

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

PRINTED: 06/30/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2009 LTC Residents Protection JUL 14 2009 Director's Office
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility June 1, 2009 through June 11, 2009. The facility census on the first day of survey was one-hundred ten (110). The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The survey sample totaled twenty-three (23), twenty (20) active and three (3) closed records respectively. There was an additional sub-sample of four (4) residents not in the sample for complete record review.	F 000			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **Administrator** (X6) DATE **7-13-09**

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 225	<p>Continued From page 1</p> <p>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (1) out of 23 (R3) sampled residents the facility failed to immediately report and thoroughly investigate an allegation of misappropriation of resident property when the resident reported a roll of stamps missing. Findings include:</p> <p>An interview with R3 on 6/2/09 revealed that he had purchased two (2) rolls of stamps and had one (1) roll stolen (value at \$42). The resident reported the incident to the staff at the "desk" (nurses station).</p> <p>A nurse's note dated 3/27/09 documented that the resident reported that an aide stole \$24 worth of stamps from his room.</p> <p>An interview with the quality assurance director (E12) on 6/5/09 revealed that there was no incident report completed for this allegation, security had not been made aware of this allegation and no investigation had been</p>	F 225	<p>Corrective Action(s): An incident report was completed for resident R3's 03/27/09 report of theft of stamps on 06/16/09 and submitted to LTCRP; a follow-up investigation was completed / reported on 06/19/09.</p> <p>Identification of Deficient Practices and Corrective Actions: 1) All nurses' notes for the time period 01/01/09 -- 06/30/09 were audited by QA for other unreported missing items / possible thefts via export from cueSHIFT [the facility's electronic medical record] and electronic search for text strings indicative of such incidents. None were found. 2) The QA office will review and revise (if necessary) the incident report/investigation P&P to assure it reflects the intent of the regulation. 3) QA staff will conduct in-services for all staff on the necessity of reporting allegations of theft / misappropriation of residents' property.</p> <p>Systemic Change: 1) Night nursing supervisors will weekly review the 24-hour interdisciplinary Notes for all residents, to assure staff is complying with the P&P for reporting allegations of misappropriation of residents' property. 2) QA will conduct monthly random electronic searches of the month's progress notes for at least 10 residents, to identify any theft/missing item events which should have triggered an incident report, and confirm that such events were timely reported.</p> <p>Monitoring: 1) Results of nursing's weekly reviews will be reported monthly at Nursing Leadership meetings, and summarized quarterly for presentation at QA Committee meetings by the DON / designee. 2) Results of QA's monthly searches / follow-up confirmation will be reported at the August 2009 QA Committee meeting by the QA Administrator, who will report subsequent months' results quarterly thereafter.</p>	06/19/09 07/13/09 07/31/09 08/15/09 08/22/09 08/01/09 08/28/09	

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F 225 F 241 SS=E	<p>Continued From page 2</p> <p>conducted. The interview confirmed that the facility failed to immediately report and thoroughly investigation the alleged theft of the stamps.</p> <p>483.15(a) DIGNITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined that two (2) out of 23 twenty-three (R11, R14) sampled residents along with three (3) additional subsampled residents (SSR1, SSR3, SSR4) were not provided care in a manner that maintained or enhanced their dignity. Findings include:</p> <p>1. (a). R11 was observed on 6/2/09 at 9:43 AM in the gold dining room wearing a white shirt with a large stain down the front of the shirt. The resident was then observed being wheeled down to the dayroom and placed in front of the television. At 10:10 AM, R11 remained in front of the TV in the presence of other residents with the stained shirt. At 10:55 AM, the resident was observed with a clean shirt on.</p> <p>(b). On 6/2/09 at 12:45 PM R11 was observed in the gold dining room feeding himself lunch. Nurse E13 approached the resident to thicken his liquids. The nurse took the spoon that the resident was eating pumpkin custard with and wiped the food debris on the resident's white clothing protector leaving a large orange stain of food debris.</p>	F 225 F 241	<p>Gold Unit Dining (items 1a & 1b): Corrective Action(s): Resident R11's shirt was changed and clothing protector removed for cleaning on the day of the survey.</p> <p>Identification of Deficient Practices and Corrective Actions: 1) Daily nursing rounds by the Nursing Supervisor and/or Nurse Manager were initiated; any observed deficient practices in providing resident care and services are immediately corrected. 2) QA staff conducted ad hoc checks of residents' clothing over a period of three days; none were found to be stained/in need of change. 3) The P&P concerning residents' dignity will be reviewed and revised (if necessary) to assure it meets the intent of the regulations. 4) Nursing staff will be in-serviced on preserving the dignity of all residents while providing care and services.</p> <p>Systemic Change: 1) A one-page "Quality of Life (QoL) Resident Review" tool was drafted to assist staff with their observations of residents in the facility (see Exhibit A). Use of the draft tool will be piloted by nursing leadership for a random sample of residents. During the pilot, the tool's design will be finalized, and the feasibility of its use by other disciplines will be assessed by a multi-disciplinary work group. 2) Staff will be notified immediately of any deficient practice identified; the deficient practice will be documented on the QoL Resident Review tool.</p>	06/02/09 06/15/09 07/10/09 07/20/09 08/15/09 07/10/09

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		F 241	<p>Monitoring: Results of the pilot will be compiled and presented at the August QA Committee meeting by the DON/designee. Results of subsequent use of the finalized tool will be forwarded monthly to the QA Administrator and summarized for quarterly presentation to the QA Committee.</p> <p>Dining Room Meal Service (item 2):</p> <p>Corrective Action: Residents identified in this citation were investigated, and factors contributing to each resident's delay in service were identified: Resident SSR3 typically orders food from our "always available" list at the time of service. This practice causes him to wait longer for his meal to be prepared. Usually SSR3 orders a grilled cheese sandwich which takes time to grill. Items such as cold sandwich and pasta marinara are on the serving line and can be prepared more quickly. Resident R14 requires feeding assistance; service awaits the availability of a CNA, to assure the meal served is at the appropriate temperature. Resident SSR4's arrival time at the dining room varies; his arrival was missed.</p> <p>Identification of Deficient Practices and Corrective Actions: Food Service completed a sweep to identify any additional issues relating to serving residents at the same table concurrently. We observed that the three areas hindering timely service are: a) Residents ordering alternate meals at the time of service; b) Residents requiring feeding assistance; and c) Residents coming into the dining room after the onset of the meal. Additionally, multiple Food Service positions remain vacant, awaiting approval from OMB to fill the positions. 2) QA staff audited timely meal delivery during three meals (two lunches; one dinner); service among tablemates typically was completed within five minutes; longer times could occur, when one or more residents arrived at the table several minutes later than other residents.</p>	08/20/09 07/01/09 07/06/09 07/09/09 & 07/10/09

