

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

LTC Residents Protection

PRINTED: 04/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ MAY 11 2010 Director's Office	(X3) DATE SURVEY COMPLETED 03/26/2010
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NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966
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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 000 INITIAL COMMENTS

A bi-annual survey was conducted at the facility from March 17, 2010 through March 26, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included thirty (30) admission and forty (40) census residents in Stage I. The Stage II sample included review of thirty-one (31) residents. Additionally, there were seven (7) sub-sampled residents.

F 174 SS=D 483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY

The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

This REQUIREMENT is not met as evidenced by:
Based upon observation and interview, it was determined that the facility failed to provide phone privacy for two (R189 and R98) out of 31 Stage II Sampled residents. Findings include:

1. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 1/14/10, revealed that R189 was coded as independent in cognitive skills for daily living and that both short and long term memory were ok. On 3/17/10, during an interview, R189 stated that he had to use the phone at the nurses' station. He stated that there was no private place to make calls to his sister or to call about appointments.
2. On 3/19/10, R98 was observed self-propelling his wheelchair to the Station II nurses' station

F 000

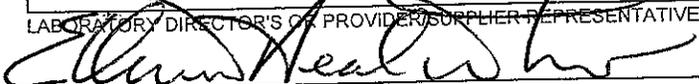
F 174

F174 Right to Telephone Access With Privacy

1. R189 and R98 were made aware the facility could provide them with a portable phone or a private area to talk on the phone when needed.
2. An initial audit was conducted to determine whether or not residents were aware of the facility's policy to provide a private area or portable phone to residents when privacy was needed for phone conversations. Residents identified as needing a portable phone or a private area for phone conversations were informed to request this with the staff when the need occurs and this intervention will be provided.
3. Staff received education regarding the facility policy to provide a private area or portable phone to residents when privacy is needed for phone conversations.

This policy and procedure is included in the admissions process and in the employee orientation process.
4. A random monthly audit x 3 months will be conducted to determine if resident's right to telephone access with privacy is provided and reported at the monthly QI meeting.

5/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X6) DATE 5/10/10

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 174 Continued From page 1
where E14 (CNA) handed him the phone. During the phone conversation, R98 was speaking about money issues including checks and could be clearly heard by anyone in the area. Upon completion of R98's phone call, E14 was interviewed. When E14 was asked if there was another place that was more private to receive phone calls, E14 responded that resident's both received and made calls from the Station II nurses' station. E14 also stated that R98 had a cell phone but because he was not in his room that the call came to the nurses' station and that she informed him to come and get the call there.

F 174

F 241 SS=D The facility failed to provide phone privacy for R189 and R98.

F 241

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

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 record review and observation of the lunch time meal on 3/18/10, 3/19/10 and 3/24/10 on Station III, it was determined that the facility failed to provide meals that promoted the care of the residents in a dignified manner. Findings include:

1. At 11:25 AM on 03/18/10, R5 while in his wheel chair and watching television, was seated next to his room mate while the room mate was eating his meal. R5 was waiting for the second seating of the assisted dining room which was to

F241 Dignity and Respect

1. R5, SSR3, SSR4, R127, SSR6, SSR7, SSR8 and SSR9 now receive their trays at the same timeframe as other residents either in their room or at their table in the dining areas.

There is no R146 identified on the survey roster.

SSR10 has napkins removed from shirt immediately after eating.

2. An initial audit was conducted at meal pass times to identify how trays are delivered to residents to assure tray delivery is provided to residents during the same timeframe when residents are in their room or seated at the same table. Meal carts were rearranged accordingly.

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F 241 Continued From page 2 commence at 11:50 AM.

2. At 11:30 AM on 03/18/10 and at 11:45 AM on 3/19/10, SSR3 was lying in bed watching his room mate, while the room mate was eating his meal. SSR3 was awaiting the second cart to arrive on the unit at 11:50 AM with his meal.

3. At 11:45 AM on 03/18/10, R127, SSR4, and R146 were seated in the Station III day/activity room in full view of a fourth resident being assisted with her meal. Three residents, R127, SSR4, and R146, were awaiting the second seating of the assisted dining room which was to commence at 11:50 AM.

4. At 11:48 AM on 03/19/10, R127, SSR6, SSR7, SSR8 and SSR9 had been seated in the Station III day/activity room in full view of a sixth resident being assisted with her meal. These residents were awaiting the second seating of the assisted dining room which was to commence at 11:50 AM.

The first cart for Station III was scheduled to arrive at 11:15 AM.

5. At 11:45 AM on 03/18/10, SSR10 was wheeled back to the Station III's nurse's station from the assisted dining room, located near the Station II nurse's station, with a paper napkin tucked in the collar of her sweat shirt. This was done in full view of staff, residents and visitors. According to the annual MDS assessment dated 10/24/09, this resident was severely cognitively impaired and had moderate impairment of vision.

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

F 241

3. Meals carts have been rearranged to accommodate residents eating together.

Dietary and nursing staff received education on providing meals to residents during the same timeframe when residents are in their room or seated at the same table.

Routine ambassador rounds are conducted to identify dignity issues (such as, but not limited, removing napkins from residents immediately after eating). Issues are addressed and resolved immediately. Issues as a result ambassador rounds are discussed at the routine AM meeting.

All staff received education regarding privacy and dignity to residents (including removing napkins from residents immediately after eating).

4. A monthly audit is conducted x 3 months to assure compliance with tray delivery is provided to residents during the same timeframe when residents are in their room or seated at the same table; and reported at the monthly QI meeting.

Routine ambassador rounds are aggregated and analyzed monthly and reported at the monthly QI meeting.

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F 279	<p>Continued From page 3</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R79 and R205) out of 31 sampled residents the facility failed to develop a comprehensive care plan for an identified resident care area. Findings include:</p> <p>1. R79 had diagnoses including Diabetes, Seizure disorder and Hypertension.</p> <p>R79's quarterly Minimum Data Set (MDS) Assessment, dated 1/25/10, revealed that R79's cognitive skills for daily decision making was coded, "2 = Moderately impaired". Review of the 1/25/10 MDS, Cognitive Patterns section also revealed that R79 was coded as, "2 = Behavior</p>	F 279	<p><u>F279 Comprehensive Care Plans</u></p> <p>1. R79 now has a care plan for mood and behavioral issues and antipsychotic usage.</p> <p>R205 now has a care plan for anxiety and psychotropic drug usage.</p> <p>2. An initial audit has been conducted on all residents to identify current treatment plan. Care plans are revised accordingly.</p> <p>An initial audit has been conducted on current care plans used and revised to meet the changes in the care plan process.</p> <p>3. The care plan process has been revised to include additional members of the interdisciplinary team, location of care plans, individualization of care plans and revision of care plans to include an evaluation component.</p> <p>The interdisciplinary care plan team now consists of: RNACs, Unit Managers, Dietitian/Dietary Manager, Activities, Social Services, Rehab., Restorative Nursing, and CNA.</p> <p>Care Plans are located at each nurses station.</p> <p>Licensed staff and other members of the interdisciplinary care plan team received education on the revised care plan process of care plans.</p> <p>4. Random monthly care plan audits are conducted by the QI nurse or designee to assure compliance with care plans being completed timely, reflects current status of resident and is evaluated accordingly, and reported at the monthly QI meeting.</p>	5/27/10
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F 279

Continued From page 4

present, over last 7 days appears different from resident's usual functioning" in the areas of periods of altered perception or awareness of surroundings, periods of lethargy, and mental function varies over the course of the day.

The Mood and Behavior Patterns section of the 1/25/10 MDS was checked in the following areas: Resident made negative statements; Repetitive verbalizations; Expressions of what appear to be unrealistic fears; Repetitive health complaints; Insomnia/change in regular sleep pattern; and Verbally abusive. The Disease Diagnoses section of the 1/25/10 MDS coded for transient organic psychotic condition and other diseases of the urinary system, urinary tract infection. Additionally, R79 coded for, "Hallucinations" in the Health Conditions section of the same MDS.

Review of R79's March 2010 Medication Administration Record (MAR) revealed that R79 was administered one dose of Risperidol (anti-psychotic medication) 0.5 mg by mouth as needed on 3/11/10, 3/12/10, and 3/14/10. Record review lacked evidence that a care plan was developed for mood and behavioral issues/anti-psychotic use. An interview with E5 (unit manager) on 3/26/10 at approximately 1:30 PM, confirmed the findings.

