

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

LTC Residents Protection
JAN 16 2009
Director's Office

PRINTED: 12/31/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2008
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NAME OF PROVIDER OR SUPPLIER RENAISSANCE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966
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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from 12/15/08 through 12/19/08. The deficiencies contained in this report are based on observations, staff interviews, review of resident's clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was one hundred fifteen (115). The survey sample totaled twenty-three (23) residents which included a review of twenty (20) active and three (3) closed records.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. F225 Treatment of Residents	
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 violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	1. Submission of the event to the appropriate state agency for resident #6 was beyond the reporting period. However, going forward investigations requiring submission to the State Survey and certification agency will be reported within five working days of the incident and if an alleged violation is verified appropriate corrective action will be taken immediately (immediately). 2. An audit of all incident reports for the past 90 days will be conducted by the Director of Nursing and/or designee on all events where abuse and neglect is suspected. The appropriate state agency will be reported as needed. (February 9, 2009). 3. (a) When the facility is notified of a suspected abuse and neglect an investigation will be initiated immediately and the NHA, DON, and/or designee will be notified (immediately). (b) All incident reports will be brought to the morning clinical meeting and reviewed. Any and all follow up to this incident will be reported and thoroughly investigated when abuse and/or neglect is suspected (immediately). (c) An in-service will be conducted by the Staff Development Coordinator/designee to all Nursing Staff which will include but not be limited to proper completion of incident report, investigation of all staff and all shifts applicable to the incident, and any related witnesses to the incident, timeline for follow-up, notification to NHA and DON and/or designee, and responsibility for submission to appropriate agency (February 9, 2009).	2/9/09 2/9/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carol Prasky NHA</i>	TITLE NHA	(X6) DATE 2/16/09
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1 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 the facility failed to immediately report and thoroughly investigate an injury of unknown source for one resident (#6) out of 23 sampled residents. Findings include:</p> <p>On 11/9/08 at 11 AM Resident #6 was found to have a large bruise to the left forearm measuring 14.7 cm x 8.8 cm. The staff generated a facility incident report indicating the bruise was an injury of unknown origin. This was not immediately reported to the state agency.</p> <p>Review of facility documentation during the survey revealed there was not a thorough investigation completed. The facility did not interview the aide who cared for the resident on the night shift prior to the reporting of the bruise until 12/8/08 when a state investigator was reviewing the incident. Other potential witnesses were also not interviewed to make a determination if abuse or mistreatment could be involved. As a result of the lack of immediate reporting and lack of thorough investigation there was no five day follow-up reported to the state</p>	F 225	<p>4. An ongoing QI audit will monitor notification, timeliness, appropriate party investigation, and follow-up for all incident reports. The Director of Nursing will report the results until substantial compliance is achieved (ongoing-February 9, 2009).</p>	2/9/09	

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F 225 F 309 SS=D	<p>Continued From page 2 agency.</p> <p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility failed to provide the necessary care and services including the assessment of pain, evaluation of pain relief interventions, failed to notify the physician and failed to develop a plan of care to treat the pain for one resident (#14) out of twenty-three (23) sampled residents. Findings include:</p> <p>Resident #14 was readmitted to the facility on 10/12/08 with diagnoses which included: gout, knee contractures, arthritis, hypertension and pulmonary disease.</p> <p>During several interviews with Resident #14 on 12/15/08, 12/16/08 and 12/19/08 he stated he had pain in his knees at a 7 on a scale of 1-10 (10 being the most severe). Resident #14 stated that he was given pain medication twice a day that helped somewhat, but the pain was never resolved. Resident #14 was not aware that he also had a physician's order to be given additional pain medication at his request.</p> <p>Review of Resident #14's admission medications</p>	F 225 F 309	<p>F309 Quality of Care</p> <p>1. When the facility was informed that Resident #14 did not have a care plan for pain it was corrected (December 19, 2008). A pain assessment was implemented and the physician was notified of resident #14 level of pain. MD implemented new orders for pain control/alleviation (December 19, 2008).</p> <p>2. A random audit will be conducted on each Nursing Unit by the Director of Nursing and/or designee to ensure that the pain scale was appropriately completed, the physician was notified and the resident has a corresponding plan of care for pain. All appropriate corrective measures will be made (February 9, 2009).</p> <p>3. (a) A revised pain scale form was implemented by the facility January 6th. The pain scale score is now part of the Medication Administrative Record for all residents that receive routine pain medication (January 6, 2009). (b) The Unit Managers will randomly audit residents records that receive PRN and/or routine pain medication to ensure that residents are being properly medicated that physician notification occurred when necessary, and the resident is care planned for pain (February 5, 2009). (c) The Staff Development Coordinator will in-service all nurses on revised pain scale, need to notify physician when necessary, and care planning (February 9, 2009).</p> <p>4. Audits will be reported to QI Committee until substantial compliance is achieved (Ongoing).</p>	<p>12/19/08</p> <p>2/9/09</p> <p>(a) 2/6/09</p> <p>(b) 2/5/09</p> <p>(c) 2/9/09</p> <p>Ongoing</p>

