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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Kentmere Rehabilitation And Healthcare **DATE SURVEY COMPLETED:** October 12, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE	
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from October 9, 2023 through October 12, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 99. The survey sample totaled 45 residents. Abbreviations/definitions used in this state report are as follows: Applicant - c. A self-employed person or a person employed by an agency for work in a facility. BCC - Background Check Center is the electronic system which combines the data streams from various sources within and outside the State in order to assist an employer in determining the suitability of a person for employment in a long-term care facility.				
3201	**Regulations for Skilled and Intermediate Care Facilities**				
3201.1.0	**Scope**				
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to,**				

Provider's Signature Susan J Ickes Title NHA. Date 1.3.24

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	and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed: F623, F625, F641, F644, F657, F700, F730, F761, F812, F842, F847, F848, and F947.				
3201.5.0	**Personnel/Administrative**				
3201.5.5	**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:**				
3201.5.5.2	**Documentation of annual influenza vaccination or refusal.** Based on interview and review of personnel records, it was determined that the facility failed to provided documentation to verify that six (AA, CNA12, DA, DA2, LPN4, RN4) out of ten (10) employees received their annual influenza immunization or declined to receive the immunization. Findings include: 10/11/23 – A review of the facility's influenza documentation provided to the Surveyor revealed the following employees did not have evidence of an annual flu immunization or declination of the same: -AA -CNA12 -DA (Director of Admissions) -DA2 (Dietary Aide) -LPN3 (Licensed Practical Nurse) -RN4		**3201.5.5.2** A. No residents were harmed by this deficient practice. B. ICP or designee will ensure paperwork for annual influenza vaccine, both acceptance and declination, is in the employee medical files. ICP or designee will distribute information regarding influenza vaccine availability to staff. Staff will complete paperwork for acceptance or declination. C. Facility has determined by root cause analysis conducted by the interdisciplinary team that turnover in the Infection control practitioner prevention position was the reason for the deficient practice. ICP will keep files of staff acceptance or declination. D. Documentation of acceptance or declination will be	12/13/2023	

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3201.5.5.3 3201.5.5.4 3201.5.5.5	**-Results of criminal background check** **-Results of mandatory drug testing** **-Result of Adult Abuse Registry check.** This requirement was not met as evidenced by: Based on interview and review of facility documentation provided to the surveyor, it was determined that for 6 (RN4, AA, OT, PT, HSK and CNA 10) out of 10 employees reviewed, the facility's personnel records lacked evidence of criminal background checks, mandatory drug testing and adult abuse registry checks. Findings include: 10/10/23 11:00 AM – During an interview, the Surveyor requested evidence of the above information from Staff Development (SD) for the following staff: -AA (Activities Aide) -CNA10 (Certified Nursing Assistant) -CNA12 (Certified Nursing Assistant) -DA (Director of Admissions) -DA2 (Dietary Aide) -HSK (Housekeeper) -LPN3 (Licensed Practical Nurse) -OT (Occupational Therapy, Agency) -PT Physical Therapy, Agency) -RN4 (Registered Nurse). 10/11/23 – A review of the State of Delaware Background Center data revealed the following: 9/9/21 – RN4's first day in the facility, and the BCC drug test was dated 10/1/21.		reviewed at least weekly and reported to the QAPI committee monthly for three months ending March 31,2024 (end of the flu season). Non-compliance will be reviewed by the NHA for remedial action. **3201.5.5.3** A. No residents were harmed by this deficient practice. B. HR coordinator will ensure criminal background checks will be completed before candidate's first day worked. HR coordinator will obtain criminal background checks through DHSS BCC after contingent offer is made. Candidate will be sent for fingerprinting at Dover facility and candidate will bring receipt as proof of finger printing at/prior to orientation.	12/13/2023 12/13/2023 12/13/2023	

Provider's Signature Alissa Jacobs Title NHA Date 1.3.24

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	11/23/21 – AA's first day in the facility, and the BCC drug test was dated 12/1/21. 2/21/23 – OT and PT first day in the facility; there was no information on the State of Delaware BCC for OT and PT. 8/3/23 – HSK's first day in the facility, and the BCC drug test was dated 8/3/23. 9/28/22 – CNA10's first day in the facility, and the BCC drug test and Adult Abuse registry check was dated 10/14/22.		HR coordinator will audit files of current and new employees. C. Facility has determined by root cause analysis conducted by the interdisciplinary team that turnover in the Infection control practitioner prevention position caused there to be issues with continuity of the hiring process. HR coordinator will meet weekly with Staff Developer to review candidates and where they are in the process and set up orientation after criteria are met. D. Reports of compliance will be reviewed weekly for 3 months and reported to the QAPI committee for three months for substantial compliance of (85-100%) with the goal of 100%. Non-compliance will be reviewed by the NHA for remedial action.	12/13/2023
3201.6.9.2 **3201.6.9.2.4**	**Specific Requirements for Tuberculosis** **Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Dis-ease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** Based on interview and review of personnel records, it was determined that the facility failed to ensure that one (RN4) out of ten (10) employees reviewed, received their pre-employment tuberculosis screening completed. Findings include: 10/10/23 11:00 AM – During an interview, the Surveyor requested evidence of the employment tuberculosis screening history for ten		**3201.5.5.4** A. No residents were harmed by this deficient practice. B. HR coordinator will send candidate for drug testing once conditional offer is made. HR coordinator will obtain proof of drug testing. Results will be placed in the employee file once they are received. C. root cause analysis conducted by the interdisciplinary	

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16 Del. Code, Chapter 11, Subchapter IV § 1141 (c)	randomly selected staff members from Staff Development (SD). 10/11/23 – A review of the facility's employment tuberculosis screening history documentation provided to the Surveyor revealed the following: 9/9/21 – RN4's first day of employment at the facility. 9/20/21 – RN4 received the first step of his pre-employment TB test. **Criminal background checks.** **An employer may not employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work.** 10/10/23 11:00 AM – During an interview, the Surveyor requested evidence of the above information from Staff Development (SD) for the following staff: -AA (Activities Aide) -CNA10 (Certified Nursing Assistant) -CNA12 (Certified Nursing Assistant) -DA (Director of Admissions) -DA2 (Dietary Aide) -HSK (Housekeeper) -LPN3 (Licensed Practical Nurse) -OT (Occupational Therapy, Agency) -PT Physical Therapy, Agency) -RN4 (Registered Nurse). 10/11/23 – A review of the State of Delaware Background Center data revealed the following:		team that turnover in the HR, Staff Development and Infection Control and Prevention positions caused there to be issues with continuity of the hiring process. New hire files will be reviewed by Staff Developer and HR coordinator weekly for three months and results reported to the QAPI committee. D. Staff Developer and HR will report results of their weekly audits monthly to the QAPI committee until substantial compliance (85%-100%) is maintained for three months with a goal of 100%. Non-compliance will be reviewed by the NHA for remedial action. **3201.5.5.5** A. No residents were harmed by this deficient practice. B. HR coordinator will input applicant's information electronically to DHSS BCC prior to offer being made. Search is completed via BCC and results are available and printed for review. C. root cause analysis conducted by the interdisciplinary team that turnover in the HR, Staff Development and Infection Control and Prevention positions caused there to be issues. Evidence of BCC will be printed, reviewed and placed in employee's file.	12/13/2023	

Provider's Signature Lisa Gillespie Title NHA Date 1.3.24

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	2/21/23 – The first day in the facility for OT and PT; no information for OT and PT was available in the State of Delaware BCC.		Review of evidence of BCC checks will be done weekly for three months and reported to the QAPI committee. D. The HR coordinator will report monthly to QAPI until substantial compliance (85-100%) is achieved for three months with 100% being the goal. Non-compliance will be reviewed by the NHA for remedial action. **3201.6.9.2.4** A. No residents were harmed by this deficient practice. B. ICP will ensure initial PPD is given and results read prior to the first day worked. ICP will meet with candidates after successful completion of drug screen and background check. At this time, infection control new hire paperwork is completed. C. Facility has determined by root cause analysis conducted by the interdisciplinary team that turnover in the Infection control practitioner prevention position caused there to be issues. Audits of new employee health records will be completed weekly for three months to ensure compliance.	

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			D. Results of weekly monitoring will be reported to the QAPI committee monthly until sub-stantial compliance (85%-100%) is achieved for three months with a goal of 100%. Non-compliance will be re-viewed by the NHA for remedial action.		

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			1141C A. No residents were harmed by this deficient practice. B. HR coordinator will ensure criminal background checks are completed via BCC before staff, including rehab, is scheduled in the facility. HR coordinator will obtain criminal background checks via BCC from Rehab company for each therapist who is scheduled in the facility. C. root cause analysis conducted by the interdisciplinary team that turnover in the HR positions caused there to be issues with continuity of the hiring process. HR coordinator will audit files of current and new contract employees. HR coordinator will meet weekly with Staff Developer to review contracted employees to ensure compliance. D. The HR coordinator will report weekly audits to the QAPI committee monthly until substantial compliance (85%-100%) for three months is achieved with a goal of 100%. Reports of compliance or non-compliance will be reviewed	

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			weekly for 3 months and re-ported to the QAPI committee. Non-compliance will be re-viewed by the NHA for remedial action.		