2. Cross refer F329, example #1.

R205 was admitted to the facility on 8/27/09 with diagnoses including Congestive Heart Failure, Hypertension, Anxiety Disorder and Depression.

The admission Minimum Data Set (MDS) Assessment, dated 9/3/09, revealed that R205's cognitive skills for daily decision making were

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F 279 Continued From page 5
coded, "2 = Moderately impaired" and periods of restlessness were coded, "1 = Behavior present, not of recent onset". Review of the Medication section of the 9/3/09 MDS, revealed that R205 received antianxiety and antidepressant medications 7 days in the last week and hypnotic medications 1 day in the last week. The quarterly MDS, dated 2/28/10, was reviewed and revealed that R205's cognitive skills for daily decision making was coded, "0 = Independent" and the Medication section continued to be coded as "7" for the number of days in the last week that R205 received antianxiety and antidepressant medications.

The 9/3/09 MDS Resident Assessment Protocol Summary (RAPS) was triggered in the area of psychotropic drug use. However, the section "Care Plan Addressed" was not checked.

R205 was receiving Xanax (anti-anxiety medication) 0.5 mg. by mouth twice a day for anxiety. Record review lacked evidence that a care plan was developed for anxiety/psychotropic drug use. An interview with E4 (unit manager) on 3/22/10 at approximately 2 PM, confirmed the findings.

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged 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

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F 280 Continued From page 6
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 for two (R205 and R97) out of 31 Stage II Sampled residents the facility failed to periodically review and revise care plans when approaches were changed or initiated. Findings include:

1. Cross refer F309, example #1. Review of R205's interdisciplinary care plan implemented 8/27/09 for chronic neuropathic pain of bilateral lower extremities (BLE) lacked evidence of periodic review or revision since the implementation date, despite the resident's readmission to the facility from the hospital on 1/11/10. Interview with the Director of Nursing (E2) on 3/25/10 at approximately 12 noon confirmed that the facility failed to revise the care plan since the initial implementation on 8/27/09.
2. R97 was admitted to the facility on 4/30/09 with diagnoses of obstructive uropathy, atonic bladder/neurogenic bladder with an indwelling Foley catheter.

F 280

F280 Right to Participate in Care Planning- Revise CP

1. R205's care plan has been revised to reflect her current status.
- R97's care plan has been revised to reflect current treatment plan for Foley catheter care.
2. An initial audit has been conducted on all residents to identify current treatment plan. Care plans are revised accordingly and interdisciplinary interventions have been implemented by appropriate disciplines.
3. The care plan process has been revised to include additional members of the interdisciplinary team, location of care plans, individualization of care plans and revision of care plans to include an evaluation component. The interdisciplinary care plan team now consists of: RNACs, Unit Managers, Dietitian/Dietary Manager, Activities, Social Services, Rehab., Restorative Nursing., and CNA. Care Plans are located at each nurses station.

Licensed staff and other members of the interdisciplinary care plan team received education on the revised care plan process of care plans.

4. Random monthly care plan audits are conducted by the QI nurse or designee to assure compliance with care plans being completed timely, reflects current status of resident and is evaluated accordingly, and reported at the monthly QI meeting.

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F 280	Continued From page 7 The Urinary Catheter Care Plan, developed on 5/11/09 and last revised 1/28/10, was reviewed. The care plan failed to be revised to reflect that the Foley care was done every shift not daily as noted in the interventions. The facility failed to revise the Urinary Catheter Care Plan to reflect R97's current status. On 3/25/10 during an interview with E4 (RN), she confirmed the findings.	F 280	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, it was determined that the facility failed to ensure that the necessary care and services were provided for five (R205, R145, R197, R53 and R179) out of 31 Stage II residents. For R205 and R145, the facility failed to provide adequate pain relief. It was determined that the facility failed to comprehensively assess R205 and R145's chronic pain upon readmission to the facility. In addition, the facility's system failed to monitor the effectiveness and appropriateness of pain management interventions which resulted in unacceptable pain level between "8" to "10" for R205 and between "6" to "8" for R145 requiring	F 309	F309 Quality of Care 1. R205 was seen by a new physician and her pain medication has been adjusted. R145 no longer resides at the facility R197's fluid restriction orders have been reviewed by the dietitian and the tray card now identifies 1500 fluid restriction as ordered by the physician. Resident is receiving appropriate amounts of fluids on her tray. R179 is now receiving her diabetic snack as ordered and the percentage is documented on the MAR. R53's bowel regimen has been reviewed and implemented per order.

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significant use of as needed pain medications. The facility failed to ensure that R197's fluid restriction orders were followed by the dietary department. Additionally, the facility failed to follow physician's orders for R53 regarding bowel regime and for R179 regarding provision of a diabetic snack and amount consumed. Findings include:

1. R205 was re-admitted from the hospital on 1/11/10 with congestive heart failure, abnormality of gait, idiopathic peripheral autonomic neuropathy, peripheral vascular disease, and anxiety.

Review of "Pain Data Collection" dated 1/11/10 documented that R205 was experiencing pain, however, no further characteristics of the pain including location were noted on this document.

Review of the quarterly Minimum Data Set (MDS) assessment dated 2/28/10 revealed R205 was cognitively intact for daily decision making and was experiencing excruciating or horrible pain on a daily basis (this assessment did not require coding for location of the pain).

An interdisciplinary care plan implemented 8/27/09[care plan never revised following readmission] for chronic neuropathic pain of bilateral lower extremities (BLE) included interventions to administer and monitor effectiveness of pharmacological interventions. The goals included that R205 will state reduction in pain intensity within 30 minutes to one hour after receiving the interventions. Although the R205 was readmitted to the facility on 1/11/10, the care plan lacked evidence of revision.

F 309

2. An initial audit was conducted on all residents to assure appropriate pain management has been implemented.

Any resident identified with pain management issues were reviewed by nursing and the attending physician, and appropriate interventions were implemented, the care plan was updated and the responsible party was notified.

An initial audit was conducted on all residents on fluid restrictions to assure they are accurately monitored, offered the appropriate amount of fluids and the documentation on the POF, MAR, Tray card and Fluid Restriction flow sheet is consistent.

An initial audit was conducted on all residents receiving diabetic snacks to assure resident's with an order is receiving the snack and documentation of the percentage is recorded.

An initial audit was conducted on all residents to identify if BM regimen or protocol is being implemented accordingly. All residents identified as not having regimen or protocol implemented are now receiving appropriate interventions as ordered.

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F 309	<p>Continued From page 9</p> <p>The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.</p> <p>Review of facility's policy titled "Pain Management" noted that a pain control plan will be mutually established with the resident, however, record review lacked evidence of a plan or an individualized pain control goals for R205.</p> <p>Review of the February and March 2010 physician's order noted the following pharmacological interventions for the BLE pain: -Oxycontin ER (extended release) 10 mg. po (by mouth) every evening (narcotic pain medication for treatment of moderate to severe pain) scheduled to be given at 9 PM. -Lyrica 50 mg. po three times a day (medication to treat pain associated with neuropathy) scheduled to be given at 6 AM, 12 noon, and 11 PM. -Oxycodone/Acetaminophen 5mg. /325 mg. (brand name of Percocet), two tablets every 6 hours for severe pain and one tablet for moderate pain. (narcotic pain medication to treat moderate to moderately severe pain).</p> <p>Review of "PRN (as needed) Pain Management Flow Sheet" from 2/1/10 through 2/28/10 revealed R205 was experiencing pain level between "8" to "10" for 20 out of 27 or 81% of the times in which</p>	F 309	<p>3. Pain policy and procedure, pain assessment tools and pain management care plan were reviewed and revised.</p> <p>Education on the revised pain process was provided to licensed nursing staff, CNA's, and the interdisciplinary care plan team. Revised pain management processes have been included in orientation.</p> <p>Residents identified with pain management issues will be reviewed with the attending physician at the bi-monthly Medical Director meeting.</p> <p>Fluid Restriction policy has been reviewed and revised to include the communication process of residents on fluid restrictions.</p> <p>Nursing and dietary staff received education on the revised fluid restriction process.</p> <p>Process was revised for residents receiving diabetic snacks to include documentation of percentage consumed.</p> <p>Education was provided to nursing staff regarding revised process for diabetic snacks and documentation of percentage consumed.</p> <p>BM protocol has been reviewed and revised by the DON and Medical Director.</p> <p>Education was provided to nursing staff regarding revised BM protocol and following specific orders for bowel regimen.</p> <p>4. Monthly audits are conducted on residents identified as having pain to assure compliance with process and appropriate pain management is implemented. Results are discussed at the monthly QI Committee.</p>	5/27/10