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		F 241	<p>Systemic Change(s): 1) An in-service was held on to inform supervisors that when a resident orders an alternate meal, it needs to be written on their ticket and re-circulated through the serving line. This practice will ensure that this person's request does not get over looked or misplaced. The cold box on the front line has been rearranged to include always available items for easy access. A diagram was placed above cold box to ensure consistency. 2) Food service supervisor will assign sections daily. The food expeditor or food service supervisor will turn tickets in to serving line as residents enter the dining room. The expeditor is responsible for constantly watching for residents who enter the dining room. Servers are responsible for their sections and must ensure that all residents in their sections are served appropriately. When a resident joins a table in their section, this will be reported to the expeditor/ food service supervisor. 3) A nursing supervisor will be available in the dining room at all times to ensure that residents requiring feeding assistance are being attended. 4) Approval to fill five Food Service positions was received.</p> <p>Monitor: 1) Weekly audits to monitor timeliness of meal service have been conducted since July 2008; timeliness has been improved from an average of > 20 minutes to an average of <=10 minutes. 2) Weekly audits will continue to be conducted by Food Service and QA staff; involvement of other disciplines will be explored. Results of the audits will be reported quarterly to the QA Committee by the Food Services Director / designee.</p> <p>Public testing/results (item 3): Corrective Action(s): Resident SSR1's finger sticks are not completed in public and the results are not repeated in the presence of others.</p>	<p>07/10/09</p> <p>07/10/09</p> <p>07/01/09</p> <p>06/02/09</p>

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		F 241	<p>Identification of Deficient Practices and Corrective Actions: 1) Daily nursing rounds by the Nursing Supervisor and/or Nurse Manager were initiated; any observed deficient practices in providing resident care and services are immediately corrected. 2) The P&P concerning residents' dignity will be reviewed and revised (if necessary) to assure it meets the intent of the regulations. 3) Nursing staff will be in-serviced on preserving the dignity of all residents while providing care and services.</p> <p>Systemic Change(s): Systemic Change: 1) A one-page "Quality of Life (QoL) Resident Review" tool was drafted to assist staff with their observations of residents in the facility (see Exhibit A). Use of the draft tool will be piloted by nursing leadership for a random sample of residents. During the pilot, the tool's design will be finalized, and the feasibility of its use by other disciplines will be assessed by a multi-disciplinary work group. 2) Staff will be notified immediately of any deficient practice identified; the deficient practice will be documented on the QoL Resident Review tool.</p> <p>Monitoring: Results of the pilot will be compiled and presented at the August QA Committee meeting by the DON/designee. Results of subsequent use of the finalized tool will be forwarded monthly to the QA Administrator and summarized for quarterly presentation to the QA Committee.</p>	<p>06/15/09</p> <p>07/20/09</p> <p>08/15/09</p> <p>07/10/09</p> <p>08/20/09</p>

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F 241	Continued From page 3 2. During two dining room observations on 06/01/09 and 06/02/09 at 12:00 Noon, three residents (SSR3, SSR4 and R14) were observed to be seated at their assigned tables with their table mates. While their table mates dined, SSR3, SSR4 and R14 remained seated without their meals. SSR3 and R14's meals were delayed by 30 minutes and SSR4's meal was delayed by 25 minutes. An interview with the dietitian, E1 on 06/01/09 at 12:30 PM stated there had been some difficulty trying to serve the residents in a timely manner and that the issue was being looked into in order to come up with a better plan. The facility failed to promote a pleasant and dignified dining experience for these three residents. 3. During medication observation on 6/2/09 at 11:05 AM, staff nurse, E6 completed a finger stick blood sugar test by pricking and obtaining blood from SSR1's finger in the front of the nurses station with several residents present. E6 verbalized the result.	F 241			
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 throughout the facility during the survey, it was determined that the facility failed to provide housekeeping necessary to maintain a sanitary, orderly, and comfortable	F 253	Dirty bedside tables: Corrective Action: The cited overbed tables were immediately cleaned. Identification of Deficient Practices and Corrective Actions: The custodial staff conducted a sweep of the building; all overbed tables were inspected and cleaned.	06/11/09 07/06/09	

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		F 253	<p>Systematic Change(s): The current and new staff will be trained/re-trained in the proper cleaning and documentation of all cleaning cycles within the facility. The custodial trainer will conduct monthly training, documenting this training in a report to the custodial supervisor, who will maintain records for one year. Overbed tables will be cleaned by custodial staff and inspected by the custodial supervisor on a daily basis; this issue has been added to the supervisor's inspection log.</p> <p>Monitor: The custodial supervisor will monitor/audit the cleaning records on a weekly basis to ensure the proper cleaning requirements are met. Monitoring/audit results will be sent monthly to the Deputy NHA and QA Administrator; summarized results will be presented quarterly to the QA Committee by the custodial supervisor / designee.</p> <p>Dried residue, personal laundry dryer: Corrective Action: The residue was immediately cleaned from the dryer.</p> <p>Identification of Deficient Practices and Corrective Actions: Custodial staff inspected and cleaned the residents' personal laundry rooms on all units.</p> <p>Systematic Change(s): The current and new staff will be trained/re-trained in the proper cleaning methods and documentation of all cleaning cycles within the facility, which shall include the resident personal laundry room. The supervisor will inspect resident personal laundry rooms on a daily basis and document findings; documentation will be kept for one year in the supervisor's office.</p>	<p>07/13/09 & ongoing</p> <p>08/01/09 & ongoing</p> <p>06/12/09</p> <p>07/06/09</p> <p>07/20/09 & ongoing</p>
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		F 253	<p>Monitor: The custodial supervisor will inspect and maintain documentation on the custodians' work to ensure that proper cleaning is done. Inspection results will be sent monthly to the Deputy NHA and QA Administrator; summarized results will be presented quarterly to the QA Committee by the custodial supervisor / designee.</p> <p>Debris in overhead lights: Corrective Action: Cited lights were cleaned.</p> <p>Identification of Deficient Practices and Corrective Action: 1) The custodial staff conducted a sweep of the building and inspected and cleaned all debris in overhead lights. 2) QA conducted ad hoc audits of a sample of overhead lights on 07/07/09, 07/09/09 and 07/10/09. Those requiring cleaning were reported to custodial staff for cleaning.</p> <p>Systematic Change(s): Lights will be put on a monthly inspection and cleaning cycle; inspection results will be kept in the custodial supervisor's office for one year. Training will be provided on the proper cleaning techniques to ensure all lights are cleaned in a safe and consistent manner.</p> <p>Monitor: The custodial supervisor will continue routinely to inspect the lights and maintain records on the custodians' work relevant to the lights. Inspection results will be sent monthly to the Deputy NHA and QA Administrator; summarized results will be presented quarterly to the QA Committee by the custodial supervisor / designee.</p>	<p>08/01/09 & ongoing</p> <p>07/06/09</p> <p>07/06/09</p> <p>07/13/09</p> <p>07/13/09</p> <p>08/01/09 & ongoing</p>

