DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 25, 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, Complaint, Emergency Preparedness and Extended Survey was conducted at this facility from August 16, 2023 through September 25, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 154. The sample totaled 76 residents. Abbreviations/Definitions used in this report are as follows: DON – Director of Nursing; NHA – Nursing Home Administrator; LPN – Licensed Practical Nurse; PTA – Physical Therapy Assistant; RCD – Regional Clinical Director; RN – Registered Nurse; and UM – Unit Manager.		
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**	Cross Refer to the CMS 2567-L survey completed 9/25/23: E037, F577, F578, F585, F600, F607, F609, F610, F623, F641, F644, F645, F655, F656, F657, F677, F679, F684, F689, F690, F692, F695, F697, F698, F710, F725, F726, F730, F732, F756, F758, F760, F761, F773, F803, F804, F812, F835, F842,	11/30/2023

Rebecca White, NHA

Provider's Signature ___Rebecca White______________Title__NHA______________Date _10/19/2023_____

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center DATE SURVEY COMPLETED: September 25, 2023

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	Delaware. Subpart B of Part 483 is hereby referred to, 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 9/25/23: E037, F577, F578, F585, F600, F607, F609, F610, F623, F641, F644, F645, F655, F656, F657, F677, F679, F684, F689, F690, F692, F695, F697, F698, F710, F725, F726, F730, F732, F756, F758, F760, F761, F773, F803, F804, F812, F835, F842, F843, F849, F867, F868, F880, F887, F943, F944.	F843, F849, F867, F868, F880, F887, F943, F944.	
3201.5.0 **3201.5.5.1**	**Personnel/Administrative** **-Results of tuberculosis screening.** **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 eight (8) out of 16 employees reviewed, the facility's personnel records lacked evidence of tuberculosis (infectious lung disease) screening results. 8/29/23 at 12:30 PM – Review of facility documentation provided to the Surveyor revealed the employees below lacked evidence of 2-step tuberculosis screening. No further information was provided to the Survey Team. -E3 (Interim DON); -E33 (Agency LPN);	**Results of Tuberculosis Screening** A. E3, E33, E38, E40, E83, E84, E85, and E86 will be administered a two-step tuberculosis test. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. A 100% audit of all employee files will be conducted by the Human Resources Director/Staff Development Coordinator to ensure two-step tuberculosis tests are completed. C. A root cause analysis identified the facility did not have a process in place while in absence of a human resources director to ensure all new hires had a	11/30/2023

Rebecca White, NHA

Provider's Signature Rebecca White Title NHA Date 10/19/2023

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: September 25, 2023**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	-E38 (Dietician); -E40 (RN); -E83 (Housekeeping); -E84 (Dietary); -E85 (PTA); and -E86 (Agency LPN). 9/8/23 at 12:30 PM – Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON).	completed two-step tuberculosis test. The Administrator will reeducate the Human Resources Director and Staff Development Coordinator on ensuring a process is in place for tracking/monitoring the two-step tuberculosis testing for all employees and contract staff. D. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Human Resources Director/Staff Development Coordinator will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 11/30/2023	
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.** **These requirements were not met as evidenced by:** Based on interview and review of facility	**Criminal Background, /Mandatory Drug Testing/Adult Abuse Registry** A.E1, E3, E4, E40, E33, E38, E83, E84	11/30/2023

Rebecca White, NHA

Provider's Signature ___Rebecca White_______________Title__NHA________________Date _10/19/2023_____

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	documentation provided to the surveyor, it was determined that for seven (7) out of 16 employees reviewed, the facility's personnel records lacked evidence of criminal background checks, mandatory drug testing and adult abuse registry checks. Findings include: 8/29/23 at 12:30 PM – Review of facility documentation provided to the Surveyor revealed the employees below lacked evidence of criminal background check, pre-employment drug test and the adult abuse registry check. No further information was provided to the Survey Team. -E1 (NHA): no drug test; -E3 (Interim DON): no criminal background check, drug test and adult abuse registry check; -E4 (RN/UM): no drug test; -E33 (Agency LPN): no criminal background check, drug test and adult abuse registry check; -E38 (Dietician): no criminal background check, drug test and adult abuse registry check; -E83 (Housekeeping): no criminal background check, drug test and adult abuse registry check; -E84 (Dietary): no criminal background and adult abuse registry checks. 9/8/23 at 12:30 PM – Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON).	and E85 will all have criminal background, drug testing, and adult abuse registry conducted. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. A 100% audit of employee/contract files will be conducted by the Human Resources Director/Designee to ensure all employees/contract staff have a criminal background check, drug test with attestation signature, and adult abuse registry completed. C.A root cause analysis identified the facility did not have a process in place while in the absence of a human resources director to ensure all new hires/contract staff had completed these requirements. The Administrator will re-educate the Human Resources Director on compliance with the regulatory requirements. The facility will have a process put in place to ensure if in the absence of a Human Resources Director, the facility will have a backup person(s) to complete this process. D. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files for compliance weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits	