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F 309	<p>Continued From page 10</p> <p>she required Percocet 5mg./325 mg. for severe BLE pain. Reassessment of pain completed 30 minutes to one hour after the Percocet administration documented that R205 had relief of pain/"0" or "hurt a little bit"/"2."</p> <p>Review of "PRN Pain Management Flow Sheet" from 3/1/10-3/27/10 continued to document that R205 was experiencing pain between "8" and "10" for 30 out of 43 or 70% of the time and required Percocet daily and up to three times a day. Reassessment of the pain varied from pain levels of "7" to "0." For reassessment of the 3/27/10 doses administered at 8:15 PM, R205 reported pain level of "7", however, record review lacked evidence that additional intervention was initiated for this level of pain.</p> <p>Although above pain flow sheets documented R205 was experiencing pain levels between "8" and "10" on a daily basis and R205 required multiple uses of as needed Percocet, the facility's system failed to monitor the effectiveness and the appropriateness of the pain management interventions including the routine Lyrica administered for neuropathic pain. Additionally the system failed to comprehensively reassess the interventions in an effort minimize or reduce the level of pain where pain could be anticipated.</p> <p>An interview with the Director of Nursing (E2) on 4/6/10 at 9:50 AM confirmed that the pain management policy does not specifically incorporate the use of routine pain medication such as Lyrica.</p> <p>Observations and interviews with R205 from 3/19/10 through 3/24/10 revealed that the resident continued to experience excruciating or</p>	F 309	<p>A fluid restriction audit will be conducted on residents on fluid restrictions on each nursing unit daily x 2 weeks; then weekly x three months and monthly thereafter. Audit results will be reviewed weekly by the dietitian or designee and discussed at bimonthly At Risk Meeting. Additionally these audits will be reviewed at the bimonthly Medical Director's Meeting. Results will be discussed at the monthly QI Committee.</p> <p>Monthly audits are conducted on all diabetic residents receiving snacks to assure compliance with consumption x 3 months, and reported at the monthly QI meeting.</p> <p>Random monthly audits are conducted on residents to assure compliance with implementation of bowel protocol or regimen x 3 months, and reported at the monthly QI meeting.</p>	5/27/10

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horrible levels of pain of "10" of BLE:
- On 3/19/10 at approximately 3 PM, R205 reported to surveyor that she is experiencing pain level of "8" of her BLE due to neuropathy that the current pain regime is not effective. R205 relayed that previously, she had taken Lyrica and Percocet two tablets every four hours while awake for the BLE pain control.
-On 3/24/10 at approximately 10 AM, R205 reported to the surveyor that she was experiencing BLE at "10+" and R205 reported "I just need to bare it." Interview with the staff nurse (E7) providing care to R205 on 3/24/10 at 10:10 AM revealed that R205 reported pain of BLE at "7" at approximately 8:30 AM and two Percocet 5 mg. were administered. Reassessment 30 minutes after the medication revealed R205 was experiencing pain level at "1." Surveyor informed E7 that R205 related to the surveyor that at 10 AM, that her pain was at "10", however, subsequent record review lacked any evidence of any action taken to address this level of pain.

A subsequent "Pain Data Collection" completed on 3/24/10 noted R205 continued to experience BLE pain with varying intensity throughout the day. During this assessment on 3/24/10, R205 reported a pain level of "8."

Record review revealed on 3/19/10 and on 3/24/10, R205 received the above pharmacological regime including Lyrica 50 mg. three times a day, however, R205 continued to experience levels of pain between "8 and 10."

During an interview with the E2 at approximately 11:20 AM on 3/25/10, E2 was informed of surveyor's above observations and interviews

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F 309	<p>Continued From page 12 related to R205's BLE pain. Subsequent to this conversation, E2 informed the surveyor on 3/24/10 at approximately 4 PM that the new attending physician (E8) would be reassessing R205's pain regime later the same date.</p> <p>Review of physician progress note dated 3/25/10 timed 7:30 PM by E8 revealed R205 offered complaints of BLE with rating of "10" with numbness. Subsequent to this visit, changes in medication related to the chronic pain and peripheral neuropathy included increasing Lyrica from 50 mg. to 75 mg. three times a day and Percocet 7.5 mg/325 mg. by mouth one to two tablets as needed every eight hours.</p> <p>Interview with the Medical Director(16) and Director of Nursing (E2) on 4/7/2010 revealed that this physician had medical reasons for not increasing R205's pain medications. E16 was the treating physician while R205 was hospitalized. The hospital discharge summary dated 1/11/2010 faxed to the Division on 4/6/2010 stated under discharge medications "I would not increase any pain medications at this point".</p> <p>Despite R205 experienced excruciating pain BLE, the facility's system failed to comprehensively assess, reassess, and monitor the effectiveness and appropriateness of R205's pain regime as it related to current standards of practice. In addition, the facility failed to modify the approaches and failed to communicate with the physician when a resident with pain was not adequately managed. Due to these multiple failures, R205 was found to be in severe to excruciating ("8-10") levels of pain during the survey.</p>	F 309		5/27/10

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F 309 · Continued From page 13
Findings were reviewed with administration on 3/26/10.

2. R145 was readmitted to the facility on 12/17/09 with diagnoses including fibromyalgia, chronic pain, rheumatoid arthritis, osteoarthritis, depression, and anxiety. The "Pain Data Collection" sheet dated 12/17/09, indicated that the resident did not report any pain at the time of the assessment.

Review of the quarterly MDS assessment, dated 1/6/10, indicated that R145 was cognitively intact and was experiencing pain less than daily with a moderate level of intensity.

A pain management care plan, with the most recent revision noted on 1/7/10, indicated that R145's pain was related to rheumatoid arthritis, degenerative joint disease, and neurogenic pain. Interventions included to monitor and record effectiveness of both routine and PRN pain medication.

Review of the March 2010 MAR revealed the following pharmacological interventions:
-Lidoderm patch 5% to be applied to lower back for 12 hours then removed for 12 hours (for relief of pain associated with post herpetic neuralgia). The March 2010 MAR revealed that R145 refused this intervention.
-Neurontin 600 mg. by mouth TID (medication to treat pain related to post herpetic neuralgia) scheduled for 9 AM, 1 PM, and 5 PM.
- Voltaren gel 1 % apply topically to tender areas TID (medication to treat osteoarthritis pain). MAR revealed that R145 refused this intervention.
- Morphine IR (immediate release) 15 mg. two tab po every four hours as needed (narcotic pain

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F 309	Continued From page 14 medication to treat moderate to severe pain). Review of R145's "PRN Pain Management Flow Sheet" from 3/2/10-3/22/10 (21 days) noted R145 reported pain levels between "7-8" (between hurts even more and hurts a whole lot) daily to twice a day and was administered Morphine IR 30 mg. for each noted complaint. Reassessment was noted four (4) out of the 12 administrations documented: a pain level of "0" or "no hurt"; (3) with no reassessment documented; (3) with "positive effect" and (2) with "sleeping." An interview with E9 (staff nurse) on 3/24/10 at approximately 11:45 AM revealed that R145 has been refusing the Lidoderm patch and Voltaren gel due to these interventions being ineffective for her pain. A review of the February 2010 MAR revealed that beginning on 2/12/10, R145 refused the Lidoderm patch and Voltaren gel was refused for the entire month of February. Although these interventions were refused by R145, the facility failed to consult the attending physician. Record review lacked evidence of a quarterly comprehensive pain assessment, as noted in the facility's policy. Observations and interviews with R145 from 3/19/10 through 3/25/10 revealed that the resident continued to experience bilateral shoulder pain with radiation down to her back at a pain level of "7-8": - On 3/22/10 at approximately 11 AM, R145 reported to surveyor that she is experiencing pain in her neck, shoulders, back, and BLE at a pain level of "8." - On 3/24/10 at approximately 12 noon, R145 reported neck and shoulder pain at a level of "6."	F 309		5/27/10	

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During an interview with the E2 (DON) at approximately 11:20 AM on 3/25/10, E2 was informed of the above surveyor's observation of R145's complaints of pain. Subsequent to this conversation, E2 informed the surveyor on 3/24/10 at approximately 4 PM that the new attending physician (E8) was contacted and that R145's current pain regime will be reassessed.