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F 253	<p>Continued From page 4 interior. Findings include:</p> <p>1. On 06/02/09, the overbed tables of resident rooms #1132 and 1274 were observed to have dried-on residue across the top surface. Follow-up observation on 06/11/09 revealed that the dried-on residue was still on the top surfaces of the tables. These tables had resident care items and / or water pitchers placed on them.</p> <p>2. The top of the drier of the personal laundry room on the Green unit was observed to have a dark brown, dried-on residue adjacent to resident care items left on top of the machine on 06/02/09. Follow-up observation on 06/11/09 revealed that the dried-on residue was still on the top surface of the machine.</p> <p>3. On 06/02/09, numerous insect carcasses were observed in two light shields in the hallway of the green unit, located outside of the clean linen room. There were roughly a couple dozen light shields in the main hallways of this unit. Follow-up observation on 06/11/09 revealed that the carcasses remained in the light shields.</p>	F 253		
F 281 SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and facility documentation, it was determined that the facility failed to recognize and identify a drug allergy for one resident (R15) out of twenty-three (23) sampled residents. Findings include:</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>R15, alert and oriented, was admitted to the facility on 07/09/07 as a bilateral amputee of the lower extremities (LE) as a result of an infection according to the resident. R15's admission history and physical examination was noted to have the antibiotic, Cipro, listed as a drug allergy. The entry had been crossed out and marked as an error. A further review of the clinical record revealed conflicting documentation regarding the drug allergy. The front of the record was labeled as no known drug allergies (NKDA) while the physician's order sheets and immunization records recognized Cipro as a drug allergan.</p> <p>Interview with the Acting Director of Nursing, E2, on 06/10/09 at 9:30 AM confirmed the conflicting documentation. As a result, E2 sought clarification from the Advanced Practiced Nurse, E3. Upon clarification, Cipro Allergy was removed from the allergy list on 06/10/09 at 1:05 PM.</p> <p>Interview with R15 on 06/11/09 at 7:00 AM revealed and confirmed that he is allergic to the drug Cipro and the reactions to the antibiotic include hives and shortness of breathe. R15 stated he was treated with Cipro approximately nine years ago during the episode of the (LE) infection. Since that time, he has not used the antibiotic because of his significant reaction to the drug.</p> <p>Facility policy and procedure for medication/food interactions states under II. Procedure, F., "All known allergies shall be documented on the resident's clinical records and on the outside front cover or the chart or identified clearly in the electronic record." The facility failed to recognize and consistently identify R15's drug allergy, failed</p>	F 281	<p>Corrective Action(s): After interviewing resident R15, Cipro was added to his clinical record as an allergy.</p> <p>Identification of Deficient Practices and Corrective Actions: All residents' clinical records are being reviewed the Advance Practice Nurses (APNs) to ensure the accuracy of the allergies documented in the clinical records.</p> <p>Systemic Change(s): During all IDCC meetings, the RNACs will review with residents and/or the residents' POAs the allergies documented on residents' clinical records to ensure all allergies are captured correctly on the clinical records. Allergy-related information and the discussion of same will be documented by the RNACs.</p> <p>Monitoring: The DON / designee will monthly audit 10% of the IDCCs conducted by each RNAC during the preceding month to ensure the RNACs: 1) Reviewed residents' allergies during the IDCC meetings; 2) Contacted the physician / APN with any changes; and 3) Documented the information correctly on the clinical record. Results of the audits will be forwarded each month to the QA Administrator and summarized quarterly by the DON / designee for presentation to the QA Committee.</p>	<p>06/12/09</p> <p>07/31/09</p> <p>07/13/09</p> <p>08/15/09</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 281	Continued From page 6 to obtain medical information from R15 and failed to include him in the development of his plan of care.	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 observation, record review and interview, it was determined that the facility failed to follow the physicians' plan of care for six (6) residents (R4, R12, SSR2, R18, R2, and R3) out of twenty-three (23) sampled residents. Findings include: 1. R12 was admitted to the facility on 02/13/09 with Chronic Kidney Disease, Myelodysplastic Syndrome, Prostate Cancer and an Abdominal Aneurysm. An indwelling Foley catheter had been employed since the date of admission. A physician's order dated 02/13/09 to change the catheter was implemented as well as an order dated 04/08/09 for Roxanol 5 mg. prior to the catheter change. The pain medication, Roxanol, was ordered due to pain expressed by the resident during the change, according to the unit manager, E4, on 06/02/09 at 9:00 AM. On May 5, 2009, the medication administration record (MAR) documented a catheter change. On the day of the change, Roxanol was not given	F 309			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 7</p> <p>prior to the change as ordered. However, on May 15, 2009, the MAR documented that Roxanol had been given without a catheter change noted. E4 stated she administered Roxanol for lower left quadrant (abdominal) pain expressed by R12. E4 further stated that Roxanol should not have been given for the abdominal pain and that the order was written only the catheter change.</p> <p>The facility failed to follow the plan of care for R12 by not following the plan of care.</p> <p>2. R4 was admitted to the facility on 01/06/08 and was later diagnosed with locally invasive metastatic bladder cancer according to physician's progress notes dated 02/19/09. R4 became ill during the month of February and began to develop significant weight loss. A physician's order on 03/10/09 was written to "please weight resident every 3 days at same time." The order was never implemented. From March 11, 2009 to March 25, 2009 R4 was weighed four times, April 1 2009 through April 30, 2009, five times, May 1, 2009 through May 21, 2009, four times and for June 2009 until the date of exit on June 11, 2009, one time.</p> <p>The facility failed to ensure that R4 was weighed every 3 days as stated in the plan of care. The facility failed to ensure R4 did not further deteriorate by failing to maintain weights every three days as ordered by the physician.</p> <p>3. During medication observation on 6/1/09 (Monday) at 2:10 PM, the staff nurse, E7 administered a capsule of Creon 10 (pancreatic enzymes) by mouth to SSR2. Review of the June 2009 Physician's Order Sheet (POS) indicated the resident was to receive Creon 10 capsule</p>	F 309	<p>Corrective Action(s):</p> <p>a. Resident R12's receipt of Roxanol before each catheter change is being monitored. b. Resident R4's order for weights every 3 days is correctly reflected on his TAR; capture of those weights is being monitored. c. Resident SSR2's order for Creon was discontinued. d. Resident R2's receipt of Levaquin without a current order was immediately stopped. e. Resident R18's use of a straw for drinking was immediately stopped; his profile has been updated to reflect that he is not to receive one. f. Resident R3's medications are available and are being administered as ordered.</p> <p>Identification of Deficient Practices and Corrective Actions: 1) 24 hour chart checks will be completed for all residents. 2) Nursing staff will be in-serviced on: a) Appropriate medication administration; b) 24 hour chart checks and the role these checks play in preventing medication errors; c) The importance of following physician orders for weights; d) Importance of and procedure for contacting the pharmacy and the physician / APN when medications are not available; and e) Special diets (thickened liquids v. thin liquids, and the use of straws).</p>	<p>06/12/09</p> <p>06/16/09</p> <p>06/05/09</p> <p>06/11/09</p> <p>06/12/09</p> <p>07/01/09</p> <p>08/15/09</p>