Rebecca White, NHA

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		conducted by the Human Resources Director/Staff Development Coordinator will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 11/30/2023	
3201.9.0	Records and Reports		
3201.9.5	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.**		
3201.9.6	**All incident reports whether or not re-quired to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection.** **9.7 Incident reports which shall be retained in facility files are as follows:** **9.7.1 All reportable incidents as detailed**		

Rebecca White, NHA

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	below. **9.7.2 Falls without injury and falls with minor injuries that do not require transfer to an acute care facility or neurological reassessment of the resident...** **9.8.4 Significant injuries.** **9.8.4.2 Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** **These requirements were not met as evidenced by:** Based on record review and interview it was determined that for one (R32) out of 14 residents reviewed for accident hazards the facility failed ensure that an incident report was completed with adequate documentation including a list of other parties involved. Additionally, the facility failed to ensure that an incident report was retained in the facility for R32's 2/26/23 fall. Findings include: R32 experienced an unwitnessed fall on 1/16/23. Review of the investigation and incident reports revealed the CNA assigned to R32 at time of fall was not identified in the investigation/incident report paperwork. 2/26/23 - R32 experienced an unwitnessed fall that resulted in transfer to the hospital for assessment of injury. There was no facility investigation or incident report available for review.	**Records and Reports** A. R32 still resides in the facility. The resident was not adversely affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. Administrator/DON will audit incident reports within the last 30 days to ensure adequate documentation is completed, in addition to a list of other parties involved. C. A root cause analysis identified the facility failed to ensure that an incident report was completed with adequate documentation including a list of other parties involved for R32, and the facility failed to ensure that the incident report was retained for R32's 2/26/23 fall. The RDCS will	11/30/2023

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	During an interview on 8/29/23 at 1:25 PM, E2 (RCD) confirmed that the incident report for R32's 1/16/23 fall lacked identification of potential witness and any corresponding statements. E2 also confirmed that the facility was unable to provide evidence of an incident report and investigation related to R32's fall on 2/26/23.	reeducate the Administrator and DON on the state regulatory requirements for records and reports. D. The DON/Designee will audit all open records and reports for compliance weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the DON/Designee will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 11/30/2023	
3201.9.8	**Reportable incidents are as follows:**		
3201.9.8.9	**Utility interruption lasting more than eight hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephones.** **This requirement is not met as evidenced by:** Based on observations, interviews and review of documentation as indicated and review of the Division of Health Care Quality's (DHCQ) incident report system, it was determined that the facility failed to notify the State Agency of the air conditioning (A/C) not working properly in certain areas of the building. Findings include: 7/8/23 at 8:51 PM – In an email between E1	**Reportable Incidents** A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. A/C unit was restored within the facility and operational. The Administrator/Maintenance Director will do a 100% audit of the facility for	11/30/2023

Rebecca White, NHA

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	(NHA) and an outside A/C contractor, E1 requested "3 portable A/C... units for one nurse's station and two hallways." Review of the contractor's documentation revealed the air conditioning contractor provided services on 7/14/23, 7/27/23 and 8/15/23. 8/16/23 at 4:15 PM - Observation by two surveyors in the new unit medication storage room (Medbridge) revealed an ambient air temperature of 83.5 degrees F by E24 (Maintenance Director). During an interview, E24 stated that an AC contractor was out last week regarding ongoing issues with the air conditioner. The Surveyor asked for repair documentation regarding the facility's air conditioner. Interviews with residents on second floor revealed: 8/17/23 at 9:35 AM – "Too hot here". 8/17/23 at 8:43 AM – "...it's been too hot... started since the temps outside has been rising...". 8/17/23 at 4:47 PM – An observation with E5 (UM/LPN) of the second-floor oxygen room revealed that the room was hot and humid. E5 immediately acknowledged the Surveyor's observation. 8/17/23 at 4:51 PM – Observation on the second floor revealed a contractor setting up three additional portable air conditioning units.	any utility interruption lasting more than eight hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephones. C.A root cause analysis identified the facility failed to notify the State Agency of the air conditioning (A/C) not working properly in certain areas of the building due to knowledge deficit of reporting requirement timeline. The RDCS will reeducate the Administrator on the reportable incident requirements for this regulation. D. The Administrator/Designee will audit the facility grounds for any utility interruption lasting more than 8 hours for compliance weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the DON/Designee will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E Date of completion: 11/30/2023	