Review of E8' physician progress note, dated 3/25/10 and timed 8 PM by E8 revealed R145 complained of "terrible pain all over the body mainly at pressure points, joints, and back with pain 8-9/10 on pain scale." Subsequent to this visit, the physician coordinated a consult with a pain management specialist for 4/7/10 for chronic pain evaluation and medication adjustment and placed the resident on Amytriptyline (medication to treat depression) 25 mg. by mouth every evening.

Despite R145 experiencing generalized pain due to chronic pain, the facility's system failed to comprehensively assess, reassess, and monitor the effectiveness of R145's pain regime as it related to current standards of practice. In addition, the facility failed to consult with the physician when both the Lidoderm patch and the Voltaren gel were refused by the resident and R145's pain was not adequately managed. Due to these multiple failures, R145 was found to be in moderate to severe pain ("6-8") levels of pain throughout the survey.

Findings were reviewed with administration on 3/26/10.

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5/27/10

3. R197 was readmitted to the facility post hospitalization on 2/12/10. Diagnoses included chronic kidney disease on hemodialysis, anemia, congestive heart failure, hypertension and history of pulmonary edema.

R197 had a physician's order, dated 2/26/10, for a 1500cc fluid restriction/24 hours. The allotment breakdown was for dietary to provide 840cc/24 hours and nursing to provide 660cc/24 hours. Review of R197's clinical record revealed that the facility was using a "Fluid Restriction Tracking Form" which noted the resident's daily fluid intake. Nurse's notes from 2/26/10 through the current time revealed that R197 was occasionally non-compliant with her fluid restriction.

On 3/25/10 R197 was observed at the noon time meal. Beverages included on the lunch tray were an 8 oz (ounce) cup of coffee, 6 oz cup water and 6 oz cup of iced tea (total equaling 20 oz. or 600 cc) The tray was observed being removed from the resident's room and it was noted that the resident did not consume any of the fluids on her tray.

On 3/25/10, E15 (Registered Dietitian) provided the surveyor with R197's meal ticket for that day. Review of the 3/25/10 meal ticket revealed that it did not indicate that the resident was on a 1500cc fluid restriction. The total beverage amount in oz for the 3 meals was 46 oz or 1380 cc, exceeding the dietary allotment of fluids for the 3 meals per day.

Observation of breakfast on 3/26/10 at 8:30 AM revealed the beverages served were an 8 oz coffee, 8 oz container of milk, and a 4 oz juice.

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R197 only consumed the 8 oz container of milk with her cereal. The total amount of fluids that had been sent by dietary was again 600 cc. The total daily dietary allotment is 840 cc divided between the 3 meals.

During an interview with R197 on 3/26/10 at 8:30 AM, she stated that she was aware that she was on a fluid restriction and that she goes on and off it.

On 3/26/10 at 9:15 AM, E15 was interviewed. E15 stated that the meal tickets should note when a resident is on a fluid restriction. E15 acknowledged that the meal ticket she had given to the surveyor yesterday failed to note the fluid restriction. Upon review of the fluid totals from yesterday's lunch and today's breakfast, E15 confirmed that the totals exceeded the allotted amount. When asked how dietary is notified of fluid restriction orders for residents, E15 stated that when an order is written dietary is to receive a communication from nursing with the order. E15 then looked in R197's dietary folder and was not able to locate the communication slip with the fluid restriction order. E15 acknowledged that a breakdown had occurred in their system.

Although the facility was tracking the fluid amounts per day consumed by the resident, it failed to ensure that R197, who was on a fluid restriction, was not served fluids in excess of the allotted amount.

4. R179 was admitted to the facility on 7/17/08 with a diagnosis of Diabetes. R179 received long acting insulin as well as sliding scale coverage of regular insulin for her Diabetes.

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F 309	<p>Continued From page 18</p> <p>The 3/10 Physician Order Sheet (POS) included the order, "Nurse to offer diabetic snack @ HS (at bedtime) - record % (percentage) consumed." This physician's order was originally written on 2/1/10. Review of the 3/10 Medication Administration Record (MAR) revealed that the MAR was blank from 3/1/10 through 3/25/10. On 3/26/10, E4 (RN) and E15 (Registered Dietitian) also reviewed R 179's 3/10 POS and 3/10 MAR and confirmed this finding. The facility failed to follow the physician's order for R179.</p> <p>5. R53 was admitted to the facility on 10/9/07. R53 had a care plan developed on 9/21/09 and last revised on 3/15/10 for "Bowel Elimination Problem as evidenced by: Constipation". Per the 3/10 POS, R53 was on Lactulose 30 mls by mouth every 3 days as needed and Senna Plus 2 tablets by mouth daily for constipation.</p> <p>Review of the 3/10 POS also revealed the following physician orders for R53: "- Milk of Magnesia Suspension (MOM) Administer 30 mls by mouth daily as needed if no bowel movement for 3 days; - Bisacodyl EC (Dulcolax) Take 2 tablets (10mg) by mouth as needed if Milk of Mag ineffective; - Fleet Ene (enema) Insert 1 enema rectally as needed if Dulcolax is not effective."</p> <p>Review of R53's record, revealed that R53 had no bowel movements (BMs) for more than 3 days from 3/6 through 3/10/10, from 3/11 evening shift through 3/16/10, and from 3/20 through 3/24/10.</p> <p>The facility failed to follow the 3/10 POS regarding R53's bowel regime as noted above. On 3/1/10, 3/2/10, 3/10/10 and 3/17/10, Dulcolax was</p>	F 309		5/27/10
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administered without MOM being given prior to Dulcolax as ordered. Additionally, the facility failed to follow the 3/10 POS when a Fleets enema was administered on 3/24/10 but there was no MOM and Dulcolax given prior to the enema as ordered. On 3/25/10, E4 confirmed the findings.

F 309

F 312 SS=D 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
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.

F 312

F312 ADL Care Provided for Dependent Residents

1. R53's fingernails have been cleaned and trimmed at the time of the survey in which they were identified.
2. An initial audit was conducted on all residents to assure nails were trimmed.
3. C.N.A.'s were in-serviced on nail care In-servicing for ADL care is part of the orientation and annual mandatory in-services. Licensed nursing staff have been in-serviced on monitoring residents for appropriate grooming and personal hygiene and will observe residents during routine rounds and med pass. Residents will also be observed during routine Ambassador Rounds with observations brought to morning meeting to be addressed by the appropriate Unit Manager.
4. Results of the Ambassador Rounds Compliance are addressed through the routine QI process.

5/27/10

This REQUIREMENT is not met as evidenced by:
Based upon observation and interview, it was determined that the facility failed to provide the necessary services to maintain good grooming for 1 resident (R53) out of 31 Stage II Sampled residents who was unable to carry out Activities of Daily Living (ADLs) for himself. Findings include:

R53 had diagnoses including Congestive Heart Failure, Chronic Renal Insufficiency and Alzheimer's Dementia and was receiving hospice services. Review of R53's quarterly Minimum Data Set (MDS) assessment, dated 3/11/10, revealed that R53 was coded as extensive assistance for personal hygiene.

Observation on 3/19/10 at 9:05 AM of R53's hands revealed his fingernails had dirt under them and were long. R53 stated that he was not able to take care of cleaning or cutting his nails

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F 312 Continued From page 20
The middle finger on his left hand was missing the distal digit.

F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER
The facility failed to provide nail care for R53 who was unable to provide ADLs for himself. On 3/19/10 at 9:20 AM, in an interview with E4 (RN), she confirmed that resident's fingernails were in need of a trim and were dirty.