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F 309	<p>Continued From page 8</p> <p>three times a day on Wednesday and Friday of each week. An interview with the unit manager, E8 on 6/1/09 at 3:15 PM confirmed that the facility failed to follow the physician's order by administering the medication on an incorrect day.</p> <p>4. R2 was ordered Levaquin (an antibiotic) 500 mg. (milligram) daily for bronchitis for two days on 5/25/09. Review of the May 2009 Medication Administration Record (MAR) documented that the above medication was administered daily on 5/25/09 and 5/26/09.</p> <p>An additional review of the June 2009 MAR revealed that R2 was administered the above medication from 6/1/09 through 6/5/09 (total of five doses), however, record review lacked an order for this medication. An interview with the ordering practitioner, E9 on 6/11/09 at 2 PM confirmed that R2 was administered Levaquin 500 mg. without an order for the 6/1/09 through 6/5/09 time period.</p> <p>5. R18 had a physician's order for puree diet with thin liquids with no straw dated 5/26/09. Review of the June 2009 monthly POS noted for diet, "puree diet with thin liquids" and failed to include that the resident was not to have a straw. In addition, review of the June 2009 MAR failed to include that R18 was not to use straws due to aspiration risks. On 6/11/09 at 11 AM, a staff nurse, E11 was observed administering medication to R18. E11 provided R18 with nectar thickened cranberry juice and used a straw. The resident was observed coughing after using the straw to draw up the juice. Above observation and findings reviewed with unit manager, E4 on 6/11/09 at 11:30 AM.</p>	F 309	<p>Systemic Change(s): 1) P &P's will be reviewed and revised (if indicated) for medication administration, 24 hour chart checks, weight monitoring, residents with special diets, and missing medications to ensure they meet the intention of the regulation. Any changes will be included in the above-noted in-services. 2) A medication administration observation and competency check was initiated by the nurse trainers/educators for all new nurses. Newly-employed nurses must pass the medication competency (and be signed-off as having done so by the nurse trainer/educator) as a condition of completing orientation. 3) A medication test, given during classroom orientation, was initiated by the nurse trainer/educators. The results of the medication test identify what (if any) areas need to be reviewed with the nurse before s/he may move on to the unit-based orientation.</p> <p>Monitoring: 1. Medication observations will be done yearly on all staff nurses by nursing leadership and/or nurse trainer/educator; results of the observation will be documented in each nurse's annual performance review. 2. Nursing Supervisors will randomly review at least 10% of each unit's residents' charts each week to ensure nursing staff are following the physician's / APN's orders for weights and medication administration, and are properly notifying the pharmacy and physician / APN when medications are not available. Results of the reviews will be reported at least monthly to the DON / designee, who will present them quarterly to the QA Committee.</p>	07/31/09	06/15/09	06/22/09	08/28/09 & ongoing

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F 309	Continued From page 9 6. R3 had diagnoses which included obesity, diabetes, hypertension, benign prostatic hyperplasia (BPH), stroke, renal insufficiency, chronic obstructive pulmonary disease (COPD) and psychosis. Review of the resident's medication administration record (MAR) revealed instances of medication not being available to the resident. Review of corresponding nurses notes revealed no contact with the pharmacy or the physician regarding the absence of the medications. The following medications were not administered as ordered by the physician: Flomax 0.4 mg hs (at night) for BPH was not available 12/11 - 12/14/08. Calcium Citrate with Vitamin D 315/200 mg (supplement) two twice a day (BID) was not available 1/9 - 1/15/09. Lipitor 20 mg hs (cholesterol lowering medication) was not available 1/15 - 1/21/09. Zocor 20 mg hs (cholesterol lowering medication) was not available 3/13 - 3/17/09.	F 309			
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined that for one (1) out of 23 (R11)	F 318	Corrective action(s): Resident R11's splint was immediately applied as ordered by the physician / Advance Practice Nurse (APN). Identification of Deficient Practices and Corrective Actions: 1) All residents with orders for splints were identified and observed during nursing rounds conducted by the nursing supervisor / nurse manager. 2) All nursing staff will be in-serviced on the provision and application of ordered splints. Systemic Change(s): 1) The P&P for the provision and application of splints will be reviewed and revised (if indicated) to ensure it meets the intention of the regulation. Any changes will be included in the above-mentioned in-services. 2) CNAs and nurses will document on residents' clinical records the application and use of ordered splints. 3) A one-page "Quality of Life (QoL) Resident Review" tool was drafted to assist staff with	06/12/09 06/13/09 & ongoing 08/15/09 07/31/09 06/13/09 & ongoing 07/10/09	