Provider's Signature [signature] Title NHA Date 1.3.24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085001	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning October 9, 2023 through October 12, 2023 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was *** For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted by Healthcare Management Solutions, LLC, on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/09/23-10/12/23 Survey Census: 99 Sample Size: 28 Supplemental Residents: 24	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		12/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/03/2023

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 623	Continued From page 1 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623		

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F 623	Continued From page 2 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 3 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure two of three residents (Rs) and/or their representatives (RR) (R 17 and R79) reviewed for facility initiated emergent hospital transfer were provided with written notice of transfer that contained all required information. This failure had the potential to affect the resident and their RR by not having the knowledge of where and why a resident was transferred. Findings include: 1. Review of the "Minimum Data State (MDS)" tab of R17's electronic medical record (EMR) revealed she had a quarterly "MDS" assessment with an assessment reference date (ARD) of 07/12/23 with a Brief Mental Status Interview (BIMS) score of nine out of 15 indicating she was moderately cognitively impaired. Review of the "Progress Notes" tab of the EMR revealed she had a "Nursing Note" dated 06/30/23 and timed 11:26 PM stating the resident was unresponsive and she was transferred to the hospital.	F 623	F tag- 623 A. Resident R17 who was transferred on 6/30/23 at 11:26pm was returned to the facility on 7/6/23 at 10:12pm. The resident was not affected by the deficient practice. The Facility was unable to correct the deficient practice of not providing written notice of transfer that contained all required information for R17. Resident R79 who was transferred on 8/22/23 at 5:35pm was returned on 8/22/23 at 10:50pm. The resident was not affected by this deficient practice. Facility was unable to correct the deficient practice of not providing written notice of transfer that contained all required information for R79. B. Every resident who is transferred out of the facility has the potential to be affected. The transfer policy will be reviewed and revised as necessary by the Quality Assurance Performance Improvement Committee to ensure it includes providing the policy to each resident as they are transferred from the facility regardless of payor type or reason	

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F 623	Continued From page 4 Review of the "Progress Note" dated 07/06/23 and timed 10:12 PM revealed R17 was readmitted to the facility. The resident's EMR was silent for a written transfer notice being issued to R17 and/or the RR. During an interview on 10/09/23 at 1:39 PM R17 stated she had been in the hospital for a few days recently. She stated she did not remember getting a written discharge notice. During an interview on 10/11/23 at 6:16 PM the Administrator confirmed that no written discharge notice was given to R17 or the RR. 2. Review of R79's "Admission Record" from the EMR "Profile" tab showed a facility admission date of 05/19/22. Review of R79's quarterly "MDS" with an ARD of 08/22/23 showed a BIMS score of 14 out of 15, indicative of being cognitively intact. Review of R79's EMR "Progress Notes" tab showed R79 was transported to the hospital on 08/22/23 at 5:35 PM to be evaluated after a fall resulting in a right forehead hematoma and complaints of her head hurting. During an interview on 10/11/23 at 6:50 PM with R79 stated, "Nobody give me nothing that I know of. I don't have no paper. Maybe they gave it to [son's name]. Call [son's name] and ask him." A voicemail message was left for R79's son on 10/11/23 at 7:59 PM. No return call was received.	F 623	for transfer. In house and future resident and/or their responsible representative will be provided the policy and procedure regarding the written notice of transfer and associated required information by the admissions coordinator at the time of admission and at the time (within 24 hours) of transfer. This policy will also be sent via email to responsible representatives for their reference. C. A root cause analysis was conducted by the interdisciplinary team and it was found that the Director of Admissions was unaware of the requirement. The admission coordinator and the social services staff, as well as the nursing management team and the professional nursing staff will be educated regarding this requirement and the policy and procedure for compliance. The education will be given by the Staff Development Nurse or designee. Inservice will include the provision of transfer policy at the time of transfer to the resident via transfer packet that accompanies the resident to the destination. It will be made clear to staff that the policy applies to all transfers. The admissions coordinator will be responsible to review each transfer within 24 hours to ensure the paper information has been relayed to the resident and/or responsible representative timely, via an envelope sent with the resident and a phone call or email communication to them. D. The provision of notice of transfer will be reviewed by the nursing managers	

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F 623	Continued From page 5 In an interview on 10/11/23 at 6:56 PM Registered Nurse (RN) 1 stated, "No I don't remember ever giving the resident anything." During an interview on 10/11/23 at 6:17 PM, the Administrator revealed we're not giving them [transfer/discharge notice or written bed hold notice] we normally tell the resident and we call the family about the transfer and we hold their bed. We don't give anything in writing. During an interview on 10/11/23 at 6:24 PM the Director of Admissions (AD) stated she did not provide the resident or the family with a transfer/discharge notice because the resident was Medicaid, and she was only providing the discharge notices to residents on Medicaid if they had been out of the facility over seven days. She stated she was not aware she had to issue a written transfer/discharge notice on the day the resident was transferred/discharged. Review of the facility policy titled "Transfer and Discharge Criteria" dated May 2018 was reviewed. The policy was silent to when a written discharge/transfer notice was supposed to be provided to the resident and/or responsible party.	F 623	(supervisors, ADONs and DON) and Admissions Coordinator daily to ensure 100% compliance and document same. Documentation will be reviewed daily and reported to the QAPI Committee weekly until substantially compliant (85 -100%) with a goal of 100% for three months. Non-compliance will be monitored and reported to the NHA for follow up.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		12/13/23

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KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

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F 625	Continued From page 6 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to notify the resident and the resident's representative of the bed hold policy upon transfer/discharge to the hospital. This involved two (Residents (R17 and R64) of three residents reviewed for hospitalization. Findings include: 1. Review of R17's "Minimum Data Set (MDS)" tab of R17's electronic medical record (EMR) revealed she had a quarterly "MDS" with an assessment reference date (ARD) of 07/12/23 with a Brief Mental Status Interview (BIMS) score of nine out of 15 indicating she was moderately cognitively impaired.	F 625	F625 A. A. Resident R17 was transferred on 6/30/23 at 11:26pm and returned on 7/6/23 at 8:20pm. The resident was not affected by the deficient practice. The facility is unable to correct the deficient practice of not providing written notice of bed hold that contained all required information for R17. Resident R64 was transferred on 9/26/23 at 8:00am was returned on 10/2/23 at 8:20pm. The resident was not affected by the deficient practice. The facility is unable to correct the deficient practice of not providing written notice of bed hold that contained all required information for	

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F 625	Continued From page 7 Review of R17's "Progress Notes" tab of the EMR revealed she had a "Nursing Note" dated 06/30/23 and timed 11:26 PM revealing the resident was unresponsive and she was transferred to the hospital. Review of R17's "Nursing Progress Note" dated 07/06/23 and timed 10:12 PM revealed the resident was readmitted to the facility. Review of R17s' entire EMR revealed it was silent for a written bed-hold notice being issued when she was transferred to the hospital. During an interview on 10/09/23 at 1:39 PM R17 stated she had been in the hospital for a few days recently. She stated she did not remember getting a written bed-hold notice when she went to the hospital. During an interview on 10/11/23 at 6:16 PM the Administrator stated that no written bed-hold notice was given to the resident or family member when she was transferred to the hospital. During an interview on 10/11/23 at 6:24 PM the Director of Admissions (AD) revealed she did not provide the resident or the family with a written bed-hold notice because the resident was Medicaid, and she was only providing the bed-hold notice to residents on Medicaid if they had been out of the facility over seven days. She stated she was not aware she had to issue a written bed-hold notice on the day the resident was transferred/discharged. Review of the facility's policy titled, "Bed Holds" "Bed Hold policy" with an effective date of April	F 625	R64. B. B. Every resident who is transferred has the potential to be affected. The transfer and bed hold policy will be reviewed and revised as necessary by the QAPI Committee to ensure compliance. In house and future residents and/or their responsible representatives will be provided the policy and procedure regarding the written notice of bed hold and associated, required information by the admission coordinator at the time of admission and at the time (within 24 hours) of transfer regardless of payer type or reason for transfer. C. A root cause analysis was conducted by the interdisciplinary team and it was found that the admissions director was not aware of the requirement. The Admission Coordinator and the Social Services staff, as well as the nursing management team and the professional nursing staff will be educated regarding the requirement and the policy and procedure for bed hold notification. This education will be given by the Staff Development Nurse or designee. The in-service will include the provision of bed hold policy at the time of transfer to the resident in a transfer packet that accompanies the resident to the destination. It will be made clear to staff that the policy applies to all transfers. The admission coordinator will be responsible to review each transfer within 24 hours to ensure the paper information has been relayed to the resident and/or responsible representative timely via an	