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 infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on a detailed investigation of the use of an indwelling catheter for 2 (R60 and R292) of 31 sampled residents, it was determined that the facility failed to ensure that these 2 residents, who had indwelling catheters, had a clinical condition which demonstrated that catheterization was necessary. Findings include:

The facility's Bladder Assessment Form stated:
"8. Evaluation for Residents With Indwelling Catheters (Skip this section if the resident does not have an indwelling catheter). Residents with indwelling catheters must have at least one of the following conditions (Check all that apply) _

F315 No Catheter, Prevent UTI, Restore Bladder

1. R60 no longer resides at the facility. The urology appointment was scheduled and the resident and family were informed of the date to take resident to Urologist since the date of the appointment was after his discharge date from the facility.

R92 no longer has a Foley catheter in place.

2. An initial audit was conducted on all residents with Foley catheters to assure each resident has medical justification for Foley catheter usage. The attending physician was notified of residents identified as not having appropriate medical justification for Foley catheter usage.

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F 315	<p>Continued From page 21</p> <p>Terminal illness or severe impairment and movement causes intractable Pain, _ Stage III, or IV pressure ulcers in an area affected by incontinence that prevents ulcer healing, _ Untreatable urethral blockage causing urinary retention (documented by PVR (post void residual) of > (greater than) 200mLs) and staff unable to perform intermittent catheterization (3 failed attempts), _ Need for exact measurement of urine output. If NONE of the above applies, initiate a voiding trial and document results in the medical record."</p> <p>1. R60 was admitted to the facility post hospitalization for repair of a left hip fracture after a fall at home. Additional admitting diagnoses included septic shock secondary to urinary tract infection (UTI), anemia, gait dysfunction, dementia and benign prostatic hypertrophy (BPH).</p> <p>The hospital History and Physical (H & P), dictated on 1/16/10, stated that R60's past medical history included "chronic kidney disease with congenital (sic) only having one kidney, history of hematuria (blood in the urine), BPH...Past Surgical History:...transurethral resection of the prostate (TURP)..." and that the resident "has had no urinary incontinence or frequency" prior to admission. The H & P also stated that while in the emergency department, evaluation revealed a UTI, an indication of sepsis and required the administration of an antibiotic.</p> <p>R60 arrived at the facility on 1/23/10 at 12:30 PM. [A physician's note dated 3/26/2010 stated patient came with Foley cath from the hospital.] Admission orders, dated 1/23/10 did not include any orders for an antibiotic (for UTI). The facility's</p>	F 315	<p>3. The Foley catheter policy and procedure has been reviewed by the Medical Director and DON, and revised to include appropriate medical justification for Foley catheter usage, reassessment of Foley catheter usage, and standardization of Foley care.</p> <p>The Bladder assessment form has been reviewed and revised.</p> <p>The Foley catheter care plan has been reviewed and revised.</p> <p>Education was provided to licensed nurses on the revised Foley catheter policy and procedure, Bladder Assessment form, and Foley catheter care plan.</p> <p>The process for communicating and scheduling consultation appointments was reviewed and revised.</p> <p>Education was provided to licensed nurses on the revised process for communicating and scheduling consultation appointments.</p> <p>4. New admissions and re-admissions are reviewed at time of admission to determine if resident has a Foley catheter and if there is medical justification for usage. This information is discussed at the routine AM meeting.</p> <p>Monthly audits are conducted on all residents with Foley catheters to determine if medical justification and management of Foley catheter is maintained x 3 months and reported at the routine QI meeting.</p>

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F 315	<p>Continued From page 22</p> <p>Bladder Assessment Form, dated 1/23/10, identified that the resident was "currently continent of bladder No further assessment necessary at this time." The reverse side of the Bladder Assessment Form, section #8 "Evaluation for Residents With Indwelling Catheters (Skip this section if the resident does not have an indwelling catheter)" was dated 1/24/10 and was left blank.</p> <p>A nurse's admission note, dated 1/23/10 and timed 5 PM, failed to note that R60 had a Foley catheter upon admission, however an order was written that day at 7 PM to "D/C (discontinue) Foley..." A nurse's note, dated 1/23/10 and timed 10:30 PM stated that the Foley catheter had been discontinued at 7 PM and that the oncoming shift was informed to monitor. On 1/24/10, a nurse's note at 6 AM stated that R60 had voided 350cc using a urinal. A 1/24/10 note, timed at 2:10 PM stated "heavily saturated wet brief x 1 this shift," however it did not specify at what time the resident had voided.</p> <p>On 1/24/10 at 5:10 PM a physician's order was written stating, "Straight cath for no void. If more than 120cc return (amount of urine obtained from the bladder during catheterization) leave Foley in #16 (size of Foley)." A nurse's note dated 1/24/10 and timed 11 PM stated, "...MD will exam (sic) tomorrow (1/25), @ 1730 (5:30 PM) per MD order 16 Fr Foley inserted using sterile technique without any difficulty. 325 ml of dark yellow urine obtained...Foley left in place. Total 1125 ml of dark yellow urine in this shift..." The nurse's note failed to document the circumstances leading to R60's having the catheter reinserted.</p> <p>During an interview with E10 (nurse on duty on</p>	F 315	<p>A random monthly audit is conducted on residents to determine if consultation appointments are ordered, if the resident was seen and if recommendations have been communicated to the physician and ordered, as appropriate; x 3 months; and reported at the monthly QI meeting. Audits are conducted by the QI nurse or designee.</p>	5/27/10
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F 315 Continued From page 23

1/24/10, 3-11 shift) she stated that she had been told at the change of shift report (approximately 3 PM) by the day shift, that R60 had last voided at 9 AM. E10 stated that she had instructed the evening aide to let her know if the resident did not void by 5 PM, because this would mean that 8 hours had lapsed since R60's last void. At 5 PM, when informed by the aide that R60 had not voided, an order was obtained to straight cath him and if more than 120mls returned, to leave the catheter in. E10 acknowledged that the resident was assessed prior to the reinsertion of the catheter and that he was not complaining of any discomfort or urge to void, nor did he have any bladder distention. When asked if the resident was offered a urinal or toileted or offered extra fluids, she stated "no."

On 1/25/10, the physician completed R60's History & Physical and noted the resident had an indwelling Foley that was draining clear yellow urine. Under "Additional Comments" he noted R60 was "S/P (status post) UTI..." and that part of the plan was to "Assess need for Foley." Despite this notation in the H & P, there was no evidence in the clinical record that the facility made any further attempts to remove the Foley catheter. The facility failed to attempt to remove a catheter from this resident who had no clinical condition demonstrating that the catheter was necessary.

On 2/3/10, the facility developed a care plan for at risk of developing UTI and complications due to catheter use related to urinary retention. The goal of this care plan stated, "...will have no signs or symptoms of UTI and indications for catheter use will be resolved and Foley discontinued by next review 5/5/10. The care plan approaches included, "Review for possible removal of

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F 315 : Continued From page 24
catheter."

F 315

Review of a nurse's note, dated 2/17/10 and timed 10:30 PM revealed that R60 had a temperature of 100.5 F and that the urine in the catheter bag was noted to be cloudy with sediment. A urinalysis (UA) and culture and sensitivity (C & S) were ordered, along with Bactrim DS (antibiotic) 1 tablet twice daily for 10 days. The urine C&S report, dated 2/21/10, revealed that the organism identified was greater than 100,000 Staph Aureus MRSA (Methicillin Resistant Staphylococcus Aureus) Coag. Pos.

On 2/26/10 an order was written for the resident to have a UA, C&S after the antibiotic was completed. A UA and C&S was obtained on 3/1/10 and later that evening R60 again developed a temperature of 100.4 F and was started on Macrobid (antibiotic) 100mg twice daily for 10 days.

A nurse's note, dated 3/2/10 and timed 10:45 PM stated that R60's Foley came out and a new catheter was reinserted. There was no evidence in the clinical record that the facility made an attempt at this time to leave the catheter out to determine if the resident was able to void on his own. The urine C&S report, dated 3/4/10 revealed the organism identified was greater than 100,000 Enterococcus Faecalis, positive for MRSA.