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F 318	Continued From page 10 resident's hand splint was not provided as ordered by the physician to prevent further decrease in range of motion. Findings include: R11 had a current physician's order originating 10/29/08 for a right (R) hand splint to be worn during waking hours. This was included on the CNA resident profile. Observations of R11 throughout the day on 6/2 and 6/5/09 revealed the hand splint was not in use. The hand splint was observed other days of the survey.	F 318	their observations of residents in the facility (see Exhibit A). Use of the draft tool will be piloted by nursing leadership for a random sample of residents. During the pilot, the tool's design will be finalized, and the feasibility of its use by other disciplines will be assessed by a multi-disciplinary work group. Staff will be notified immediately of any deficient practice identified; the deficient practice will be documented on the QoL Resident Review tool. Monitoring: Results of the pilot will be compiled and presented at the August QA Committee meeting by the DON/designee. Results of subsequent use of the finalized tool will be forwarded monthly to the QA Administrator and summarized for quarterly presentation to the QA Committee.	08/20/09
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Corrective Action(s): An AIMS test was completed 04/14/09 for resident R10; an AIMS test was completed 06/03/09 for resident R13. Identification of Deficient Practices and Corrective Actions: Residents receiving antipsychotics are identified monthly from reports supplied by PharMerica. Each applicable resident's history is tracked by the Medical Records (MR) Technician for completion of an AIMS: a) at baseline (at admission to the facility [if already receiving an antipsychotic medication] or upon initiation of antipsychotic medication); b) every six (6) months post date of baseline; c) with initiation of a new psychotropic medication within the six (6) month interval; and d) with any significant change while taking antipsychotic medication. Tracking results were reviewed from January 2009 forward to identify any additional residents whose tests were not done timely; none were found.	06/03/09 07/02/08 07/15/09

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F 329	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, interview and facility documentation it was determined that the facility failed to monitor medication for two residents (R10, R13) out of twenty-three (23) sampled residents. Findings include: 1. R10 was admitted to the facility on 01/17/08 and later known to have the diagnosis of Intermittent Explosive Disorder. On 03/04/09 the anti-psychotic drug Risperdal 0.25 mg. was ordered at bedtime for behavior control. On 04/08/09 the same drug was increased to 0.5 mg. and later decreased back to 0.25 mg. on 06/02/09 until 06/09/09. Between 03/04/09 and 06/09/09, the drug Risperdal was not monitored for the known side effects including tardive dyskinesia by utilizing the assessment form Abnormal Involuntary Movement Scale (AIMS). These findings were confirmed with the Acting Director of Nursing, E2. 2. R13 was on the antipsychotic medication Seroquel 300mg in PM and 200 mg in AM. The resident had an AIMS test completed on 7/15/08. The next AIMS text available in the facility was dated 4/14/09, nine months months from the last completed test. Facility policy and procedure on Assessing Abnormal Involuntary Movements during Antipsychotic Drug Therapy stated an AIMS should be performed upon initiation of antipsychotic therapy, after significant changes and every six months thereafter.	F 329	Systemic Changes: 1) The MR Technician will continue to maintain the tracking tool that includes all applicable residents, date of last AIMS test and due date of next (6-month) AIMS test. Additionally, the pharmacy consultant reviews applicable residents' histories for presence of an AIMS test and alerts the facility to those not found. 2) The MR Technician will continue to alert the advance practice nurses of the upcoming need to reassess the resident when duration of use reaches five months. 3) The MR Technician will notify the QA Administrator, the Director of Nursing (DON) and the Medical Director (MD) if, upon the subsequent month's review, any required AIMS tests have not been completed timely. 3) The DON and MD will intervene as necessary to assure prompt completion of any delinquent AIMS tests. Monitoring: The QA Administrator will report tracking / notification results monthly to the Pharmacy & Therapeutics Committee and quarterly to the Quality Assurance Committee.	08/01/09 08/20/09	
F 367	483.35(e) THERAPEUTIC DIETS	F 367			