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F 625	Continued From page 8 2017 stated if a resident left the facility for emergency treatment at a hospital the Admission Director would call the resident's family member or legal representative that the written notice will be mailed to them for review. Review of R64's clinical record revealed: 12/17/21 - R64 was admitted to the facility. 9/26/23 -10/2/23 - R64 was hospitalized for treatment of an abscess of the scrotum. 10/10/23 - A review of R64's clinical record revealed that a written notification of the facility's bed hold policy was not communicated to R64's representative for R64's 9/26/23 -10/2/23 hospitalization. 10/11/23 9:30 AM - During an interview, the Director of Admissions (DA) stated that for R64's 9/26/23 -10/2/23 hospitalization, that she verbally told R64's nephew that the facility would hold the resident's bed until he returned from the hospital, but that she did not send a written bed hold notice through the mail. 10/11/23 0615 - During an interview, the ED stated her understanding from the AD that a bed hold notification was was not sent to R64's representative when R64 was hospitalized 9/26/23 -10/2/23. 10/12/23 8:00 PM - The findings were reviewed with the ED and DON.	F 625	envelope sent with the resident and a phone call or email communication with them. D. D. The provision of notice of bed hold policy will be reviewed by the nursing managers (supervisors, ADONs, DON) and Admissions Coordinator daily to ensure compliance and document same. Documentation will be reviewed daily and reported to the QAPI Committee weekly until substantially compliant (85 - 100%) for three months. Non-compliance will be monitored and reported to the NHA for follow up.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		12/13/23

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F 641	Continued From page 9 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to provide an accurate resident assessment regarding a Level II screening of a Pre-Admission Screening and Annual Resident Review (PASARR) on an admission "Minimum Data Set (MDS)" assessment for one (Resident (R) 67) out of 28 residents reviewed. Findings include: Review of R67's "Admission Record" from the electronic medical record (EMR) "Profile" tab showed a facility admission date of 08/25/23 with medical diagnoses that included bipolar disorder - severe with psychotic features, panic disorder (episodic paroxysmal anxiety), suicidal ideations, depression, and cognitive communication deficit. Review of R67's EMR "MISC (Miscellaneous)" tab showed a Level II PASARR was completed on 08/15/23. Review of R67's admission "MDS" with an assessment reference date (ARD) of 08/31/23 (along with an 08/31/23 modification sent the same day) showed R67 was coded for not having a Level II PASARR completed. During a telephone interview on 10/12/23 at 11:06 AM, the covering MDS Coordinator (MDSC) reviewed R67's admission "MDS" and stated, "The prior RNAC [Registered Nurse Assessment	F 641	F641 A. Resident R67 who was admitted on 8/25/23 was not affected by the deficient practice. R67□s PASARR will be reviewed/revised as needed by the RNAC and the Social Services Director or designee to reflect their correct Level II status and that is correctly coded in the MDS. This resident□s PASARR is currently under routine review for recertification effective November 9,2023. B. An audit of current residents□ PASARRs will be completed by the RNAC and Social Services designee to ensure the resident PASARRs are accurate and properly coded on their MDS and corrections made as needed. This audit will be presented to and reviewed by the QAPI Committee for recommendations and/or follow up. C. A root cause analysis was conducted by the interdisciplinary team and it was found that the social service and RNAC Failed to coordinate proper PASARR coding of R67 MDS to align with R67□s Level II PASARR. The policy and procedures titled MDS/Care Plan Process will be reviewed by the QAPI Committee and revised as needed to include accuracy of the MDS and related PASARR coding. The Social Services and Admissions Departments,	

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F 641	Continued From page 10 Coordinator] completed that one. MDSC reviewed the 08/31/23 admission "MDS" and confirmed the PASARR screening was a level II, then confirmed it was not coded on the "MDS" accurately. In an interview on 10/12/23 11:27 AM with the Director of Nursing (DON), the DON revealed we use the RAI Manual for "MDS" assessment, but I'll check my policy book. During an interview on 10/12/23 at 5:50 PM, the DON stated an expectation that "MDS" assessments would be "accurate and timely." Review of the facility policy titled, "MDS/Care Plan Process," effective July 2016 revealed the policy did not address the need for the "MDS" to be accurate. Review of the October 2019 "RAI Manual," page 1-8 read in pertinent part, ". . .In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Inter-Disciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. . . .	F 641	as well as the RNAC and nursing management team (supervisors, ADONs and DON) will be re-educated by The Staff Development Nurse regarding accurate PASARR coding on the MDS. The Social Services designee and the RNAC will review the PASARR coding together before closing the MDS and document this additional step with both signatures on a sign off sheet. The social worker who received this resident on admission is no longer employed but realized she missed the Level II on the PASARR. The acting social service designee and the admission coordinator, RNAC, and nursing management team will be educated regarding accuracy of PASARRs on admission. The social service designee will ensure accuracy of the PASARR and the RNAC will ensure proper coding of the PASARRs on the MDS. Each new admission□s PASARR will be reviewed by the social service designee and the nurse managers or designee daily at a morning clinical meeting as they are admitted to ensure accuracy and proper MDS coding. D. The initial audit results and audits of new residents□ PASARRs will be reported to the QAPI Committee weekly until substantially compliant for three months with a goal of 100%. Non-compliance will be monitored and reported to the NHA for follow up.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		12/13/23

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F 644	Continued From page 11 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure of one (Resident (R) 14) of 28 sampled residents reviewed had a "Pre-Admission Screening and Resident Review (PASARR)" re-submitted upon a new mental health diagnosis. This had the potential to place the resident at risk for unmet care needs and not receiving appropriate mental health support/services as needed. Findings include: Review of R14's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab showed a facility admission date of 04/11/22. Review of R14's "Miscellaneous" tab of the EMR	F 644	F644 A. Resident R14 was not affected by the deficient practice. Resident R14□s PASARR was reviewed and a Preadmission evaluation (PAE) is now in progress by the Social Service Director/designee to accurately reflect the resident□s new mental health diagnosis and a PASARR Level II. B. Any resident with a psychiatric diagnosis has the potential to be affected. An audit of resident PASARRs and psychiatric diagnoses will be completed by the Social Service Director of designee and a nurse manager (DON, ADON) or designee to ensure residents with psychiatric diagnosis have a	

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F 644	Continued From page 12 revealed a "PASARR" dated 06/04/22. Review of R14's "Diagnosis" tab located in the EMR revealed medical diagnoses were input with the effective dates of: Schizoaffective Disorder - 06/08/23 Bipolar Disorder- 06/08/23 Review of R14's "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an "Assessment Review Date (ARD)" of 08/17/23 included psychiatric/mood disorder to include schizophrenia (e.g., schizoaffective, and schizophreniform disorders). Review of R14's "Care Plan" located in the EMR under the "Care Plan" tab revised on 08/26/23 included use of psychotropics for schizophrenia and bipolar disorder. During an interview on 10/12/23 at 4:38 PM, the Social Services Director (SSD) was asked to provide R14's "PASARR" for the new mental health diagnoses dated 06/08/23. The SSD confirmed that R14 did not have a "PASARR" resubmitted and should have.	F 644	corresponding Level II PASARR. Residents who receive a new mental health diagnosis will have a Level II PASARR completed by the social service designee. Results of this audit will be reported to the QAPI Committee for review and recommendations. C. A root cause analysis was conducted by the interdisciplinary team and it was found that the Director of Social Services failed to do a new PASARR assessment and create a level II PASARR for resident R14 upon a new diagnosis of mental disorders and code the MDS for same. Psychiatry staff (contract), Social Services, Admissions Coordinator, and Nursing Managers (ADONs, DON and Supervisors) will be educated by Staff Development or designee regarding the need to create a new Level II PASARR for residents who receive a new mental health diagnosis. Psychiatry staff and medical director will report any new psychiatric diagnoses to social service/designee. D. Residents who receive a new mental health diagnosis will have a Level II PASARR completed and a copy provided to the QAPI Committee daily at morning meeting. Monthly reports to the QAPI Committee will be made until substantial compliance is achieved with a goal of 100% compliance for three months. Noncompliance will be reported to and reviewed by the NHA for follow up.	