On 3/14/10, a nurse's note, dated 3/14/10 and timed 12 PM, stated that R60 complained of itching at the catheter insertion site and a small amount of drainage was noted. The physician was called and ordered that a urine C&S be obtained the next day and a follow up with a urologist be scheduled due to "repeat UTI's." The

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F 315	<p>Continued From page 25</p> <p>facility failed to consider the indwelling catheter as a source of infection and continued to leave the catheter in place. The urine C&S report, dated 3/18/10, identified greater than 100,000 colony count of three (3) organisms; Pseudomonas Aeruginosa, Enterococcus Faecalis and Staph Aureus MRSA Coag. Pos. R60 was again treated with Macrobid 100mg daily for 10 days.</p> <p>Observation of R60 on 3/24/10 at 8:30 AM revealed that the indwelling catheter remained in place. During an interview with E11 (Unit Manager) on 3/24/10 at 2:30 PM it was determined that the facility failed to arrange an appointment with a urologist, which was ordered on 3/14/10. E11 acknowledged that a request slip was never forwarded to the facility's appointment scheduler and that despite a 24 hour chart check (oncoming 11 PM - 7 AM shift verifies all orders written in the preceding 24 hours) having been signed off as completed, it failed to identify the omission on the treatment record for the urology appointment.</p> <p>On 3/24/10 a physician's order stated, "Remove Foley cath in a.m. Check for voiding q (every) 8 hr. Reinsert Foley cath in 8-12 hr if distended + unable to void, measure residual." In an interview with E10 on 3/25/10 at 4 PM, she confirmed that R60's catheter had been removed that morning. E10 also stated that the resident had voided twice since removal of the catheter without difficulty. During the exit conference on 3/26/10 at approximately 5 PM, E2 (Director of Nursing) also stated that R60 was continuing to void without difficulty.</p> <p>The facility's Medical Director (E16) reviewed R60's medical record and on 3/26/10 submitted a</p>	F 315	5/27/10

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F 315	<p>Continued From page 26</p> <p>written statement. In this statement, E16 wrote, "...Pt (patient) came with Foley cath from the hosp (hospital) was ordered to remove Foley on 01/24/10 and straight cath and keep Foley for urinary retention or urine > 120cc...Foley was removed yesterday 03/25/10 Pt has hx (history) of, UTIs/BPH, urinary retention in the past...After chart review and staff interview I found, 1. no harm done to the pt. 2. there was a piece of miscommunication between staff and physician, 3. pt has chronic UTI/and possible retention Foley was only small piece of (increased) risk of UTI, 4. staff education will occur more and better documentation." E16 was interviewed on 3/26/10 and stated that he feels there was no harm because the resident came from the hospital with a diagnosis of UTI/Sepsis. When asked if this would not be all the more reason to try to remove the catheter, given that it is a potential source for infection, he did not answer.</p> <p>In summary, the facility failed to have valid medical justification for use of an indwelling catheter for R60, failed to reassess the need for the catheter, failed to identify the catheter as a potential of source of infection and failed to obtain a urology consult per physician's orders.</p> <p>2. R292 was admitted to the facility on 2/26/10 post hospitalization for rehabilitative services. Admitting diagnoses included atrial fibrillation, hyperlipidemia, coronary artery disease, diabetes mellitus, hypertension and chronic obstructive pulmonary disease. Admission orders, dated 2/26/10 included the order, "Foley catheter to gravity straight drainage for wound healing."</p> <p>Review of R292's Nursing Admission Assessment and Interim Care Plan, dated</p>	F 315	5/27/10

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F 315: Continued From page 27

2/26/10, identified the presence of an excoriated bottom (buttocks). This area was not identified as a Stage 3 or 4 pressure ulcer. The Bladder Assessment Form, dated 2/26/10, identified the resident as being "currently continent of bladder" (had indwelling catheter in place) and in, "8. Evaluation For Residents With Indwelling Catheters," handwritten was "Bottom excoriated." This failed to meet the criteria warranting use of an indwelling catheter.

The RAPS (Resident Assessment Protocol Summary), dated 3/9/10, for Urinary Incontinence and Indwelling Catheter stated, "...admitted to center on 022610 with an indwelling Foley catheter...During her hospitalization, she did receive treatment for a UTI...(R292) reports she had no difficulty maintaining urinary continence at home and denies history of UTI. Will proceed with care planning with goal for discontinuation of catheter and absence of recurrent UTI."

On 3/9/10, the facility developed a care plan for the problem at risk of developing UTI and complications due to catheter use. This care plan failed to identify a reason for the catheter use. The goal of the care plan was to have no signs or symptoms of UTI through the next review and to have the catheter discontinued by 6/9/10. An approach included, "review for possible removal of catheter."

Review of the clinical record lacked evidence of a clinical condition warranting use of an indwelling catheter for R292. The catheter remained in place until 3/13/10, a total of 16 days in the facility, at which time it was discontinued. The facility failed to remove an indwelling catheter which presented the potential for infection and lacked a clinical

F 315

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F 315

Continued From page 28
condition demonstrating that the catheter was necessary.

F 315

F 329
SS=E

During an interview with E11 (Unit Manager) on 3/24/10, she acknowledged that there was no indication for the use of the catheter for R292.
483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

F 329

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that for 7 (R205, R145, R53, R179,

F329 Drug Regimen is Free From Unnecessary Drugs

1. R205 continues to receive Xanax and now has a behavioral flow sheet; care plan has been revised to reflect treatment plan R145 no longer resides at the facility R53 continues to receive Ativan and the reason for usage is documented on the MAR; care plan has been revised to reflect treatment plan.
R179 continues to receive Ambien CR and the reason for usage is documented on the MAR; care plan has been revised to reflect treatment plan.
R189 is still on Vesicare and Vitamin B12 and the reason for usage is documented on the MAR; care plan has been revised to reflect treatment plan.
R211 now has indicators/diagnosis for all of her medications.
R295 no longer resides at the facility

2. An initial audit was conducted on all residents to determine if medications ordered by the physician have a reason/dx for usage. The attending physician was notified of resident's identified as having medications without an indicator/dx for usage, and orders were obtained accordingly.

An initial audit was conducted on residents receiving psychotropic medications to assure behavior modification flow sheets and documentation of PRN usage includes reason given and effectiveness. Care Plans were revised accordingly.

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F 329

Continued From page 29
R189, R211 and R295) out of 31 Stage II sampled residents, the facility failed to have the resident's drug regimen free from unnecessary drugs including excessive dose, excessive duration, without adequate indication for use, and without adequate monitoring. Findings include:

Review of the facility's policy entitled, "Psychopharmacological monitor" indicated that each resident receiving anti-psychotic or anxiolytics will be monitored for:

- Episodes of behaviors being treated and/or manifestations of the disordered thought process;
- Adverse reactions and side effects;
- Appropriateness of drug selection and dosage.

1. Review of R205's readmission physician's orders, dated 1/11/10, noted that R205 was administered Xanax 0.5 mg. by mouth twice a day for anxiety. The record lacked evidence of a target behavioral symptom or the monitoring of the symptoms for which R205 was receiving the Xanax. An interview with E2 (Director of Nursing) on 3/26/10 at approximately 11 AM, revealed that the facility's system to monitor behavioral symptoms was previously through documentation on a flow sheet. However, through clerical error the flow sheet had been terminated.

2. R145 was receiving Valium for behavior symptoms. The record lacked evidence of a target behavioral symptom or the monitoring of the symptoms for which R145 was receiving the Valium. An interview with E2 on 3/26/10 at approximately 11 AM revealed that the facility's system to monitor the behavioral symptoms was previously through documentation on a flow sheet. However, through clerical error the flow sheet had been terminated.

F 329

3. Policy and procedure for obtaining physician orders was revised.

Licensed nurses and medical staff received education regarding including indication for use/dx. of medications when obtaining and/or writing orders.

Policy and procedure for "Behavior Modification Flow Sheets" was revised.

Licensed nurses received education regarding completing "Behavior Modification Flow Sheets" and the policy and procedure revisions.

4. Random monthly medication audits are conducted by the pharmacist to determine if medications ordered by the physician have an indication for use/dx.; and reported at the monthly QI meeting.

Random monthly audits are conducted by the pharmacist to determine compliance with completion of Behavior Modification Flow Sheets for residents receiving psychotropic medications and reported at the monthly QI meeting.