Rebecca White, NHA

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	8/17/23 at approximately 5:00 PM – During an interview, E1 (NHA) was asked if the air conditioning was reported to the State Agency as required. E1 stated that she would report it today. 8/17/23 at 8:49 PM – According to the DHCQ's incident reporting system, E1 (NHA) reported "The facility is experiencing an outage of air conditioning on the second floor of the building. Portable A/C units are in place." 8/31/23 at 4:30 PM - Finding was reviewed with E1 (NHA) and E3 (Interim DON).		
16 Del. C. Chapter 11 Subchapter IV § 1146	**Health and Safety** **Regulatory Provisions Concerning Public Health** **Long-Term Care Facilities and Services** **Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act.** **Mandatory drug screening.** **(b) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(d) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.**		

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(3) Opiates. **(4) Phencyclidine ("PCP").** **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department under regulations promulgated under this section.** **(f) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **This requirement was not met as evidenced by:** Based on review of the facility documentation, it was determined that four (4) out of four in-house drug screenings reviewed during the personnel audit, the facility failed to ensure that the pre-employment mandatory drug testing that was being performed onsite by facility staff included testing of Marijuana/cannabis and Phencyclidine ("PCP"). Findings include: The facility's Initial Drug Screen Result Forms lacked evidence for testing of Marijuana/cannabis and PCP: -E4 (RN/UM) on 5/25/23; -E84 (Dietary) on 7/7/23; -E85 (PTA) on 7/27/23; and -E40 (RN) on 5/22/23. In addition, E40's Form lacked evidence of the designated facility staff person's signature and date attesting to the following "I hereby certify that I collected the	**Criminal Background, /Mandatory Drug Testing/Adult Abuse Registry** A. E1, E3, E4, E40, E33, E38, E83, E84 and E85 will all have criminal background, drug testing, and adult abuse registry conducted. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. A 100% audit of employee/contract files will be conducted by the Human Resources Director/Designee to ensure all employees/contract staff have a criminal background check, drug test with attestation signature, and adult abuse registry completed. C. A root cause analysis identified the facility did not have a process in place	11/30/2023

Rebecca White, NHA

Provider's Signature ___Rebecca White_____________ Title__NHA_____________ Date _10/19/2023_____

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center DATE SURVEY COMPLETED: September 25, 2023

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	specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color are acceptable."	while in the absence of a human resources director to ensure all new hires/contract staff had completed these requirements. The Administrator will re-educate the Human Resources Director on compliance with the regulatory requirements. The facility will have a process put in place to ensure if in the absence of a Human Resources Director, the facility will have a backup person(s) to complete this process. D. The Human Resources Director/Designee will audit 10 existing and 3 newly hired employee files for compliance weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Human Resources Director/Staff Development Coordinator will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 11/30/2023	
Chapter 11	**Long-Term Care Facilities and Services**		
Subchapter VII	**Minimum Staffing Levels for Residential Health Facilities**		

Provider's Signature ___Rebecca White______________Title__NHA______________Date _10/19/2023_____

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
§ 1162	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **This requirement is not met as evidenced by:** Based on review of facility documentation, it was determined that on the three days reviewed, the facility failed to provide a staffing level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of the Facility Staffing Worksheets, completed and signed by E1 (NHA) revealed the following: 4/15/23 – PPD = 3.05 4/16/23 – PPD = 2.90 7/31/23 – PPD = 3.24 The facility failed to maintain the minimum PPD staffing requirement of 3.28. 9/8/23 at 12:30 PM – Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON). **(j) All residential health facilities licensed for 100 beds or more shall have, at a minimum, the following supervisory and administrative nursing staff, in addition to the personnel listed in subsections (b) through (i) of this section: a full-time assistant director of nursing**		

Rebecca White, NHA

Provider's Signature ___Rebecca White______________Title__NHA_______________Date _10/19/2023_____

NAME OF FACILITY: Pike Creek Nursing & Rehabilitation Center **DATE SURVEY COMPLETED:** September 25, 2023