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F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure that one of two residents (Resident (R) 441) reviewed for bed rail use had documented safety assessment for the use of bed rails and the Resident or Resident Representative (RR) were advised of the risks and/or benefits of rail use. This failure had the potential for the resident or the RR to be uninformed of the risks associated with bed rail use. Findings include:	F 700	F700 A. Resident R441 did not have any negative effect from the deficient practice. The resident was assessed for the appropriateness of enablers by the Physical therapy assistant (PTA) on 10/18/23 and it was determined that the resident uses the enablers as a means of repositioning herself and maintaining her independence. Resident 441 will have alternate enablers provided on an alternate bed (non-bariatric). Bed will be changed out by Maintenance Director or	12/13/23

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F 700	Continued From page 14 Review of R441's "Admission Record" from the facility electronic medical record (EMR) "Profile" tab showed a facility admission date of 09/20/23 with medical diagnoses that included hemiplegia and hemiparesis (paralysis) following a cerebral infarction (stroke), muscle wasting and atrophy. A review of R441's EMR "Assessments," "MISC [Miscellaneous]," and "Progress Notes" tabs on 10/11/23 at 9:40 AM did not reveal any assessments, risk/benefit advisements, or signed consents for the use of the bedrails. Observation and interview on 10/09/23 at 12:05 PM, with R441's RR was asked about the bilateral upper side rails on R441's bed and if they had been advised of the risks and/or benefits for having the rails or an informed consent signed, the RR stated, "No not really. I've signed a lot of papers but not sure if I signed a consent for side rails." In an interview on 10/11/23 at 4:39 PM, the Administrator stated, "[R441's name] confirmed R441 did not have a side rail assessment." Review of the undated, untitled, facility policy regarding mobility bars revealed in pertinent part, "Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of enablers. Purpose: To ensure residents have full mobility; Procedure: 2. If a resident requests siderails upon admission, it will be explained to them that the facility uses enablers and offer education if needed. 4. Therapy will assess the resident for ability to use enablers and make recommendations. 5. If the resident is able to demonstrate that they can use enablers, they will be placed on the bed by maintenance."	F 700	designee and appropriate enablers provided. The physician will write orders for enablers. B. The policy and procedure for enablers will be reviewed by the QAPI Committee and revised as needed for compliance. New beds will not have side rails upon installation. The current beds will be audited for the presence of enablers by the Director of Rehabilitation and compared to the residents orders for enablers by nursing management (DON, ADON, supervisors) or designee to ensure residents need, orders, and enablers match. The Director of Rehab will coordinate further assessments as indicated and recommend changes as needed. C. A root cause analysis was conducted by the interdisciplinary team and it was determined that the bariatric beds cannot accommodate enablers verses siderails. The professional nursing staff, nursing management, rehab team, admissions staff and maintenance staff will be educated by the staff development nurse or designee regarding the policy and procedure and regulations pertaining to side rails and enablers. Unnecessary bariatric beds will be changed out to appropriate size beds. Side rails found in the audit will be removed by maintenance staff. The Director of Rehab will consult on beds where side rails are to be removed to assess the resident for the need for enablers. If needed, orders and enablers will be obtained.	

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F 700	Continued From page 15	F 700	D. A report of side rails/enablers usage, requests, assessments, installations, elimination and education will be made to the QAPI Committee weekly until substantial compliance is achieved for three months with a goal of 100% compliance. Non-compliance will be reported to and reviewed by the NHA for follow up.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) 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. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to ensure a performance review was completed every 12 months for five (Certified Nursing Assistants (CNA)4, CNA7, CNA5, CNA8, CNA1) of five nurse aide performance reviews reviewed. Findings include: On 10/11/23 at 9:07 AM the personnel files and the performance reviews of five CNAs were reviewed with the Human Resources/Payroll Coordinator (HR). Review of the performance reviews revealed the following:	F 730	F730 A. No residents were harmed by this deficient practice. There is no resident involvement in the deficient practice. Facility is unable to correct deficient practice for performance evals not having been done. Employees (CNA4, CNA7, CNA5, CNA 8 and CNA1) will have performance evaluations done by a nurse manager. B. Policy for performance evaluations will be reviewed and revised as needed. There is no resident involvement in the	12/13/23

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F 730	Continued From page 16 1. CNA4 had a hire date of 05/20/20. The last performance review in her personnel file was a 90-day evaluation dated 08/27/20. 2. CNA7 had a hire date of 12/16/20 and the last performance review was dated 02/05/22. 3. CNA5 had a hire date of 12/15/21 and the last performance review was dated 10/07/19. The HR stated CNA5 was a rehire and she had not had a performance review since she was rehired on 12/25/21. 4. CNA8 had a hire date of 02/05/20 and her last performance review was dated 03/30/22. 5. CNA1 had a hire date of 12/19/21 and her last performance review was dated 04/08/22. During an interview on 10/11/23 at 9:07 AM the HR verified each of the CNAs had not had a yearly performance review. He stated it was the facility policy to complete an annual performance review for each of the CNAs and the facility had not completed them.	F 730	deficient practice. Staff will have performance reviews by their 90th day of employment, and annually thereafter, near their date of hire anniversary. C. A root cause analysis was conducted by the interdisciplinary team and it was determined that turnover of the human resources and staff development departments caused performance evaluations not to be completed as scheduled. Staff development is a permanent full-time employment who will continue should the HR consultant not be present. Managers, Directors and Nursing Administration (DON, ADONs) will be educated by the Staff Development Nurse or designee regarding the policy and procedure and regulations pertaining to employee performance evaluations. Employee files will be audited by the Human Resources Consultant for completion of performance evaluations. Evaluations will be completed, going forward, by the Department heads, and nursing administration (DON, ADONs) or designee as scheduled by Human Resources to ensure accuracy of files and compliance with the policy and procedure D. Monitoring of employee performance evaluations by Administrator/designee will occur weekly to ensure substantial compliance with the schedule. Reports of weekly monitoring will be submitted to and reviewed by the QAPI Committee monthly until substantial compliance is attained for three months with a goal of 100%. Non-compliance will be reported to and	

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F 730	Continued From page 17	F 730	reviewed by the NHA for follow up.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure there were no loose pills in the medication carts and failed to properly store medication for one (Resident (R) 79) that was located in another resident's room (R16). This had the potential for unauthorized residents or staff to access the	F 761	F761 A. The medication labelled for resident R79 was removed from resident R16□s room RN. during the survey. 3 loose pills were removed by LPN and 17 loose pills were removed by LPN during the survey. No residents were harmed by this	12/13/23

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F 761	Continued From page 18 medications. Findings include: 1.Review of R79's "Order Summary Report" located in the EMR under the "Orders" tab included an order for Voltaren Gel 1% (Diclofenac Sodium) to be applied to the left thumb base topically two times a day for thumb pain as of 06/27/23. During an observation on 10/09/23 at 3:10 PM revealed Voltaren Gel (Diclofenac Sodium) 1% was on R16's over the bed table with a medication label for R79. Review of R16's "Order Summary Report" located in the EMR under the "Orders" tab did not include Voltaren Gel (Diclofenac Sodium) 1% (percent) (arthritic pain reliever). During an interview on 10/09/23 at 3:10 PM with R16 stated she was not aware of the cream on her over the bed table and that the overnight nurse must have left it there. The resident confirmed that her name was not R79, and that the diclofenac cream was not hers. During an interview on 10/09/23 at 4:07 PM with Registered Nurse (RN)1 confirmed that Volatren Gel was located in R16's room and belonged to R79. RN1 did not know how the medication was left in the wrong resident's room but should have been secured in the medication cart. 2.During an observation and interview on 10/11/23 at 11:09 AM revealed the medication cart for the second-floor rooms 201-209 and 232-239 in use by Licensed Practical Nurse	F 761	deficient practice. B. Nursing managers and pharmacy consultant will meet to determine if additional cart(s) are needed to provide sufficient space for med cards to prevent breakage resulting in loose pills. Nurses on that assignment, the day of discovery, will be interviewed by the DON to determine why medication was inappropriately stored on nightstand. DON will follow up with re-education and other indicated steps to ensure compliance. C. A root cause analysis was conducted by the interdisciplinary team and it was determined that the medication carts are very full and medication cards rub each other causing pills to fall into medication cart. The facility is unable to identify the nurse responsible for leaving the tube of gel in the bed side table or the reason for same. (education attach Item 761). Medication carts will be observed by assigned nurse on each shift for loose pills. Pills will be removed if found by assigned nurse. Medications and treatments will be maintained in the medication or treatment cart belonging to each resident. Nursing staff will be educated by Staff Development Nurse or designee on proper storage and handling of medications and treatments. Nursing staff will also be educated by the Staff Development Nurse or designee on the five rights of medication. D. Med and treatment carts and resident	

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F 761	Continued From page 19 (LPN)2 had three loose tablets in the medication cart. LPN2 confirmed loose pills were located in the cart and should have been removed. During an observation and interview on 10/11/23 at 11:22 AM revealed the medication cart for the second-floor rooms 211-230 in use by LPN1 had three loose capsules, 17 loose tablets, and three half tablets loose in the medication cart. LPN1 confirmed loose capsules/pills were located in the cart and should have been removed. During an interview on 10/12/23 at 5:20 PM with the Director of Nursing (DON) confirmed that the facility policy was that the medication carts were supposed to be cleaned out when nursing staff visualize loose pills. Additionally, the pharmacist visits once monthly and should have noticed the loose pills and removed them. Review of facility's policy titled "Storage and Expiration Dating of Medications, Biologicals" dated 01/01/22 stated in part" ...Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions ...Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with the Pharmacy return/destruction guidelines.."	F 761	rooms will be audited by nursing administration (DON and ADONs, supervisors) or designee weekly to ensure proper storage of meds and treatments as well as no loose pills. Weekly reports to the QAPI Committee will be made until three months of substantial compliance is achieved with a goal of 100%. Noncompliance will be reported to and reviewed by the NHA for follow up.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		12/13/23