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F 309	<p>Continued From page 3</p> <p>revealed that he had a physician's order for Vicodin (narcotic pain reliever) 5/500 to be given at 10:00 AM and 4:00 PM. On 11/1/08 the physician ordered additional pain medication, Vicodin 5/500 PRN (to be given at the residents request) every 6 hours as needed for pain.</p> <p>The admission pain assessment completed on 10/12/08 stated that Resident #14 had pain at a level 5 daily in his right knee, secondary to arthritis and contractures; which was relieved with medication and repositioning. The pain management goal stated by Resident #14 was to have the pain reduced to a 0 (zero) level. No initial care plan was developed to address Resident #14's pain.</p> <p>Review of the facility pain management policy stated that a resident identified as having pain would have a care plan initiated and if the resident was receiving routine pain medication they would be assessed weekly to determine the intensity of the pain; moderate to severe pain would be treated and the physician notified. For residents receiving PRN medications, the pain level would be determined on a scale of 1-10 and 30-60 minutes after giving the pain medication the pain would be assessed again for effectiveness of the pain relief intervention; using the same 1-10 scale. The pain management policy also stated that if pain was identified on the MDS (minimum data set) assessment, a care plan would be developed. The MDS dated 10/22/08 identified that Resident #14 had mild pain less than daily; a care plan was not developed as required by the facility policy.</p> <p>On 11/1/08 the physician ordered Resident #14 PRN Vicodin 5/500; there were no corresponding</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>nurses' notes. Resident #14 received the PRN Vicodin on 11/1, 11/16, 11/22, 11/23 and 11/30 for a pain level of 8; the efficacy of the medication was not documented according to the facility policy using a scale of 1-10.</p> <p>Weekly pain assessments were done on 12/1, 12/8 and 12/15/08 with corresponding pain levels of 7, 5 and 6; there were no corresponding nurses' notes, physician notification, care plan or PRN pain medication given; to indicate that the resident's pain was evaluated or treated.</p> <p>Interview with the two MDS coordinators, the corporate nurse and the LPN #1 on 12/19/08 confirmed that Resident #14 did not have a care plan to address his pain and that the weekly assessments that were done were not evaluated and the physician was not notified. LPN #1 and the corporate nurse stated that it was the unit managers responsibility to evaluate the weekly pain assessments and there hadn't been a unit manager for several months; so the evaluation of the pain assessments most likely fell through the cracks. During interview with the MDS coordinator on 12/19/08 she confirmed that Resident #14 had a pain care plan prior to his hospitalization and readmission on 10/12/08. The MDS coordinators stated that each individual nurse giving pain medication and doing weekly pain assessments was responsible for implementing a care plan and notifying the physician.</p> <p>The facility failed to have a consistent procedure to asses the pain, evaluate the effectiveness of the pain relief interventions, failed to notify the physician and failed to develop a care plan to address Resident #14's pain.</p>	F 309			

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F 312 SS=D	<p>483.25(a)(3) ACTIVITIES OF DAILY LIVING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, it was determined that the facility failed to provide nail care to two residents (#16 and #17) out of twenty-three (23) sampled residents. Findings include:</p> <p>1. Resident #16 was admitted to the facility on 08/11/08. An observation on 12/15/08 at 10:00 AM revealed Resident #16 with unkempt and long toenails. Record review revealed a physician's order for a podiatry consult for thick and painful nails, as needed. Review of facility policy and procedures for podiatry/foot care of residents stated residents will receive proper foot care and are to be seen by a specialist as requested or required. Facility Procedure #6 stated residents whose nails are thickened or long are to be reported to the Charge Nurse. Procedure #7 stated no resident's toe nails are to be cut by the licensed nurses and that the podiatrist will complete this task. An interview with the Director of Nursing on 12/16/08 at 12:20 PM, stated Certified Nursing Assistants (CNA) were responsible to report to nursing any resident in need of podiatry care and that the resident would be placed in the podiatry book for the podiatrist to visit. In addition, the unit manager, LPN #1 stated that no CNA reported that Resident #16 needed podiatry care. The last podiatry consult for</p>	F 312	<p>F312 Activities of Daily Living</p> <p>1. (a) When the facility was informed that Resident #17 required a fingernail clipping the nursing assistant completed the nail clipping (12/18/08). (b) When the facility was notified that Resident #16 required a podiatry consult a consult was called in to the podiatrist. Resident was seen by the podiatrist on January 9, 2009.</p> <p>2. A random audit will be conducted by the Director of Nursing and/or designee on walking rounds to visualize residents finger nails and toe nails and any needed consults will be obtained immediately (February 9, 2009).</p> <p>3. The Unit Managers/designee will do random audits of toenails and fingernails to ensure that they are properly kept (February 5, 2009).</p> <p>4. Results of audits will be reported to the QI Committee until substantial compliance (ongoing-February 9, 2009).</p>	<p>1/9/09</p> <p>2/9/09</p> <p>2/5/09</p> <p>2/9/09</p>