5/27/10

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2010
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966		
(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 329	<p>Continued From page 30</p> <p>3. R53's 3/10 Physician's Order Sheet (POS) noted an order for Ativan 1 mg tablet by mouth every 12 hours as needed. Review of the 3/10 Medication Administration Record revealed that R53 received Ativan 13 times from 3/1/10 through 3/24/10 and lacked indication for use and monitoring regarding the effectiveness of the medication except once on 3/13/10. Review of the Nurse's Notes (NN) from 3/1/10 through 3/26/10 revealed that there was no NN on 3/1, 3/2, 3/3, 3/8, 3/14, 3/16, 3/20, 3/21/10 to indicate why Ativan was administered and whether it was effective.</p> <p>The facility failed to have an indication for the use of Ativan and failed to monitor its effectiveness. On 3/24/10, findings were confirmed by E4 (RN).</p> <p>4. R179's 3/10 Physician Order Sheet (POS) included an order for Ambien CR (extended release) tab 12.5 mg tab by mouth at bedtime as needed for insomnia. R179 received Ambien CR 15 times from 3/6/10 through 3/23/10.</p> <p>Review of the 3/10 Medication Administration Record (MAR) revealed that the reason that Ambien CR was given was listed only 4 out of the 15 times that it was administered. However, monitoring the result of Ambien CR was blank. Review of the 3/10 Nurse's Notes (NN) through 3/24/10, revealed that there was no NN regarding Ambien administration.</p> <p>The facility failed to consistently indicate the reason for Ambien being administered and failed to monitor the result of its use. On 3/24/10, findings were confirmed by E4.</p>	F 329		5/27/10

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F 329: Continued From page 31

F 329

5. R189's 3/10 POS included an order for Vitamin B12 injection 1 ml IM (intramuscular) every month on the first and Vesicare (used for overactive bladder) 10 mg tablet by mouth daily.

R189's Bladder Assessment Form, dated 4/29/09 stated, " Resident is currently continent of bladder (sic) No further assessment necessary at this time X Yes ". There was no indication for the use of Vesicare.

Vitamin B12, was originally ordered on 12/30/09 but had no indication for use. Review of the 1/10 - 3/10 POS ' and the lab results on R189's record revealed that no Vitamin B12 level was drawn.

On 3/25/10, in an interview with E17 (Pharmacist), he stated in reviewing the original orders sent to the pharmacy that there was no diagnosis listed for Vesicare and Vitamin B12 on the original orders. Additionally, E17 stated that he would have expected a pernicious anemia diagnosis for the Vitamin B12 injection.

The facility failed to have indications for the use of Vesicare and Vitamin B12 injections. On 3/26/10, findings were confirmed by E17.

6. R211 was admitted on 2/3/10 with diagnoses of muscle weakness, Alzheimer's Disease, and Depression. Upon admission, R211's physician ordered Seroquel 25 mg twice a day until 2/8/10 then Seroquel 50 mg twice a day. On 2/16/10, R211's physician discontinued Seroquel and started Risperdal 0.25 mg at 9 AM and 0.5 mg at 9 PM. Review of the record including the 2/10 MAR revealed the lack of consistent monitoring regarding behaviors and the effectiveness of the

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F 329	<p>Continued From page 32</p> <p>psychoactive medications, Seroquel and then Risperdal through 2/24/10.</p> <p>According to the 2/10 POS, R211's physician ordered Xanax 0.25 mg every 6 hours as needed for anxiety. Review of the 2/10 MAR revealed that Xanax was given 13 times from 2/5/10 through 2/23/10. However, there was a lack of consistent monitoring regarding the effectiveness of the Xanax, both on the MAR and in the NN.</p> <p>The facility failed to consistently monitor behavior and the effectiveness of both the psychoactive medications, Seroquel and Risperdal through 2/24/10 and well as Xanax as needed. On 3/24/10 during an interview with E4, she confirmed the findings.</p> <p>7. R295 was admitted to the facility from the hospital on 3/4/10 with diagnoses that included exacerbation of chronic obstructive pulmonary disease (COPD), respiratory failure, hypertension, rheumatoid arthritis, gout and anxiety disorder. Review of the hospital record noted that R295 could possibly have pneumonia and was started on Zithromax (antibiotic), although this diagnosis was not included on admission to the facility.</p> <p>Review of R295's current drug regimen revealed the resident was receiving the medications Remeron (antidepressant) 7.5 mg daily at bedtime, Claritin (antihistamine) 10 mg daily and Zithromax (antibiotic) 500 mg every Monday, Wednesday and Friday. The clinical record lacked an indication for the use of the Zithromax, Claritin and Remeron. Additionally, the Zithromax order did not specify the duration of administration. The facility was administering the Zithromax for an excessive duration without an</p>	F 329		5/27/10

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F 329 Continued From page 33 indication for it's use.

F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=D PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, it was determined that the facility failed to serve food that was palatable and at acceptable temperatures. Findings include:

During Stage 1 of the survey, residents (who preferred not to be identified) complained of hot foods served too cold and cold foods served too warm. Four (4) resident trays were pulled to test at the evening meal on 3/24/10.

1. A test tray was sampled on Station 3 at 5:03 PM on 3/24/10. Food temperatures were as follows: Soup = 122 degrees F; Grilled ham & cheese = 110 degrees F; tater tots = 92 degrees F; Iced Tea = 40 degrees F; Fruit cup = 52 degrees F.

The surveyor tasted the food and found the grilled ham and cheese and tater tots not palatable due to the cool temperatures.

2. On 3/24/10 at 5:42 PM on Station 2, units 300 and 400, a test tray was sampled. The food and beverages had the following temperatures:
Potato tots = 113.7 degrees F lukewarm, not

F 329 F364

F 364

1. Residents chose to be anonymous during the survey.

2. Facility has already determined this is a house-wide issue for all residents and has started the corrective process, as below.

3. The facility has been researching a heating system to implement to maintain warm food temperatures. We reviewed several heating systems by calling different distributors; Aladdin Heat on Demand, Cambro, Dinex Smart Therm, and Silo Wax Pellet Heater System. We have already implemented the Silo Wax Pellet Heater System; which is one of the top of the line systems.

Tray carts will be announced when brought to the floor and all available staff will assist in passing of trays so trays to provide timely passing of trays.

Ice cream will be kept in freezer and not pulled until the tray line starts.

Ice is poured into cups and placed in freezer and maintained there until tray line starts. Beverages will then be poured into the cups with ice.

Milk will be chilled down in freezer 20 minutes prior to tray line starting.

Cold foods will be plated and stored in walk in refrigerator and pulled out right at the point tray line starts.

4. Routine audits will be conducted by the Food Services Director and will occur on a monthly basis for a minimum of 3 months to assure compliance with temperatures of cold and hot foods; compliance will be reported at the monthly QI meeting until QI determines food temps are resolved.

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F 364 Continued From page 34
palatable
Grilled tuna melt = 11 7.3 degrees F lukewarm, not palatable
Minestrone soup = 144.5 degrees F
Pears with white topping = 56.3 degrees F
Iced tea = 63.1 degrees F warm, not palatable
Milk = 50.9 degrees F warm, not palatable
Water = 57 degrees F.

The facility failed to provide food that was palatable when it was tasted by the surveyor with the temperatures as noted above.

3. Test tray of a regular diet on 3/24/10 at 5:29 PM during dinner revealed the water 124.7 F for hot water was lukewarm. The facility failed to have hot water at a temperature that was palatable.

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, it was determined that the monthly Medication Regimen Review failed to identify the lack of indication for use and/or monitoring of the effectiveness of medications for 3 (R53, R179 and R189) out of

F 364

F 428

F428 Drug Regimen Review, Report Irregular, Act on

1. R53 now has an indication of use/dx for Ativan and the effectiveness is addressed. R179 now has an indication of use/dx for Ambien CR and the effectiveness is addressed. R189 now has an indication of use/dx for Vitamin B12.

2. An initial audit was conducted on all residents to determine if medications ordered by the physician have a reason/dx for usage. The attending physician was notified of resident's identified as having medications without an indicator/dx for usage, and orders were obtained accordingly.

An initial audit was conducted on all residents to determine if effectiveness of PRN medications is monitored and documented.