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F 812	Continued From page 20 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, documentation review, and facility policy review, the facility failed to ensure food was stored in a sanitary manner; failed to ensure the dishwasher was at the correct temperature level to sanitize the residents' dishes; failed to ensure sanitizer was at the correct level, and failed to ensure a food storage container was maintained in a clean and sanitary manner. This had the potential to affect 98 of the 99 residents who receive meals from the kitchen. The facility identified one resident who received nothing by mouth (NPO). Findings include: 1. Observation on 10/09/23 at 9:15 AM revealed there was an undated/unlabeled plate of food (a bun with chopped meat on it and some other item) covered with another plate and a bag from a restaurant with leftover food that was not dated or labeled in the third-floor resident refrigerator. The Dietary Manager (DM) was present and verified the observation and stated the items should have	F 812	F812 A. Facility is unable to correct deficient practice during days of survey. The refrigerators were swept of all food on the first day of the survey 10/9/23 by ADON 1 and ADON 2 No residents were affected by the deficient practice. Residents□ temperatures and signs and symptoms were monitored by nursing management per medical director□s directives for forty-eight hours to ensure no signs or symptoms of food borne illness occurred. Any issues were to be reported to the medical director. No issues were noted. B. Non-resident food, leftover food and improperly labeled/dated food will not be stored in refrigerators in the resident care areas. Refrigerators on all three units will be purged of non-compliant food daily regardless of its source of origin. The refrigerators will be purged by designated	

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F 812	Continued From page 21 been dated and labeled. 2. Observation on 10/09/23 at 9:18 AM revealed the second-floor resident refrigerator contained a quart size container of macaroni and cheese. The store label on the container stated it was packaged on 09/19/23. The container was not labeled with a resident name or the date the container was opened and/or placed in the refrigerator. There was also a clear container with six, four-ounce cups of melted ice cream. At 9:20 AM observation of the first-floor resident refrigerator contained a container of unidentified unlabeled food dated 09/15/23; a container of soup with no label or date; a quart baggie with unidentified food with a resident's name on it and dated 09/15/23; a container of green whip cream looking food no date or label; a container of undated unlabeled food. The DM stated the food in the container looked moldy. The refrigerator also contained a cup of red juice and a cup of orange juice neither of the beverages were dated or labeled; and an open pizza box with 2 pieces of pizza in it dated 05/07/23; two undated and unlabeled pint size containers of a red food item; an opened undated quart size container of nectar thickened milk; an open bottle of ranch dressing with a use-by-date of 08/31/23. The DM was present and verified the observations and stated the items should have been dated and labeled and disposed of before the use by date or within three days of being placed in the refrigerator. Review of the facility policy titled "Food brought into the Facility" with an effective date of April 2017 revealed perishable food items must be labeled with the resident's name and date and discarded after three days.	F 812	nursing staff indicated on daily assignment sheets. Dietary Managers and Nursing Managers (DON, ADONs, supervisors) and/or designees will check refrigerators in the resident care areas daily to ensure compliance and record compliance on a resident refrigerator review form. This form will be provided to the QAPI Committee weekly after being signed by the DON or designee to ensure compliance. C. A root cause analysis was completed by the interdisciplinary team and it was found that nursing and dietary were unclear who is responsible to maintain the unit refrigerators in compliance. Staff Development will educate staff regarding the requirements of storage in the unit refrigerators. Family members of new residents will be made aware of requirements by admissions coordinator via the admissions packet. Family members of existing residents will be made aware of requirements by NHA via an email to the responsible party of record. Residents will be made aware by presentation to resident council by NHA. D. Documentation of the refrigerator monitoring will be made daily by the food service director and/or sous chef and presented weekly to the QAPI Committee until three months of substantial compliance (85-100%) occurs, with a goal of 100%. The administrator/designee will review daily monitoring reports. Noncompliance will be reported to the NHA for review and follow up. The	

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F 812	Continued From page 22 4. Observation on 10/09/23 at 9:06 AM and on 10/11/24 at 10:30 AM revealed the lid of the flour container located under the food preparation counter in the salad preparation area of the kitchen was soiled with dried food residue and a Styrofoam plate was laying in the flour. On 10/11/24 at 10:30 AM Sous-Chef 1 verified the top of the container was soiled and verified the Styrofoam plate was laying in the flour. He stated the employees used the plate to scoop the flour out of the container because they did not have a scoop for it. 5. On 10/11/23 at 10:37 AM Dietary Aide 1 (DA1) and DA2 were observed running the dishes through the dishwasher from the breakfast meal. The wash and sanitizer water temperatures of the dishwasher were checked multiple times as the staff were running the soiled dishes through the dishwasher. The temperatures obtained were 136 to 141 degrees Fahrenheit (F) for the wash and 175 to 177 degrees F for the rinse. DA1 was queried about what the temperature was supposed to be, and she stated the wash should be 150 degrees F, and the rinse should be 180 degrees F, or higher. She verified the temperature of the dishwasher was not reaching those temperatures. The employees continued running the dishes through the dishwasher without it reaching the proper temperature to ensure the dishes were being sanitized and DA2 continued to stack the dishes from the clean end of the dishwasher and put them away. On 10/11/23 at 10:38 AM the DM was notified the dishwasher temperature was not reaching the proper temperatures to ensure the dishes were sanitized. She stated she was aware the temperatures were too low, and she put in a work	F 812	process will remain in place ongoing bases as described indefinitely. After the three months period noncompliance will be reported to QAPI as it occurs. It will be monitored by nursing management(DON, ADON, Supervisors). 812 A. The facility is unable to correct dishwasher temperatures on the day(s) of deficient practice. No residents were affected by the deficient practice. Dish machine was converted and calibrated to utilize chemical sanitation during the survey by a contracted service pending repair of the hot water sanitation process. B. The policy and procedure for recording dish machine temperatures and the dish machine temperature log will be reviewed and revised by the QAPI Committee as needed. C. A root cause analysis was completed by the interdisciplinary team and it was found that the food service director failed to initiate changes to the dish washing sanitation process upon discovery of the dish machine not reaching 180 degrees. Possible changes could have include use of three compartment sink with chemical sanitation, use of disposable dishes, or converting dish machine to chemical sanitation process. The dietary staff will be educated by the Staff Development Nurse or designee regarding dishwashing and dish rinsing temperatures as well as what to do when the temperatures are inadequate. The Dietary Director will be	

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F 812	Continued From page 23 order a couple of days ago to have the dishwasher serviced because of the low temperature levels. When asked if they were continuing to use it to wash the dishes she stated yes. She stated she had no alternate method (such as heat changing test strips) to test the temperature of the dishwasher water. She was asked what date the work order was submitted. She asked the Maintenance Director (MD), and he stated it was on Friday 10/06/23. He stated he called the service company and they had not come to the facility to look at or service the dishwasher. He stated he would put in a second call. Observation on 10/11/23 at 10:46 AM of the dish washer temperature log hanging on the wall revealed the wash temperature on the log was recorded as being between 156 and 164 degrees F, and the rinse temperature was recorded as being between 180 and 185 degrees F or the dates of 10/06/23 through 10/10/23. Each of the temperatures logged for breakfast and lunch were initialed by DA2. On 10/12/23 9:30 AM the temperature log and the schedule were reviewed with the DM. Review of the schedule revealed DA2 was not working on Monday 10/09/23, however he recorded on the dishwasher temperature log that the wash temperature of the dishwasher was 160 degrees F, and the rinse was 180 degrees F for both the breakfast and the lunch meals. The DM stated she did not know whose initials were on the log for the water temperatures for the evening meal, but she would check into it. A request was made to interview both employees who documented the dishwasher water temperatures from 10/06/23 to 10/11/23. The surveyor was never informed of	F 812	educated by the Staff Development Nurse or designee regarding timely replacement of dishwashing methods upon discovery or report of inadequate temperatures. The Maintenance Director will be educated regarding action to be taken upon notification of inadequate temperatures. The dish machine temperatures will be taken twice daily by the Dietary director or the sous chef or other designee. D. Daily documentation of the dish machine temperatures will be audited by the dietary director/designee and sent to the QAPI Committee weekly for review of compliance. Audits will be completed daily until substantial compliance (85 to 100%) is achieved, with a goal of 100%. Noncompliance will be reported to and reviewed by the NHA for follow up. 812 ex 4 A. The lid to the flour bin was cleaned by the Food service director during the survey. The plate was removed and replaced with scoop. B. The flour lid will be cleaned daily and as needed by the dietary aides. C. A root cause analysis was conducted by the interdisciplinary team and it was found that the dietary employees failed to locate the scoop and improvised using the plate rather than communicating to the Food service director. The use of the plate	