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F 312	Continued From page 6 Resident #16 was performed six (6) months prior, on 06/27/08. The facility failed to ensure that Resident #16, who is dependent upon staff to maintain activities of daily living, was provided with podiatry care and services 2. Resident #17 was admitted to the facility on 12/9/08 with diagnoses which included dementia. The resident was cognitively impaired and required the assistance of staff for activities of daily living. Observations on 12/16/08 and 12/18/08 revealed the resident had long nails that were jagged and broken creating sharp edges. The underside of the nails was also noted to be encrusted with debris. Staff confirmed these findings on 12/18/08 and trimmed Resident #17's nails.	F 312		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334	F334 Influenza and Pneumococcal Immunization 1. When the facility was informed that Resident #7 had not received the vaccination and consent was on the medical record the facility administered the vaccination that day (12/18/08). The facility was also informed that Resident #18 had no documentation indicating that he had received or had been offered the pneumococcal immunization. The pneumococcal immunization was offered to Resident #18 on 12/18/08 and the vaccination was given with appropriate consent (12/18/08).	12/19/08

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F 334	Continued From page 7 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative	F 334	2. Once informed about missing vaccination the facility conducted an all house audit which was completed by nursing administration and vaccines were given appropriately (12/18/08). 3. Unit clerks will maintain and track all vaccines on a spreadsheet (February 5, 2009). 4. Spread sheets will be presented to QI committee until substantial compliance is achieved (Ongoing-February 5, 2009).	12/18/08 2/5/09 2/5/09

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F 334	Continued From page 8 refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have a record of the pneumococcal immunization for two (2) residents (#7, #18) out of twenty-three (23) sampled residents. Findings include: 1. Resident #7 was admitted to the facility on 06/27/08. Record review revealed a pneumococcal vaccine informed consent was signed on 07/10/08 by the legal representative. However, the consent form did not indicate a previous history or a refusal of the vaccine. Further, record review failed to state that Resident #7 had not received the pneumococcal vaccine due to medical contraindication. An interview on 12/18/08 at 10:00 AM with the Director of Nursing confirmed these findings and added that Resident #7 would be administered the vaccine the same day. The facility failed to maintain a record of a pneumococcal vaccine for Resident #7, prior to admission, or, received the vaccine and or refused the vaccine subsequent to admission. 2. Resident #18 was admitted to the facility on 8/7/08. There was no documentation indicating that Resident #18 had the pneumococcal immunization. Review of this information with the facility on 12/18/08 revealed that there was no documentation to indicate that Resident #18 was given or offered the pneumococcal immunization.	F 334			
F 514	483.75(l)(1) CLINICAL RECORDS	F 514			

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F 514 SS=B	Continued From page 9 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 it was determined that the facility failed to ensure complete and systematically organized clinical records were maintained for four (4) residents (#2, #7, #4, #1) out of twenty-three (23) sampled residents. Findings include: 1. Resident #2's clinical record revealed sixty (60) day physician progress notes dated 06/26/08, 08/29/08 and 10/27/08 respectfully, did not have the resident's name affixed. It could not be determined, should the progress notes become separated from the chart, the identify of the resident for whom the notes were written 2. Resident #7 was admitted to the facility on 06/27/08 with multiple diagnosis. Record review revealed the current diagnosis list as incomplete. A further review reflected an incomplete list of diagnoses on the physician's order sheet. Upon a complete review of the clinical record, it was determined that significant diagnoses such as	F 514	F514 Clinical Records 1. (a) Resident #2 name was written on their progress notes for 6/26/08, 8/29/08 and 10/27/08 (January 12, 2009). (b) Resident #7 collective diagnosis was added to her face sheet (January 12, 2009). (c) Resident #4's history and physical was placed in the physician's box for his signature. (d) Resident #1 peripherally inserted central line catheter was discontinued (December 16, 2008). 2. The Director of Nursing/designee will do random audits on all units to ensure that progress notes are signed, collective diagnosis are located in one spot on the chart, history and physicals are signed by the physicians and that arm circumference for residents that have PICC line insertions in their arms are completed. All necessary corrections will be made. (February 5, 2009). 3. Ongoing audits of progress notes, collective diagnosis's, history and physical will be made by Unit Manager/designee. 4. Audits will be reported to QI Committee until substantial compliance is achieved (ongoing).	(a) 1/12/09 (b) 1/12/09 (d) 12/14/08 2/5/09 ongoing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2008
NAME OF PROVIDER OR SUPPLIER RENAISSANCE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 26002 JOHN J WILLIAMS HIGHWAY 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 514	<p>Continued From page 10</p> <p>Diabetes Mellitis (DM), Dysphagia, Glaucoma and Cerebellar Vascular Accident (stroke) were not collectively in one organized place in the chart but scattered throughout the chart. An interview with the unit manager on 12/15/08 at 2:00 PM revealed that he was not aware of two (2) of the diagnoses, DM and Glaucoma for Resident #7. The facility failed to organize information in the clinical record to reflect the current and accurate health status of Resident #7.</p> <p>3. On 11/13/08 an admission history and physical was completed on Resident #4. The physician failed to sign the history and physical form. On 12/16/08 at 9:50 AM interview with the unit manager confirmed this finding.</p> <p>4. Resident #1 had a peripherally inserted central line catheter (PICC) inserted in his arm for the administration of intravenous (IV) antibiotics between 10/30 and 12/16/08. The facility failed to consistently document the arm circumference and external catheter length on a weekly basis. Interview with staff revealed that it was completed but not always documented.</p>	F 514			