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F 367 SS=D	<p>Continued From page 12</p> <p>Therapeutic diets must be prescribed by the attending physician.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (1) out of 23 (R11) sampled residents the facility failed to ensure liquids were served thickened as ordered by the physician. Findings include:</p> <p>R11 had a current physician order for nectar thickened liquids. The indication for nectar liquids was included on the CNA resident profile and on the meal tickets from the dietary department.</p> <p>A speech therapy discharge summary dated 12/8/08 documented the resident demonstrated moderate to severe signs and symptoms of aspiration with thin liquids. The therapists recommendation was for nectar thick liquids.</p> <p>Observations on 6/2/09 lunch and 6/5/09 breakfast revealed that R11's liquids were served at a thin consistency. During both observations the surveyor alerted staff to thicken the liquids before the resident was able to consume them. An interview with aide E14 on 6/5/09 at 8:42 AM revealed that liquids used to come from the dietary department already thickened but were now thickened on the unit when staff set up the residents' trays.</p> <p>The facility's current policy dated 6/5/07 for Provision of Thickened Liquids states that the dietary department is responsible for providing the appropriate liquid consistency.</p>	F 367	<p>Corrective Action: Resident R11's liquid was immediately corrected to the appropriate consistency.</p> <p>Identification of Deficient Practices and Corrective Actions: All residents were observed during meals by the DON / designee; all were found to have received fluids of the ordered consistency.</p> <p>Systemic Change(s): 1) The P&P on thickening liquids was revised to state that dietary staff is responsible for providing the thickening agent and trained nursing staff is responsible for thickening liquids to the proper consistency. 2) Nursing staff were in-serviced on use of the commercial thickener to prepare liquids at the proper consistency; new staff are being oriented on thickening of liquids during orientation. 3) A nursing supervisor will be in the dining room at meal times to ensure residents receive fluids of the appropriate consistency. 4) Dining room fluid consistency will be added to the audit tool used during periodic audits conducted by QA staff.</p> <p>Monitoring: QA staff will audit fluid consistency as part of the routine (weekly) audit of dining services; discrepancies will immediately be reported to the DON and the Food Service Director. Overall findings will be reported monthly to those individuals and to the QA Administrator, and summarized for quarterly presentation to the QA Committee.</p>	<p>06/05/09</p> <p>06/12/09</p> <p>07/10/09</p> <p>05/14/09; all orientations 06/10/09 & later</p> <p>07/10/09</p> <p>07/13/09</p> <p>07/17/09</p>
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F 371 SS=E	<p>483.35(i) SANITARY CONDITIONS</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations in the dietary area, it was determined that the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Findings include:</p> <ol style="list-style-type: none"> Six out of nineteen clean steam table pans stored on the clean pots and pans shelf had dried-on food debris on the food contact surfaces. These pans were stored in ready-to-use status. The True-brand reach-through refrigerator located behind the main dining room trayline had no temperature monitoring device. Two out of two large, batch mixers had dried-on residue on the chuck located directly over the mixing bowl. These units were covered and stored in ready-to-use status. The GE-brand microwave oven located in the pantry of the Red unit had spatters, spills, and debris on the internal surfaces. This unit was used to reheat resident food. 	F 371	<p>Dietary Area: Corrective Action(s): The cited steam table pans and large, batch mixers were cleaned immediately. An internal thermometer was placed immediately in the cited True-brand reach-through refrigerator.</p> <p>Identification of Deficient Practices and Corrective Actions: A sweep was conducted of the entire kitchen to identify any other instances where food contact surfaces could be contaminated; none were found.</p> <p>Systemic Change(s): 1) A shipment of higher quality, metal thermometers (that will not break as easily / need to be replaced as frequently as those previously used) was received. 2) Cleaning of mixers was added to the daily master cleaning schedule. 3) Staff were in-serviced by the Food Service Supervisor on proper dish washing methods.</p> <p>Monitoring: Audits of cleanliness – to include checking for soiled dishes in a ready-to-use area and checking our large, batch mixers for debris - and appropriate Food Service practices will be performed at least weekly by the Food Service Director / designee. Results will be reported monthly to the Deputy NHA, and presented quarterly at least quarterly to the QA Committee.</p>	06/01/09 06/02/09 07/06/09 07/09/09 07/10/09 07/13/09
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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		F371	<p>Red (Nursing) Unit: Corrective Action(s): The microwave oven was cleaned immediately.</p> <p>Identification of Deficient Practices and Corrective Actions: Microwave ovens on all nursing units were inspected and cleaned as necessary.</p> <p>Systemic Change(s): The lead CNAs added inspection/cleaning of the nursing unit microwave ovens to the assignment list for the evening shift CNAs.</p> <p>Monitoring: Lead CNAs will inspect the microwave ovens on their units three times per week, and document their findings. Any concerns will be addressed immediately by the lead CNAs. Inspection results and response to any required follow-up will be reported weekly to the nurse manager for the unit, who will summarize/report monthly results to the DON / designee for inclusion with nursing's quarterly report to the QA Committee.</p>	<p>06/11/09</p> <p>06/12/09</p> <p>07/01/09</p> <p>07/13/09 & ongoing</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
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F 425	<p>Continued From page 14</p> <p>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.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate 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 F309 example #5 Based on record review and interview it was determined that for one out of 23 (R3) sampled residents the facility failed to ensure that the pharmaceutical services provided the dispensing and acquiring of medications to meet the needs of administration as ordered. Findings include: Medication was not always available from the pharmacy to administer to the resident as ordered by the physician. Flomax 0.4 mg hs (at night) for BPH was not available 12/11 - 12/14/08. Calcium Citrate with Vitamin D 315/200 mg</p>	F 425	<p>Corrective Action(s): Resident R3's medications are available and are being administered as ordered.</p> <p>Identification of Deficient Practices and Corrective Actions: A 24-hour chart check was completed on all residents' clinical records to ensure medications were available for each resident; all residents' medications were available.</p> <p>Systemic Change(s): 1) The P&P for medication administration will be reviewed and revised (if indicated) to ensure it meets the intent of the regulation. 2) An ongoing 24-hour chart check process will be initiated to ensure consistency of staff reviews. Both medication and treatment administration records (MARs and TARs) will be reviewed to ensure residents' medications are available. 3) Nursing staff will be In-serviced on the importance of and procedure for contacting the pharmacy and the physician when medications are not available; the 24-hour chart checks and the role these play in preventing medication errors; and any changes made to the P&P.</p> <p>Monitoring: An audit of at least 10% of residents' clinical records per unit will be done monthly by the nurse manager / designee to ensure residents' medications are available and that any instances of unavailability were appropriately followed-up / documented. Results of the audits will be reported to the DON monthly and presented quarterly to the QA Committee.</p>	06/01/09 07/10/09 07/31/09 07/13/09 08/15/09 08/28/09	

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F 425	Continued From page 15 (supplement) two twice a day (BID) was not available 1/9 - 1/15/09. Lipitor 20 mg hs (cholesterol lowering medication) was not available 1/15 - 1/21/09. Zocor 20 mg hs (cholesterol lowering medication) was not available 3/13 - 3/17/09	F 425		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to appropriately maintain a urinary medical appliance for one resident (R12) and screen for tuberculosis for two residents (R6, R1) out of twenty-three (23) sampled residents. Findings include: 1. R12 was admitted was to the facility on 02/13/09 with multiple diagnoses requiring the use of an indwelling Foley catheter. During the initial tour of the facility on 06/01/09, R12's bedside drainage bag was observed laying on the floor of the shower stall with the drainage system open. The surveyor tagged the bag for later identification. Again, on 06/02/09 at 6:00 AM, the same bag was observed attached to the resident	F 441	Urinary Medical Appliance: Corrective Action(s): Resident R12's urinary drainage bag was secured in a plastic bag in a basin, in a private location (R12's bedside table). Identification of Deficient Practices and Corrective Actions: A full-facility sweep was done to identify residents with urinary drainage bags, to assure bags were properly stored. Systemic Change(s): 1) The P&P for urinary drainage bags will be reviewed and revised (if indicated) to address the storage of catheter bags. 2) Staff will be in-serviced on proper storage of urinary drainage bags (when not in use) to prevent infections, and on any revisions made to the P&P. Monitoring: Nursing supervisors / designees will audit storage of urinary drainage bags weekly, immediately intervening (if necessary) to correct any problems identified. Audit findings will be documented and reported monthly to the DON / designee for summarization / inclusion in nursing's quarterly report to the QA Committee. Tuberculosis Screening: Corrective Action(s): Resident R6 is no longer a resident at the facility. Resident R1's TB test was completed and documented in his clinical record.	06/12/09 06/30/09 07/31/09 08/15/09 08/22/09 & ongoing 06/25/09