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F 812	Continued From page 24 who recorded the dishwasher temperatures for the evening meal for 10/06/23 through 10/11/23. During an interview on 10/12/23 at 9:49 AM DA2 stated he just writes down the temperature after all the dishes have been washed. He stated that the dishwasher did reach 160 degrees F and 180 degrees F at times, however, it will drop down five degrees and he continues to remove the dishes and they are used for the next meal. He verified he did not work on 10/09/23 but he wrote down the temperature of 160 degrees F and 180 degrees F because he knew all the spaces needed to be completed. Observations on 10/11/23 at 11:33 AM the staff continued running the dishes through the dishwasher and then putting them away for the next meal without any alternate method to sanitize them. At that time, the wash was 130 degrees F, and the rinse was 175 degrees F. During an interview on 10/11/23 at 6:41 PM the Administrator 6:41 PM the Administrator stated she was not aware of the temperature of the dishwasher and rinse temperatures not reaching the proper temperatures until 4:00 PM when the surveyor brought it to her attention. She stated she should have been told and the staff should have immediately stopped using the dishwasher. On 10/11/23 at 6:57 PM the Administrator stated she told the staff there were to chemically sanitize the dishes starting tonight until the dishwasher was repaired. She stated the technician from the company had not come to the facility yet and she informed the MD to call any emergency company that could come to the facility to repair the dishwasher.	F 812	rather than the scoop contributed to the dirty lid of the flour bin. The dietary department will be in serviced in proper cleaning of the flour bin and use of proper tools (scoop) in the flour by staff developer/designee. D. Food service Director and/or Sous chef will audit cleanliness of flour container lid and use of proper utensil (scoop) twice daily and document same. Weekly reports to QAPI committee will be monitor for three months until substantial compliance (85-100%) is achieved with a goal of 100%. 812 ex5 A. The facility is unable to correct the deficient practice during day of survey of dietary aide 1 and Dietary Aide 2. B. No residents were affected by the deficient practice. C. A root cause analysis was done by the interdisciplinary team and found that dietary aide 1 and dietary aide 2 were not clear that the deficient practice warranted ceasing to use the dish machine until alternate sanitizing procedures were put in place. D. The Food Service Director and sous chef will monitor the dish machine wash and rinse temperatures daily and report them weekly until substantial compliance (85-100%) is achieved for three months with a goal of 100%. The director of maintenance and/or administrator will randomly validate the documentation. In	

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F 812	Continued From page 25 Review of the facility policy titled "Recording of Dish Machine Temperatures" with an issued date of 05/01/19 revealed the dishwasher water temperatures were to be recorded on the "Dish Machine Temperature Log" and the temperatures should be 150 degrees F or greater for the wash and 180 degrees F or greater for the rinse. The policy stated, to report the temperatures that are below the required levels to the DM immediately and convert to paper service until the temperature is corrected. 6. On 10/11/23 at 11:03 AM the sanitizer in the red wiping cloth container was tested by the DM and measured zero parts per million (PPM). Cook1 stated she made it about an hour ago and was using it to wipe off her food preparation counters. The water was visibly soiled. The DM verified the sanitizer in the red sanitizer container should have been maintained at 200 PPM. Review of the policy titled "Red Sanitizer and Green Clean buckets" with an issued date of 05/01/19 stated the quaternary sanitizer solution should have been maintained at 200 PPM. Review of the manufacturer's information titled "Sani-T-10 Plus" "food contact sanitizer" stated the sanitizer should be maintained at a range of 150 to 200 PPM.	F 812	the event the dish machine is using alternate sanitation (chemical) method or the three compartment sink chemical rinse, or paper products that will be noted in the daily monitoring sheet with Parts per millions (PPMS) noted. 812 ex 6 A. The facility corrected the deficient practice during the days of the survey. No residents were affected by this deficient practice. Cook 1 disposed of red bucket solution and replaced it with new solution of 200 ppm. B. The policy and procedure Red Sanitizer and Green Clean Buckets will be reviewed by the QAPI Committee and revised as needed. C. A root analysis was done by the interdisciplinary team and found that Cook 1 was noncompliant with procedures for mixing solution for red bucket and frequency of changing red bucket solution. The Dietary Manager and dietary employees will be educated on the Red Sanitized and Green Clean Buckets policy and procedure by the Regional Manager of the contracted management company. D. Daily supervision of proper use of red and green buckets will be done by the food service director and sous chef will monitor red bucket solutions ppm and changing of solutions daily and report	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 26	F 812	weekly to QAPI committee until substantial compliance is achieved for three months with a goal of 100%. Attach audit tool (	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		12/13/23

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	085001	A. BUILDING _____ B. WING _____	C 10/12/2023

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F 842	Continued From page 27 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to maintain an accurate medical record for four residents (Residents (R) R10, R23, R30, and R90) of four reviewed for nursing documentation related to laboratory	F 842	F842 1. A. Resident R10 was not affected by the deficient practice. The physician had been made aware of the abnormal lab results on 9/30/23 by the 3/11 shift	

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F 842	Continued From page 28 findings and activities of daily living (ADLs) task documentation. Findings include: 1. Review of R10's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab showed a facility admission date of 07/19/19. Review of R10's "Orders" located in the EMR under the "Orders" tab included urinalysis with culture and sensitivity dated 09/28/23. Review of R10's "Urinalysis" located in the EMR under the "Results" tab, dated 09/28/23 indicated she had a mixed culture with greater than three organisms including gram negative rods (bacteria), with a note to repeat the urinalysis per laboratory recommendation. During an interview on 10/11/23 at 9:54 AM with Licensed Practical Nurse (LPN)1 stated that he was not aware of R10's abnormal urinalysis results. LPN1 stated that the facility protocol was for the nurse on duty to receive the laboratory results from the computer or the fax machine, then call the physician, receive orders, and place the laboratory results in the physician binder book. Additionally, the laboratory sometimes calls the facility with abnormal results, the results are then passed on to the physician, and the nurse would document any new orders and results in the progress notes. During an interview on 10/11/23 at 10:03 AM, the Assistant Director of Nursing (ADON)1 confirmed R10 had an order for urinalysis with culture and sensitivity on 09/28/23 and had abnormal results.	F 842	Nurse/RN but no documentation in the EMR. B. The facility has determined that all residents have the potential to be affected. C. A root cause analysis was conducted by the interdisciplinary team and it was identified that the staff nurse/RN failed to documented lab results and notification of MD in the EMR. The Director of Nursing will provide an education to staff nurse/RN upon her return from medical leave, addressing documentation guidelines for EMR related to abnormal labs and notification of MD. Staff Developer/designee will in-service licensed staff on the policy of provider notification of abnormal test results and documentation in a progress note. The Director of Nursing/designee will complete an audit of abnormal test results documentation in progress notes. The audit will be completed weekly until consecutive audit results of 100% for three weeks. Audits will then be done monthly for three months until consecutive audit results of 100%. D. Weekly audit results will be reported to and monitored by the Quality Assurance Performance Improvement Committee until three months of substantial compliance (85-100%) is achieved. 2. A. The facility cannot retroactively address the lack of documentation for R23, R30 and R65 on point of care tasks for passive range of motion/active range of motion. Residents R23, R30, and R65 were not affected by the deficient practice.	

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F 842	Continued From page 29 The ADON stated that normally the nurses would write a progress note indicating lab results, and any communication with the physician. After reviewing R10's progress notes, ADON1 confirmed there was no documentation that the abnormal results had been reviewed with or by the physician. It was confirmed that the physician had been made aware of the abnormal results. 2. Review of R23's "Admission Record" located in the EMR under the "Profile" tab showed a facility admission date of 12/03/14 with a primary medical diagnosis of hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left non-dominant side. Review of R23's "Orders" located in the EMR under the "Orders" tab dated 09/26/21 included "PROM (passive range of motion) to bilateral shoulders, elbows wrists, hands, knees and ankles BID x [times]15 minutes on contracture management program." Review of R23's "Care Plan" located in the EMR under the "Care Plan" tab, initiated 12/17/21 indicated R23 was to receive passive range of motion (PROM) exercises to bilateral shoulders, elbows, wrists, hands, knees, and ankles twice daily for 15 minutes related to contractures. Review of R23's Quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab had an "Assessment Review Date (ARD)" of 09/04/23 revealed that R23 had no limitation to range of motion to the upper extremities, and that he had impairment on both sides of lower extremities. R23's "Brief Interview of Mental Status (BIMS)" score was 15 out of 15 indicating he was cognitively intact.	F 842	B. The facility has determined that all residents have the potential to be affected. C. A root cause analysis was conducted by the interdisciplinary team and it was identified that the cna□s failed to documented in the POC. In house staff was verbally made aware of lack of documentation and charge nurses, supervisor, ADON will monitor all POC documentation during their shift under the clinical dashboard in point click care to monitor the POC assignment status. Residents with an order for passive/active range of motion will be reviewed by nursing management (DON, ADON, Supervisor/designee) to determine if nursing documentation is complete. The policy for Documentation Guidelines was reviewed/revised on 11/13/2023 and nursing staff will be in-serviced by Staff Developer/designee. D. The Assistant Directors of Nursing/designee will complete a weekly audit of point of care PROM/AROM documentation. Audits will then be done monthly for three months until substantial compliance is achieved (85-100%). Audit results will be reported to the Quality Assurance Performance Improvement Committee. 3. A. The facility cannot retroactively address the lack of documentation for R90 on point of care for activities of daily living. Resident has been discharged to home. Resident was not affected by the deficient practice. B. The facility has determined that all residents have the potential to be	