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	who is an advanced practice nurse or a registered nurse and a full-time equivalent director of in-service education who is an advanced practice nurse or a registered nurse.	**Minimum Staffing Levels**	
	This requirement is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to have both a full-time assistant director of nursing (ADON) and full-time director of in-service education (staff development). Findings include: According to the State of Delaware's Division of Health Care Quality records, the facility is licensed for 177 certified beds. 8/24/23 at 1:04 PM – The Surveyor requested in writing the names of all Assistant Director of Nursing (ADON) and Director of In-Service Education with their start/end dates of working in the facility for Year of 2023. 8/29/23 at 10:46 AM – In an email response, E1 (NHA) provided the following information: -E77 was the last Assistant Director of Nursing. E77's last day in the facility was 6/20/23. -E53 was the last Director of In-Service Education. E53's last day in the facility was 3/20/23. The facility failed to have a full-time ADON in the facility from 6/20/23 to 8/30/23. In addition, the facility failed to have a full-time Director of In-Service Education from 3/20/23 through 8/31/23. 8/31/23 at 4:30 PM - Findings were reviewed	A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. At the beginning of each week the DON/Designee will review the next 7 days with the staffing scheduler in the daily staffing meeting to ensure the nursing staffing hours meet the minimum of 3.28 daily. C.A root cause analysis identified the facility failed to maintain the minimum PPD nurse staffing requirement of 3.28 on 4/15/2023, 4/16/2023, and 7/31/2023 due to facility not conducting daily staffing meeting review to ensure adherence to minimum staffing level. The Administrator will educate the DON and Staffing Scheduler on the importance of meeting the minimum daily staffing requirements and conducting daily staffing meetings. D. The DON/Designee will audit all the 7-day nurse staffing schedule for compliance weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the DON/Designee will be submitted	11/30/2023

Rebecca White, NHA

Provider's Signature ___Rebecca White______________Title__NHA_______________Date _10/19/2023_____

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	with E1 (NHA) and E3 (Interim DON). 9/8/23 at 12:30 PM – Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (Interim DON).	to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 11/30/2023	

Provider's Signature ___Rebecca White______________ Title__NHA_______________ Date _10/19/2023_____

Rebecca White, NHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

(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 from from August 16, 2023 through September 8, 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 154.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and	E 037		11/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/19/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING ______ B. WING ______	C 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(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 037	Continued From page 1 procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 2	E 037		

procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency

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E 037	Continued From page 3 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected	E 037		

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E 037	Continued From page 4 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that for five (E40, E66, E87, E88 and E89) out of five employees sampled the facility failed to provide emergency preparedness training at least annually. Findings include: The facility was provided a list of fives names selected randomly and instructed to provide documentation of in-service training for emergency preparedness training for new and existing staff. 9/20/23 1:29 PM - An email communicated to E1 (NHA) requested emergency preparedness training records for E40 (RN), E66 (LPN), E87	E 037	E037- EP Training Program A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. E40, E66, E87, E88, E89 will have emergency preparedness training by 11/30/23 C. A root cause analysis identified the facility failed to train new and existing employees in emergency preparedness due to a training system not being implemented. A facility-wide training on emergency preparedness policies and procedures will be completed, and to include, individuals providing services	

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E 037	Continued From page 5 (LPN), E88 (CNA) and E89 (SS). 9/25/23 10:36 AM - A second email communicated to E1 (NHA) requested emergency preparedness training records for E40, E66, E87, E88 and E89. 9/25/23 11:39 AM - An email communication from E1 stated, "we do the training verbally." 9/25/23 11:43 AM - An email sent to E1 requested, "an outline of emergency preparedness trainings that had been done verbally." 9/25/23 11:45 AM - E1 communicated and confirmed in another email "I do not have them." 9/25/23 12:45 PM - Review of a training schedule titled 'Relias Learning Module Assignments"dated 2023 MFA documented ...Monthly descriptive training modules from 1/1/2023 through 12/31/2023. 9/25/23 1:05 PM - In a brief interview E1 said, "the company changed hands around February 1, 2023, and moving forward Relias module assignments will be started and scheduled. In addition, E1 revealed, "Relias modules had not started because of timing and change in ownership." The facility failed to provide purposeful training requirements for all staff providing direct and indirect care and services for the residents. 9/25/23 3:15 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	E 037	under arrangement, and volunteers consistent with their expected role. The training will be conducted by the Administrator/Designee. The Administrator will re-educate the Human Resources Director and Staff Development Nurse on ensuring all new employees and existing employees receive Emergency Preparedness training upon hire and annually. D. The Human Resources Director/designee will audit newly hired staff for compliance weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion : 11/30/2023	

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F 000	Continued From page 6	F 000		
F 000	INITIAL COMMENTS	F 000		

An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from August 16, 2023 through September 9, 2023. An Extended Survey was conducted September 20, 2023 through September 25, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 154. The sample totaled 76 residents.