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F 441	Continued From page 16 at bedside. At 12:50 PM later the same day, the bag was observed in the bathroom, behind the commode on the floor with the drainage system opened. Interview with staff nurse, E5, confirmed the opened system bag on the floor and agreed the bag should be discarded and replaced but only after reading the facility policy and procedures. The facility failed to identify and prevent the possibility of infection for a high risk resident with an invasive device. 2. R6 was admitted to the facility on 06/13/08. Subsequent to the admission, there was no evidence that R6 had been screened for tuberculosis. 3. R1 was admitted to the facility on 09/04/08. Subsequent to the admission, there was no evidence that R1 had been screened for tuberculosis. Both findings in examples 2 and 3 were confirmed with the Acting Director of Nursing, E2 on 06/10/09 at 9:30 AM.	F 441	Identification of Deficient Practices and Corrective Actions: All residents' records will be reviewed to ensure all have received their appropriate TB screening. Systemic Change(s): 1) The P&P regarding PPD administration / documentation will be reviewed and revised (if indicated) to ensure it meets the intent of the regulation. 2) A separate matrix – outside of the medical record – will be developed and utilized by the Infection Control nurse to monthly monitor annual PPD administration. Screenings due / done will be reported monthly to the ADON/DON and to the Infection Control Committee. 3) Staff will be in-serviced regarding any revisions made to the PPD P&P. Monitoring: 1) Residents' clinical records will be reviewed monthly by the DON / ADON / designee to assure newly-admitted residents and those whose annual PPDs are due have received their screenings timely, with appropriate documentation of same. 2) The results of these reviews will be reported quarterly to the Infection Control Committee and included with nursing's quarterly report to the QA Committee.	07/15/09	07/31/09 08/01/09 08/15/09 08/28/09
F 497 SS=B	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	F 497	Corrective Action(s): The nurse trainers / educators and the seven CNAs found to have deficient in-service education were notified of their failure to achieve the required amount of contact hours. However, since this was retrospective analysis, nothing could be done to correct the previous year Identification of Deficient Practices and Corrective Actions: All CNA training records were audited to verify the number of contact hours received. Each CNA was notified of current hours on record and hours needed to be in compliance.	06/12/09	07/01/09

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F 497	Continued From page 17 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 review of the Certified Nursing Assistant (C.N.A.) in-service files, it was determined that the facility failed to provide 12 hours per year of in-service for 7 out of 9 files (employees #15 through #21) reviewed. Findings include: Seven out of nine C.N.A.'s reviewed did not complete 12 hours of in-service for the previous anniversary year. 1. Employee #15 had 5.75 hours of in-service for the previous anniversary year. 2. Employee #16 had 10.50 hours of in-service for the previous anniversary year. 3. Employee #17 had 11.25 hours of in-service for the previous anniversary year. 4. Employee #18 had 8.00 hours of in-service for the previous anniversary year. 5. Employee #19 had 3.75 hours of in-service for the previous anniversary year. 6. Employee #20 had 9.75 hours of in-service for the previous anniversary year. 7. Employee #21 had 7.75 hours of in-service for	F 497	Systemic Change(s): 1) A manual tracking and notification system has been put in place. 2) Nurse Managers were provided the in-service training status of each CNA, for use in preparing performance reviews. 3) In addition to posted opportunities to receive contact hours, self-study packets have been placed on each unit. 4) The P&P regarding in-service education will be reviewed and revised (if indicated) to ensure it meets the intent of the regulation. Staff will be in-serviced on any revisions. 5) Monthly calendars listing educational opportunities were made more prominent on the units; CNAs are encouraged to attend scheduled in-services. 6) The nurse trainers / educators will audit each CNA's contact hour sheet monthly to ensure that s/he has attended or completed sufficient contact hours to achieve 12 contact hours by his / her anniversary date. The applicable nurse manager and the DON / designee will be notified of any who appear to be at risk of failure, to assure prompt intervention and resolution. CNAs subsequently found deficient in completing sufficient contact hours to maintain licensure will be counseled. Monitoring: 1) The nurse trainers / educators will monthly report to the DON / designee: a) The number of in-services scheduled and the number of CNAs attending; and b) The number of individual CNA contact hour sheets audited that month, the number of CNAs found to be "on track" with regard to hours, and the number found to be "at risk." 2) Nurse managers will monthly report to the DON / designee the number of CNAs coached re: their contact hour requirements and the number counseled for failure to achieve sufficient hours. 3) The DON / designee will include summarized CNA contact hour results / status in nursing's quarterly report to the QA Committee.	07/01/09 07/10/09 07/10/09 08/15/09 07/01/09 08/01/09 08/01/09 08/01/09	

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F 497	Continued From page 18 the previous anniversary year.	F 497			
F 514 SS=D	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 interviews, it was determined that the facility failed to ensure accurate clinical records for one (R14) out of 23 residents in the sample. Findings include: R14 had a physician's order signed by the facility's nurse practitioner, E9 on 4/30/09 to "add 240 ml. (milliliter) fluids TID (three times per day) with meals to POS. Current order, resident already receiving." An interview with the Registered Dietician who wrote the above recommendation, E10 on 6/8/09 at 11 AM revealed that the above recommendations for additional fluids was due to R14's decrease in oral fluids intake. Observation of R14's breakfast tray and meal ticket on 6/9/09 at 7 AM revealed the additional 240 ml (water) of fluids.	F 514	Corrective Action(s): Resident R14's clinical record was corrected with the proper orders written by the APN. Identification of Deficient Practices and Corrective Actions: An audit of all residents' clinical records will be completed to assure there are no additional missed orders involving dietitians' recommendations. Systemic Change(s): 1) The dietitians will enter their recommendations in the physician / APN book (NOT on a sheet of paper labeled "physician order form." 2) The physician / advance practice nurse will enter any order resulting from these recommendations into cueSHIFT (the facility's electronic medical record). 3) Staff will be an in-serviced on the process of doing a 24-hour chart check to identify missed orders. 4) The QA Administrator will work with the dietitians and the Deputy NHA to develop and implement a tool to audit dietary recommendations and orders over a 30- to 90-day period. Results of the audit will be presented for discussion at a multidisciplinary meeting convened for that purpose, and are intended to inform a discussion of the feasibility of expanding dietitians' privileges at the facility to include self-placement of orders for services falling within a dietitian's scope of practice. Interest in this derives from the possibility that such an expansion could speed residents' receipt of dietary services as well as reduce the likelihood of overlooked orders. 5) The 24-hour chart check will include reviewing the dietitians' notes to see if recommendations were acknowledged and if orders did/did not result.	06/12/09 07/17/09 07/15/09 08/15/09 08/28/09 08/28/09	