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F 842	Continued From page 30 Review of R23's "POC (Point of Care) Response History" located in the EMR under the "Tasks" tab indicated it was not documented that R23 had restorative nursing (PROM) exercises twice daily on 09/01/23, 09/16/23, 09/21/23, 09/24/23, 09/28/23, 09/29/23, 09/30/23, 10/01/23, 10/03/23, 10/05/23, and 10/07/23. 3. Review of R30's "Admission Record" located in the EMR under the "Profile" tab showed a facility admission date of 01/23/20. Review of R30's "Orders" located in the EMR under the "Order" tab dated 09/26/21 included active range of motion (AROM) to bilateral shoulders, elbows, wrists, hands, knees, and ankles twice daily for 15 minutes on contracture management program. Review of R30's "Care Plan" located in the EMR under the "Care Plan" tab, initiated 12/21/21 indicated R30 was to receive PROM exercises to bilateral shoulders, elbows, wrists, hands, knees, and ankles twice daily for 15 minutes contracture management program. Review of R30's Quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab had an "Assessment Review Date (ARD)" of 09/21/23 indicating R30 was receiving restorative nursing program services. Additionally, the "MDS" indicated that R30 had no limitation to range of motion to the upper extremities, and that she had impairment on both sides of lower extremities. R30's "Brief Interview of Mental Status (BIMS)" score was four out of 15 indicating she was severely cognitively impaired.	F 842	affected. C. A root cause analysis was conducted by the interdisciplinary team and it was identified that the cna□s failed to documented in the POC. In house staff was verbally made aware of lack of documentation and charge nurses, supervisor, ADON will monitor all POC documentation during their shift under the clinical dashboard in point click care to monitor the POC assignment status. The policy for Documentation Guidelines was reviewed/revised on 11/13/2023 by DON, NHA, and QAPI committee and nursing staff will be in-serviced by Staff Developer/designee. D. The Assistant Directors of Nursing/designee will complete a weekly audit of point of care activities of daily living task documentation. Documentation will be reviewed weekly and reported to the QAPI committee. Audits will then be done monthly for three months until substantial compliance is achieved (85-100%). All audit results will be reported to the Quality Assurance Performance Improvement Committee.	

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F 842	Continued From page 31 Review of R30's "POC (Point of Care) Response History" located in the EMR under the "Tasks" tab indicated R30 did not documentation that she received restorative nursing AROM exercises BID [twice a day] on 10/03/23 and 10/06/23, or PROM exercises twice daily on 10/03/23 and 10/06/23. During an interview on 10/11/23 at 9:54 AM with LPN2 confirmed that R23 and R30 were on a restorative nursing program and should be receiving PROM for 15 minutes twice daily. During an interview on 10/11/23 at 10:25 AM with the ADON1 confirmed that R23 and R30 were on a restorative nursing program, and that if the resident refused the restorative services then the Certified Nursing Assistant's (CNAs) should document the refusal. During an interview on 10/12/23 at 11:45 AM with the Director of Nursing (DON) confirmed that R23 and R30 did not have documentation indicating that the residents received restorative nursing services twice daily as ordered. 4. Review of R90's "Admission Record" from the EMR "Profile" tab showed a facility admission date of 10/14/22. Review of R90's November 2022 (up to discharge date) Certified Nursing Assistant (CNA) documentation from the EMR "Reports" tab showed missing documentation for the following: Bathing: 1 of 8 scheduled baths Bed Mobility: 11 of 64 shifts Dressing: 9 of 43 shifts Locomotion off unit: 9 of 43 shifts Locomotion on unit: 9 of 43 shifts	F 842		

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F 842	Continued From page 32 Personal Hygiene 9 of 43 shifts Toilet Use: 11 of 64 shifts Transfers: 9 of 43 shifts Walk in Corridor: 9 of 43 shifts Walk in Room 9 of 43 shifts Bowel and Bladder: 11 of 64 shifts Eating: 16 of 64 shifts Turn and Reposition: 10 of 64 shifts Nutrition (amount consumed): 15 of 64 shifts In an interview on 10/12/23 at 3:00 PM with CNA4 stated, "We chart ADLs, like bathing, changing, toileting, and eating. We're expected to chart at the end of each shift, or during the shift if you have the time." During an interview on 10/12/23 at 5:50 PM regarding CNA documentation, the Director of Nursing (DON) stated an expectation that it would be charted every shift. Review of a policy provided by the facility titled, "Documentation in Medical Records," revised 07/05/17, indicated the policy was in place "To assure that residents' medical records are documented in an accurate manner and maintained by the facility ..." Review of the undated facility policy titled "Documentation Guidelines" showed: "Procedure: . . . 6. By the end of each scheduled shift, CNA's will document their shift duties and observations on the ADL Flow Sheets established for each resident. 7. Flow Sheets will be filled out using the accepted abbreviations as written on the form. Numbers will be used where needed. 8. Late entries to the Activity of Daily Living form	F 842		

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F 842	Continued From page 33 (ADL Flow Sheet) can only be made within 48 hours of care given. . . ." 5. Review of R65's clinical record revealed: 5/14/21 - R65 is admitted to the facility with multiple diagnoses including a stroke with hemiparesis (weakness or paralysis on one side of the body). 10/21/21 - A Physician's order was written for R65 to receive range of motion activity to both shoulders, elbows, wrists, hands knees and ankles twice a day, every day and evening shift. 10/11/23 - A review of R65's CNA task list in the facility Electronic Medical Record (Emr) revealed the task to perform range of motion activity to both shoulders, elbows, wrists, hands knees and ankles twice a day every day and evening shift. The Range of motion task was not documented as done on the day shift on the following days: 10/2/23, 10/3/23, 10/4/23, 10/6/23, 10/7/23, 10/8/23 and 10/10/23. 10/11/23 1:20 PM - During an interview, CNA6 confirmed that that the CNA range of motion documentation was not present for the day shifts on the following days: 10/2/23, 10/3/23, 10/4/23, 10/6/23, 10/7/23, 10/8/23 and 10/10/23. 10/11/23 1:30 PM - During an interview, RN3 confirmed that that the CNA range of motion documentation was not present for the day shifts on the days: 10/2/23, 10/3/23, 10/4/23, 10/6/23, 10/7/23, 10/8/23 and 10/10/23. RN3 stated that he looked in the EMR to possibly find a reason that the documentation was not done, such a	F 842		

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F 842	Continued From page 34 resident refusal perhaps, but that there was no reason for the lack of documentation that he saw documented. 10/12/23 8:00 PM - The findings were reviewed with the ED and DON.	F 842		
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar	F 847		12/13/23

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F 847	Continued From page 35 days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview, review of facility admission paperwork, and facility policy review, the facility failed to ensure that Residents and/or Resident Representatives (RRs) who signed the "Arbitration Agreement" would be allowed 30 days to rescind their signature, and failed to ensure the "Arbitration Agreement" was fully explained. This affected 34 (Residents (R)2,R7,R9, R10, R12, R14, R15, R17, R19, R20, R24, R28, R30, R31, R37, R44, R46, R49, R58, R64, R68, R69, R70, R74, R75, R77, R78, R79, R83, R85, R92, R93, R94, and R442 of 99 residents who had signed the "Arbitration Agreement," and had the potential to affect any future residents who might sign the agreement. Findings include: Review of the facility admission paperwork that	F 847	F847 A. Residents R2, R7, R9, R10, R12, R14, R15, R17, R19, R20, R24, R28, R30, R31, R37, R44, R46, R49, R58, R64, R68, R69, R70, R74, R75, R77, R78, R79, R83, R85, R92, R93, R94 and their responsible representatives will have a new corrected binding arbitration agreement, drafted by counsel, that meets the requirements to allow thirty days for residents and/or responsible representatives to rescind their signatures The new arbitration agreement will be fully explained within the document. If they are still residents of the facility, they will receive a copy of the new binding arbitration agreement and given seven days opportunity to review and sign, or decline, the agreement. If not returned,	