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F 428	<p>Continued From page 35</p> <p>31 Stage II Sampled Residents. Findings include:</p> <p>1. Cross refer F329, example #3 Review of R53's Medication Regimen Review (MRR) on 3/15/10 revealed that the box, "No New Suggestions" was checked despite Ativan being administered as needed with no indication for use and the lack of monitoring regarding the effectiveness/result.</p> <p>The MRR failed to identify that there was no indication for the use of Ativan as well as monitoring its effectiveness.</p> <p>2. Cross refer F329, example #4 Review of R179's MRR on 3/15/10 revealed that the box, "No New Suggestions" was checked despite the lack of monitoring regarding the effectiveness/result of Ambien CR use.</p> <p>The MRR failed to identify that there was lack of monitoring regarding Ambien CR's effectiveness.</p> <p>3. Cross refer F329, example #5 Review of R189's MRRs on 1/15/10, 2/16/10 and 3/15/10 revealed that, "No Recommendations Made" was circled despite the lack of indication for the use of Vitamin B12 injections monthly.</p> <p>The MRR failed to identify that there was no indication for use of the Vitamin B12 injections.</p>	F 428	<p>3. Policy and procedure for obtaining physician orders was revised.</p> <p>Licensed nurses and medical staff received education regarding including indication for use/dx. of medications when obtaining and/or writing orders.</p> <p>Licensed nurses received education regarding monitoring and documentation of effectiveness on PRN medications.</p> <p>4. Random monthly medication audits are conducted by the pharmacist to determine if medications ordered by the physician have an indication for use/dx.; and reported at the monthly QI meeting.</p> <p>Random monthly PRN medication audits are conducted by the pharmacist to determine if monitoring and effectiveness of medications are completed; and reported at the monthly QI meeting.</p>	5/27/10
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug</p>	F 431		

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F 431

Continued From page 36

records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based upon observation and interview, it was determined that the facility failed to properly store medication in the medication refrigerator at the temperature the medication required for 2 (R106 and R20) out of 31 Stage II sampled residents. Findings include:
1. R106 had Aranesp PFA (Darbepoetin ALFA) stored in the medication refrigerator which was

F 431

F431 Drug Records, Label/Store Drugs and Biologicals

1. R106's Aranesep PFA was destroyed at the time the medication was found to be stored at an inappropriate temperature. The medication was re-ordered, received, and stored at the adequate temperature.
- R20's TOBI Tobramycin Inhalation Solution was destroyed at the time the medication was found to be stored at an inappropriate temperature. The medication was re-ordered, received, and stored at the adequate temperature.
2. An initial audit was conducted on all medication refrigerators to determine if temperatures were adequate and appropriate for the medications stored in them, medications inadequately stored are destroyed.
3. Policy and Procedure for storing medications and logging temperatures in medication refrigerators was reviewed and revised.

Licensed Nurses received education regarding storing medications appropriately, logging temperatures of medication refrigerators, reporting abnormal temperatures and actions taken, destroying and re-ordering of medications when inappropriately stored.

4. Medication refrigerator temperatures are obtained daily and logged by nursing staff; the information is aggregated by the QI Nurse or designee and reported at the monthly QI meeting.

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F 431	<p>Continued From page 37</p> <p>dispensed from the pharmacy to the unit on 3/15/10. Review of the instructions on the injectable medication stated that it required a storage temperature between 36 and 46 degrees F. However, review of the temperature log revealed that from 3/15/10 through 3/24/10 the temperature in the refrigerator was 52 degrees F. Observation of the medication refrigerator on 3/24/10 was also 52 degrees F. The facility failed to store Aranesp PFA medication at the proper temperature in the medication refrigerator. On 3/24/10, E18 (LPN) and E4 (RN) confirmed the findings.</p> <p>2. R20 had TOBI Tobramycin Inhalation Solution stored in the refrigerator which was dispensed from the pharmacy to the unit on 3/22/10. Review of the instructions on the medication stated that the med required a storage temperature between 36-46 degrees F. However, review of the temperature log revealed that from 3/22/10 through 3/24/10 the temperature in the medication refrigerator was 52 degrees F. Observation of the medication refrigerator on 3/24/10 was also 52 degrees F. The facility failed to store TOBI Tobramycin Inhalation Solution medication at the proper temperature in the medication refrigerator. On 3/24/10, E18 (LPN) and E4 (RN) confirmed the findings.</p> <p>While the facility recorded the temperatures of the refrigerator they failed to notify the person responsible for the repairs when the temperatures were in an unacceptable range.</p>	F 431		5/27/10
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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085037	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 3/26/2010
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166 SS A	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to make prompt efforts to resolve a grievance for one (R205) out of 31 sampled residents. Findings include:</p> <p>On 3/22/10 at approximately 10 AM, R205 reported to the surveyor that she has been missing her lower denture for the past two weeks. R205 stated that she had informed the nursing staff, as well as the laundry staff. Interview with E12 (Director of Social Services) on 3/22/10 at approximately 12 noon revealed that she was not aware of R205's missing property. Subsequently to this conversation, E12 located a denture that had been forwarded to her department on 3/12/10 from the laundry department E12 proceeded to show the denture to R205, who confirmed it was hers. An interview with E13 (laundry staff) on 3/25/10 at approximately 11 AM revealed that she had been informed by R205 that she was missing her denture within the past couple of weeks. E13 confirmed that she had not communicated this to her supervisor</p> <p>Findings were reviewed with administration on 3/26/10.</p> <p style="text-align: right;"><i>Completed May 27, 2010</i></p> <p><u>F166 Right to Prompt Efforts to Resolve Grievances</u></p> <ol style="list-style-type: none"> 1. R205 dentures were found and given to her. 2. Laundry staff was interviewed to determine if other resident's have reported missing items within the past 30 days and if this information has been relayed to Social Services. 3. Laundry staff received education regarding reporting missing items or finding of dentures, glasses, money, etc. to social services in a timely manner 4. A monthly review of complaints and concerns is conducted to identify residents with missing items x 3 months. Outcomes are discussed with laundry staff and at the routine QI meeting.

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 4 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

LTC Residents Protection
MAY 11 2010
Director's Office

STATE SURVEY REPORT

DATE SURVEY COMPLETED: March 26, 2010

NAME OF FACILITY: Atlantic Shores Rehabilitation & Health Center

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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The State Report incorporates by reference and also cites the findings specified in the Federal Report.

A bi-annual survey was conducted at the facility from March 17, 2010 through March 26, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included thirty (30) admission and forty (40) census residents in Stage I. The Stage II sample included review of thirty-one (31) residents. Additionally, there were seven (7) sub-sampled residents.

Delaware Regulations for Skilled and Intermediate Care Nursing Facilities

Services to Residents:

General Services:

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.

3201.6.0

3201.6.1

3201.6.1.1

Provider's Signature: [Signature] Title: ADMINISTRATOR Date: May 10, 2010



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

DATE SURVEY COMPLETED: March 26, 2010

NAME OF FACILITY: Atlantic Shores Rehabilitation & Health Center

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

STATEMENT OF DEFICIENCIES
Specific Deficiencies

SECTION

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 3/26/10, F166, F174, F309, F312, F315, F329, F364, F428 and F431.

Nursing Administration

3201.6.5

3201.6.5.6

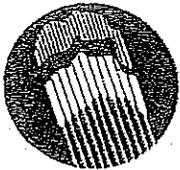
A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L, survey date completed 3/26/10, F279.

*Please refer to responses for F166, F174, F309, F312, F315, F329, F364, F428, F431 on the CMS 2567
Completion Date: 5/27/2010*

*Please refer to response for F279 on the CMS 2567
Completion Date: 5/27/2010*



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

DATE SURVEY COMPLETED: March 26, 2010

NAME OF FACILITY: Atlantic Shores Rehabilitation & Health Center

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

SECTION STATEMENT OF DEFICIENCIES
Specific Deficiencies

3201.6.5.7

The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 3/26/10, F280.

16 Del. C.,
Chapter 11
Subchapter II,

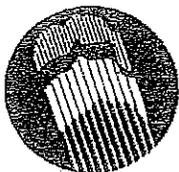
§1121 Patient's Rights (1)

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 the CMS 2567-L survey report date

Please refer to the response for F280 on the CMS 2567. Completion Date: 5/27/2010



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	completed 3/26/10, F241.	<i>Please refer to the response for F241 on the CMS 2567 Completion Date: 5/27/2010</i>