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F 514	Continued From page 19 Review of May 2009's MAR and Treatment Administration Records (TAR) lacked evidence of the additional 240 ml with meals. In addition, the June 2009 POS, MAR, TAR, and the Resident Profile failed to incorporate the above intervention. An interview with the unit manager, E8 on 6/9/09 at 3:15 PM confirmed that the facility failed to incorporate the above intervention. An additional interview with the ordering practitioner, E9 on 6/11/09 at 2:15 PM revealed that the above order was not on the monthly POS since she did not have the forms.	F 514	Monitoring: The nursing night supervisor will audit at least 10% of the charts on each unit each month to ensure the accuracy of the clinical record and the 24-hour chart check. Results of the audit will be reported to the DON / designee and summarized for inclusion in nursing's quarterly presentation to the QA Committee.	08/28/09	
F 518 SS=D	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on review of the fire drill records, it was determined that facility failed to periodically carry out unannounced staff drills. Findings include: 1. No drill was conducted for the third quarter of 2008 on the first shift of staff. No drill was conducted on the 7AM to 3PM shift of staff from 06/30/08 to 10/20/08.	F 518	Corrective Action(s): The missed fire drill was made up on October 20, 2008: A day-shift drill was done with a "fire in the kitchen" scenario. Identification of Deficient Practices and Corrective Actions: All drills for 2008 and 2009 (to date) were reviewed for appropriate number, shift distribution and timeliness of conduct; one additional belated make-up was identified in 2008. All 2009 drills (to date) have been conducted timely and fell on the requisite shifts. Systemic Change: Drills are now charted by month / quarter and by shift, making readily apparent the status (done, not done) of drills for a given month / quarter and shift. The chart is maintained by the Physical Plant Maintenance (PPM) administrative assistant. Monitoring: The PPM administrative assistant monthly forwards the updated chart to QA; it will be presented quarterly at QA Committee meetings, effective with the July 2009 meeting.	10/20/08 06/10/09 06/10/09 07/23/09	



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT
LTC Residents Protection

JUL 14 2009
DATE SURVEY COMPLETED: June 11, 2009

NAME OF FACILITY: Delaware Veterans Home

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 survey and complaint visit was conducted at this facility June 1, 2009 through June 11, 2009. The facility census on the first day of survey was one-hundred ten (110). The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The survey sample totaled twenty-three (23), twenty (20) active and three (3) closed records respectively. There was an additional sub-sample of four (4) residents not in the sample for complete record review.

Nursing Home Regulations for Skilled and Intermediate Care Nursing Facilities

Services to Residents

General Services

The skilled care nursing facility shall provide to all patients the care deemed necessary for their comfort, safety, nutritional requirements and general well-being.

This requirement is not met as evidenced by:

Director's or Representative's Signature

Title

Administrator

Date

7-13-09



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: June 11, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.9	<p>Cross refer to the CMS 2567-L survey report date completed 6/11/09, F281, F309, F318, F329, F367, F441 (Example #1)</p> <p>Housekeeping and Laundry Services</p>	<p>Cross-reference F281, F309, F318, F329, F367, F441</p>
3201.6.9.1	<p>The facility shall employ sufficient housekeeping to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.</p> <p>Based on observations throughout the facility during the survey, it was determined that the facility failed to provide housekeeping necessary to maintain a sanitary, orderly, and comfortable interior. Findings include:</p>	<p>Cross-reference F253</p>
3201.6.12	<p>Communicable Diseases</p>	
3201.6.12.2	<p>Specific Requirements for Tuberculosis</p>	



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NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: June 11, 2009

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3201.6.12.2.3	All facilities shall have on file results of tuberculin tests performed on all newly admitted residents and newly hired employees, and annually thereafter on all employees. A tuberculin test as specified, done within the twelve months prior to employment, or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. If an individual was previously documented as a positive reactor or has a history of hypersensitivity to the PPD test, a negative chest x-ray shall meet this requirement.	
3201.7.5	This requirement is not met as evidenced by: Cross refer to the CMS 2657-L survey report date completed 6/11/09, F441 (Examples #2-3). Kitchen and Food Storage Areas:	Cross-reference F441
3201.7.5.1	Facilities shall comply with the Delaware Food Code Based on observations in the dietary area and nutrition pantries on the units, it was determined that the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Findings include: This requirement is not met as evidenced by:	



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.8.0	<p>Cross-refer to CMS 2567-L survey date completed 6/11/09 F371.</p> <p>Emergency Preparedness</p>	Cross-reference F371
3201.8.2	<p>Regular Fire Drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on review of the fire drill records, it was determined that the facility failed to hold quarterly fire drills on each shift. Findings include:</p>	Cross-reference F518
3201.10.0	<p>Records and Reports</p> <p>Lost items which are not subject to financial exploitation,</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2657-L survey report date completed 6/11/09, F225.</p>	Cross-reference F225



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Division of Long Term Care
Residents Protection

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3 Mill Road, Suite 308
Wilmington, Delaware 19806
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STATE SURVEY REPORT

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<p>16 Del. C., Chapter 11, Subchapter II, §1121</p>	<p>The facility failed to complete an incident report of R3's report that a roll of stamps was missing from his room.</p> <p>Patient's Rights (1)</p> <p>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.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 6/11/09, F241.</p> <p>Nursing Staffing</p> <p>(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct</p>	<p>Cross-reference F241</p>
<p>16 Del. C., §1162</p>		



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**SECTION STATEMENT OF DEFICIENCIES
Specific Deficiencies**

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

caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.

This requirement was not met as evidenced by:

Observations 6/2/09 through 6/5/09 on the Gold and Red units revealed that the required staff posting was not conspicuously displayed in a common area. A small print version was posted behind the nurses station that was only accessible to staff. This was corrected on 6/5/09 at the request of the survey team

16 Del. C., §1162 Nursing Staffing Posting Corrective Action(s): The staff posting was corrected immediately upon notification.	06/05/09
Identification of Deficient Practices and Corrective Actions: 1) The DON / designee visited all nursing units to check for / confirm proper posting. 2) QA staff made ad hoc visits to each unit on three occasions to conduct follow-up checks of staff postings; all postings were found to be in place on all occasions.	06/06/09
Systemic Changes: The nurse manager will ensure staffing is posted appropriately and conspicuously on each unit.	06/06/09
Monitoring: 1) The nursing supervisor will check on a weekly basis for appropriate staff posting. 2) QA staff will add occasional a monthly spot-check of staff postings to their ad hoc audit list.	06/13/09
	08/01/09