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F 847	Continued From page 36 included an "Arbitration Agreement" showed: ". . .The Resident understands that (1) the Resident should seek legal counsel concerning this Agreement, (2) the Resident does not have to sign this Agreement as a precondition to the Facility providing services to the Resident, and (3) this Agreement may be rescinded by written notice sent to the other party via Certified Mail, return receipt requested, within twenty-one (21) days of the date upon which it is signed. Rescission or waiver of this Agreement can only be affected in writing. If this Agreement is not rescinded within twenty-one (21) days of the date upon which it is signed, it is binding upon the parties in all matters regarding care and services provided to the Resident by the Facility, regardless of subsequent discharges and readmissions. . . ." Review of a list of residents provided by the Director of Nursing (DON) revealed 34 residents (R2, R7, R9, R10, R12, R14, R15, R17, R19, R20, R24, R28, R30, R31, R37, R44, R46, R49, R58, R64, R68, R69, R70, R74, R75, R77, R78, R79, R83, R85, R92, R93, R94, and R442) of the 99 residents had signed an "Arbitration Agreement." During an interview with the Director of Admissions (DA) on 10/12/23 at 12:27 PM regarding the "Arbitration Agreement," the DA stated she explains to the residents, if they have a claim against the facility, we don't go and you don't go, it's the lawyers that go, and then I give bits and pieces of the agreement and that it could be revoked in 21 days. The DA further revealed she didn't always read the agreement to the residents. She said if they had questions she encouraged them to call, and we would go over	F 847	the issue will be considered resolved/declined and closed. Upon receipt, the new agreement will replace the old, incorrect one. B. A new binding arbitration agreement will be drafted by counsel that meets the requirements to allow thirty days for residents and/or their responsible representatives to rescind their signatures. The new arbitration agreement will be fully explained within the document and reviewed by the admissions coordinator with the resident or resident's responsible representative at the time of admission. C. The admissions coordinator and social services will be reeducated regarding the binding arbitration agreement and its process by the Staff Development Nurse. The residents and the responsible representatives will be made aware of the agreement by the admissions coordinator upon new and readmission to the facility. The residents will be made aware of this agreement at a resident council meeting. Responsible representatives will be made aware of this new agreement and correct parameters by the NHA. D. The admissions coordinator will audit and report each admission's compliance weekly to the QAPI Committee for three months until substantial compliance (85-100%) is achieved. Noncompliance will be reported to and reviewed by the NHA for follow up.	

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	085001	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENTMERE REHABILITATION AND HEALTHCARE CENTER	1900 LOVERING AVENUE WILMINGTON, DE 19806

(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 847	Continued From page 37 anything. I do tell them they're giving up the right to trial and that it's optional to sign and not to sign if they didn't understand. During an interview with the Administrator on 10/12/23 at 2:40 PM he confirmed the agreement only allowed 21 days to rescind and said he was aware it was wrong. "Review of the undated facility policy titled "Binding Arbitration Agreements" showed: "Policy Explanation and Compliance Guidelines: 1. When explaining the arbitration agreement, the facility shall: a. Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, this facility. b. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure the resident or his or her representative acknowledges that he or she understands the agreement. . . ."	F 847		
F 848 SS=E	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident	F 848		12/13/23

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F 848	Continued From page 38 resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on interview, review of the "Arbitration Agreement," and facility policy review, the facility failed to ensure that the "Arbitration Agreement" presented to Residents (Rs) and Resident Representatives (RR) during admission included a clause that a mutually convenient venue for the Arbitration would be selected. This had the potential to affect the 34 residents (R2, R7,R9, R10, R12, R14, R15, R17, R19, R20, R24, R28, R30, R31, R37, R44, R46, R49, R58, R64, R68, R69, R70, R74, R75, R77, R78, R79, R83, R85, R92, R93, R94, and R442) of 99 residents who had signed the "Arbitration Agreement" and any future resident who might the agreement. Findings include: Review of the facility provided "Arbitration Agreement" showed: ". . .Notice that the Resident or the Facility wishes to arbitrate a dispute ("Notice") shall be provided to the other party in writing setting forth the basis of the dispute, including relevant dates, the alleged harm, and the requested relief, via Certified Mail, return receipt requested. The parties shall, within three (3) weeks of receipt of the Notice, mutually agree on an arbitrator or, if the parties cannot so agree, shall each select an arbitrator, and the selected arbitrators shall agree on a third arbitrator. All arbitrators must be a retired state or federal court judge or a member	F 848	F848 A. A new, corrected arbitration agreement will be drafted by counsel and provided to the following residents: R2, R7, R9, R10, R12, R14, R15, R17, R19, R20, R24, R28, R30, R31, R37, R44, R46, R49, R58, R64, R68, R69, R70, R74, R75, R77, R78, R79, R83, R85, R92, R93, R94 and their responsible representatives (if they are still in the facility). The new corrected arbitration agreement will allow the provision of a mutually agreeable venue for arbitration. B. A new binding arbitration agreement will be drafted that meets the requirements to allow a mutually agreeable venue. The new corrected arbitration agreement will be fully explained within the document and reviewed by the admissions coordinator with the residents and/or responsible representative upon admission or readmission. Any resolutions of a dispute through arbitration will have a copy of the signed agreement for binding arbitration and the arbitrator's final decision that will be retained by the facility for 5 years after the resolution of the dispute. C. The admissions coordinator and	

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F 848	Continued From page 39 of the state bar with at least ten (10) years of experience as an attorney. The parties shall request from the arbitrator(s) an estimate of the arbitrator(s)' proposed fees and expenses, and arbitration shall proceed, in accordance with the rules and conditions for the arbitration process established by the arbitrator(s), only upon the parties' acceptance of the estimate. The decision of the arbitrator(s) shall be final and binding. Judgment may be entered upon the decision of the arbitrator(s) in any court of competent jurisdiction. The arbitrator(s)' fees and expenses shall be paid directly to the arbitrator(s), and shall be paid equally by the parties, except to the extent the arbitrator(s) may award fees in accordance with applicable law. . . ." Nothing in the agreement addressed a mutually convenient venue for arbitration. Review of a list of residents provided by the Director of Nursing (DON) revealed 34 residents (R2, R7, R9, R10, R12, R14, R15, R17, R19, R20, R24, R28, R30, R31, R37, R44, R46, R49, R58, R64, R68, R69, R70, R74, R75, R77, R78, R79, R83, R85, R92, R93, R94, and R442) of the 99 residents had signed an "Arbitration Agreement." During an interview on 10/12/23 with the Administrator at 2:40 PM regarding the mutually convenient venue inclusion confirmed he was aware this was missing in the "Arbitration Agreement." Review of the undated facility policy titled "Binding Arbitration Agreements" showed: "Policy Explanation and Compliance Guidelines: . . .2. The agreement must: a. Provide for the selection of a neutral arbitrator	F 848	social services designee will be educated regarding the binding arbitration agreement and its process by the Staff Development Nurse or designee. The residents and the responsible representative will be made aware of the agreement by the Admissions Coordinator upon new and readmission to the facility. The affected responsible representatives will be made aware by the NHA if still in the facility. The residents will be made aware by the NHA at resident council. D. The admissions coordinator will report each admission's compliance weekly to the QAPI Committee and must audit and report until substantial compliance (85-100%) is achieved for three months.	

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F 848	Continued From page 40 agreed upon by both parties. b. Provide for selection of a venue that is convenient to both parties. . . ."	F 848		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) 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 documentation review and staff interview, the facility failed to ensure each Certified Nursing Aide (CNA) received at least 12 hours of in-service training per year. This involved three CNA5, CNA7, and CNA8 of five CNAs education records reviewed. Findings include: On 10/11/23 at 4:32 PM the training records of	F 947	F947 A. The facility was unable to correct this deficiency for employees CNA 5, CNA 7 and CNA 8. These employees will have a minimum of 12 hours of training annually going forward. B. CNA files will be reviewed monthly by the Staff Development Nurse to ensure 12 hours of education are afforded annually	12/13/23

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F 947	Continued From page 41 five certified nursing assistants (CNA) were reviewed with the Staff Development Coordinator (SD). Review of the training records revealed the following: 1.CNA4 had a hire date of 12/16/20. Review of her untitled list of training dated 12/16/21 through 12/16/22 revealed she received 10 hours of in-service training. The SD Coordinator verified CNA7 had not received 12 hours of in-service training in the last year of her employment. 2. CNA5 had a hire date of 12/15/21. Review of her untitled list of training dated 12/15/21 to 12/15/22 revealed she received four hours of in-service training. The SD Coordinator verified CNA5 had not received 12 hours of in-service training in the last year of her employment. 3. CNA8 had a hire date of 02/05/20. Review of her untitled list of training dated 02/05/22 to 02/05/23 revealed she received 11.3 hours of in-service training. The SD Coordinator verified CNA8 had not received 12 hours of in-service training in the last year of her employment.	F 947	to CNA staff. Employees CNA 4, CNA 5, CNA 7, and CNA8 will be scheduled for annual training as per schedule. Policy and procedure for CNA education will be reviewed by the Staff Development Nurse and revised as needed. C. A root cause analysis was completed by the interdisciplinary team and found that staff turnover in the staff development director position cause required in servicing to not follow required program necessary to attain all in-service hours. Additionally, not all in-services had documentation of the length (number of minutes/hours) of the in-services that were provided. HR Consultant, Nursing management team and CNA□s will be educated by Staff Development Nurse on number of hours (12) required annually for each CNA. Staff Development Nurse will maintain education records to ensure staff has required number of hours of education as well as required topics. D. A report of staff education compliance will be made to QAPI Committee by administrator/designee monthly for 3 months for review and recommendations. Reports will continue monthly until substantially compliant (85-100%) Non-compliance will be reported to and reviewed by NHA for follow up.	