 14, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility and hospital documentation as indicated. The facility census the first day of the survey was 162. The survey sample totaled 25 residents, which included a review of 22 active records and three (3) closed records. Additionally, there were eight (8) sub-sampled residents.

3201 Skilled and Intermediate Care Nursing Facilities

3201.6.0 Services To Residents

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.

Provider's Signature [Signature] Title Administrator Date 10/6/09



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STATE SURVEY REPORT

NAME OF FACILITY: Regal Heights

DATE SURVEY COMPLETED: August 14, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.5	<p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 8/14/09, F281, F309, F312, F315, F323, F425 and F508.</p>	Cross-refer to POC for CMS 2567-L survey F-tags 281, 309,312,315,323,425 and 508
3201.6.5.7	<p>Nursing Administration</p> <p>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.</p>	
3201.6.6	<p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 8/14/09, F279 and F280.</p> <p>Activities</p>	Cross-refer to POC for CMS 2567-L survey F-tags 279 and 280
3201.6.6.1	<p>The nursing facility's activities program shall provide diversified individual activity plans and group activities for each resident based on the comprehensive assessment as well as an</p>	



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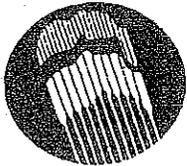
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	<p>activity assessment conducted by the activity director. The activities offered shall reflect the needs, interests, abilities, preferences, limitations and age of each resident.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 8/14/09, F248.</p> <p>Social Services</p> <p>The facility shall identify each resident's need for social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident; and shall assist each resident to obtain all required services to meet the individual resident's needs. These social services shall include, but not be limited to:</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 8/14/09, F250.</p> <p>Kitchen and Food Storage Areas.</p> <p>Facilities shall comply with the Delaware Food</p>	<p>Cross-refer to POC for CMS 2567-L survey F-tag 248</p>
3201.6.7		
3201.6.7.1		
3201.7.5		
3201.7.5.1		Cross-refer to POC for CMS 2567-L survey F-tag 250



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NAME OF FACILITY: Regal Heights

DATE SURVEY COMPLETED: August 14, 2009

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<p>3201.6.10</p> <p>3201.6.10.1</p>	<p>Code.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on the dietary observations on 8/6/09 at 8:48 AM, it was determined that the facility failed to comply with section 3-304.14 (B) (2) of the State of Delaware Food Code.</p> <p>3-304.14 Wiping Cloths, Use Limitation.</p> <p>(B) Cloths used for wiping food spills shall be:</p> <p>(2) Wet and cleaned as specified under § 4-802.11 (D), stored in a chemical sanitizer concentration specified in § 4-501.114, an used for wiping spills from food-contact nonfood-contact surfaces of equipment.</p> <p>This requirement is not met as evidenced by:</p> <p>Observations on 8/6/09 at 8:48 AM of the sink behind the food tray line revealed cloths not being stored in a sanitizer solution.</p> <p>Records and Reports</p> <p>There shall be a separate clinical record maintained on each resident as a chronological</p>	<p>Cloths used for wiping food spills will be stored in a chemical sanitizer at the correct concentration specified in 4-501.114. In-servicing will be completed by the Dietary Director.</p>



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STATE SURVEY REPORT

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3201.10.1.6	<p>history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:</p> <p>Nursing notes, which shall be recorded by each person providing professional nursing services to the resident, indicating date, time, scope of service provided and signature of the provider of the service. Nursing notes shall include care issues, nursing observations, resident change of status and other significant events.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L, survey date completed 8/14/09, F514, examples #1, 2 and 3.</p>	Cross-refer to POC for CMS 2567-L survey F-tag 514 Examples #1, 2, and 3
3201.10.1.8	<p>Inventory of resident's personal effects upon admission.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L, survey date completed 8/14/09, F166, example #1</p> <p>Patient's rights</p> <p>It is the intent of the General Assembly, and the</p>	Cross-refer to POC for CMS 2567-L survey F-tag 166

16 Del. C.,
Chapter 11,
Subchapter II,



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STATE SURVEY REPORT

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§ 1121

purpose of this section, to promote the interest and well-being of the patients and residents in sanatoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interest 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 shall include but not be limited to the following:

(1) Every patient and 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 basic personal and property rights which include dignity and individuality.

This requirement is not met as evidenced by:

Cross-refer to CMS 2567-L survey date completed 8/14/09, F241.

(8) Every patient and resident shall receive from the administrator or staff of the facility a courteous, timely and reasonable response to requests and the facility shall make prompt efforts to resolve grievances. Responses to

Cross-refer to POC for CMS 2567-L survey F-tag 241



DELAWARE HEALTH AND SOCIAL SERVICES

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STATE SURVEY REPORT

NAME OF FACILITY: Regal Heights

DATE SURVEY COMPLETED: August 14, 2009

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	<p>requests and grievances shall be made in writing upon written request by the patient or resident.</p> <p>Cross-refer to CMS 2567-L, survey date completed 3/11/09, F166.</p> <p>(11) Every patient and resident may associate and communicate privately and without restriction with persons and groups of the patient's own choice (on the patient's or resident's own or their initiative) at any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 8/14/09, F174.</p> <p>Nursing staffing</p> <p>(f) There shall be a Nursing Supervisor on duty and on site at all times.</p>	<p>Cross-refer to POC for CMS 2567-L survey F-tag 166</p> <p>Cross-refer to POC for CMS 2567-L survey F-tag 174</p>
<p>16 <u>Del. C.</u>, Chapter 11, Subchapter VII, § 1161</p>		



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STATE SURVEY REPORT

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Nursing Supervisor shall mean an Advanced Practice Nurse or Registered Nurse who is assigned to supervise and evaluate nursing services direct caregivers no less than 25 percent of the Nursing Supervisor's time per shift.

An individual serving as a Nursing Supervisor must be an employee of the facility, thus excluding temporary employment agency personnel from serving in this capacity unless Exigent Circumstances exist. The term "Exigent Circumstances" means a short-term emergency or other unavoidable situation, and all reasonable alternatives to the use of either a temporary employee or a nurse of lesser than Registered Nurse designation have been exhausted.

Within 24 hours of the Exigent Circumstances that require the use of temporary employment agency staffing to fill a Nursing Supervisor position in a residential health facility, the facility shall notify the Division in writing of the Exigent Circumstances and the expected duration.

The law was not met as evidenced by:



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	<p>Per the Staffing Worksheets, Regal failed to show the presence of a Registered Nurse (RN) on duty rendering direct resident care on the following seven (7) day shifts. An Exigent Circumstance form was not received for any of these dates and shifts.</p> <ol style="list-style-type: none"> 1. Tuesday, 7 July 2009. 2. Wednesday, 8 July 2009. 3. Thursday, 9 July 2009. 4. Friday, 10 July 2009. 5. Friday, 17 July 2009. 6. Wednesday, 22 July 2009. 7. Friday, 24 July 2009. 	<p>An RN was hired in August. Unit Managers who are Registered Nurses will at times participate in resident care.</p>