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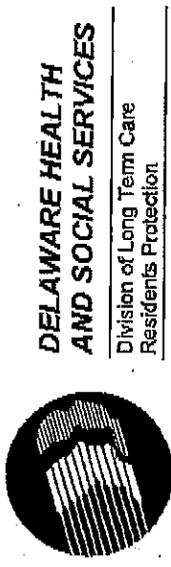
DHSS - DLTCRP
 3 Mill Road, Suite 308
 Wilmington, Delaware 19806
 (302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Renaissance Healthcare

DATE SURVEY COMPLETED: 12-19-08
 ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH
 ANTICIPATED DATES TO BE CORRECTED

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>The State report incorporates by reference and also cites the findings specified in the Federal report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from 12/15/08 through 12/19/08. The deficiencies contained in this report are based on observations, staff interviews, review of resident's clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was one hundred fifteen (115). The survey sample totaled twenty-three (23) residents which included a review of twenty (20) active and three (3) closed records.</p>	
3201.9.1	<p>3201 Nursing Home Regulations for Skilled Care General Services:</p>	
3201.9.1.1	<p>The skilled care nursing facility shall provide to all patients the care deemed necessary for their comfort, safety, nutritional requirements and general well-being.</p> <p>This requirement is not met as evidenced by:</p>	





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NAME OF FACILITY: Renaissance Healthcare

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3201.9.8.8	<p>Cross refer to the CMS 2567-L survey report date completed 12/19/08, F309, F312.</p> <p>All facilities shall have on file evidence of vaccination against pneumococcal pneumonia for all residents after the age of 65 years and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control unless medically contraindicated.</p> <p>This requirement is not met as evidenced by:</p>	
3201.9.10.1.2	<p>Cross refer to the CMS 2567-L survey report date completed 12/19/08, F334.</p> <p>History and physical examination: Prepared by a physician within seven (7) days of the patient's admission to the home. If the patient has been admitted to the home immediately after discharge from a hospital, the patient's summary and history which was prepared at the hospital and the patient's physical examination which was performed at the hospital, if performed within seven (7) days prior to admission to the home, may be substituted in lieu of the above records. Additionally, a record of an annual medical evaluation performed by a physician must be contained in each patient's file.</p>	



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3201.9.10. 1.3	<p>This requirement was not met as evidenced by:</p> <p>Resident #7's last History and Physical was performed on 06/29/07. There was not a record of a current physical on file for the year 2008. This finding was confirmed on 12/18/08 at 3:00 PM with the Director of Nursing.</p> <p>Statement of complete diagnosis and prognosis.</p> <p>This requirement was not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 12/19/08, F514.</p> <p>§1132 Reporting requirements:</p> <p>(a) Any employee of a facility or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis who has reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, neglected or financially exploited shall immediately report such abuse, mistreatment, neglect or financial exploitation to the Department by oral communication. A written report shall be filed by the employee or</p>	

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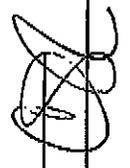
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	<p>service provider within 48 hours after the employee or service provider first gains knowledge of the abuse, mistreatment, neglect or financial exploitation.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 12/19/08, F225.</p>	<p>Refer to Plan of Correction as stated on CMS-2567-L completed on 12/19/08 For F-309, F-312, F-334, F-514, and F-225.</p>

**DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

Provider's Signature



Title NHA

Date 1/16/09