Abbreviations/definitions used in this report are as follows:

Advance Directive - a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor;
Agitation - emotional state of restlessness;
AIMS (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications;
Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness;
Bipolar Disorder - mood disorder with periods of sadness and excitement;
Blood pressure - the measure of the force of the blood against the walls of a blood vessel;
Brachial - term relating to the arm;
Deciliter - a metric unit of capacity, equal to one

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F 000	Continued From page 7 tenth of a liter; DVT (Deep Vein Thrombosis) - blood clot in the body; CNA - Certified Nursing Assistant; COPD - Chronic Obstructive Pulmonary Disease - a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing; DON - Director of Nursing; Diuretics - medicines that help reduce the amount of water/excess fluid in the body; Edema - retention of fluid into the tissue resulting in swelling; EMR - Electronic Medical Record; Family Member - FM; Heart Failure - (congestive heart failure - CHF) inability of heart muscle to pump blood. Leads to fluid accumulation in the lungs, which make breathing difficult and causes swelling of the legs, feet, liver, and other internal organs Hemoglobin (Hgb) - protein in red blood cells to carry oxygen from lungs to the body; Hospice - service that provides care to residents that are terminally ill; HVAC - heating ventilation and air conditioning; Hypotensive - abnormally low blood pressure; Intravenous (IV) - within the veins OR administration of medications/fluids through a tube directly into a vein; LPN - Licensed Practicle Nurse; Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause. Medication Administration Record (MAR) - list of	F 000		

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F 000	Continued From page 8 daily medications to be administered; mg (milligrams) -unit of weight, 1 mg equals 0.0035 ounce; mL (milliliters) -unit of liquid volume, 5 ml equals 1 teaspoon; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; Midodrine is used to treat low blood pressure in patients who have symptoms like dizziness when going from a sitting to a standing position; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties PASSR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; PEG tube (Percutaneous Endoscopic Gastrostomy) - a tube is passed into the stomach through the abdominal wall, often used to provide feeding when oral intake is not adequate; PICC (Peripherally Inserted Central Catheter) - special catheter in the vein that can be used for a longer period of time; Prostate - gland surrounding the neck of the bladder in a male; RCD- Regional Clinical Director; RUE - Right Upper Extremity (Right Arm); Schizoaffective disorder - mental disorder with	F 000		

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F 000	Continued From page 9 hallucinations or delusions along with a mood disorder such as mania or depression SLP - Speech Language Pathologist; UM - Unit Manager; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0-7: Severe impairment	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F 577		11/30/23

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F 577	Continued From page 10 information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the State survey results were available for residents to read. Findings include: The facility bulletin board located in the front lobby to the right of the entrance door indicated that the results of the State survey would be located in a binder in the lobby. On 9/5/23 at 9:39 AM during an inspection of the facility binder for State survey results, the binder contained survey results from the 5/12/22 annual survey; the facility's 10/28/21 and 4/13/23 complaint survey results were not located in survey binder. During an interview on 9/5/23 at 10:24 AM, E1 (NHA) confirmed the finding. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 577	F577- Right to Survey Results A. No residents were affected by the deficient practice. The survey results for the 4/13/2023 were in the survey binder at the time the surveyor reviewed the binder, but placed under the 2022-year tab. B. All residents have the potential to be affected by the deficient practice. A 3-year survey audit was completed and was placed in the survey binder. C. The 10/28/2021 complaint survey has been placed in the survey binder. A root cause analysis revealed a knowledge deficit on of the requirement to ensure all survey results for the last 3 years were in the survey binder. The Administrator and administrative staff will be educated by the RDCS to ensure that the defined timeframe of survey results is available. The administrator will have a receptionist on a weekly basis review the survey binder to ensure that the surveys are within the defined timeframe. D. The Administrator/business office staff will audit the survey binder for compliance weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		11/30/23

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F 578	Continued From page 12 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for four (R132, R513, R26 and R124) out of twelve residents reviewed for advance directives, the facility failed to ensure residents were offered the choice to formulate an advance directive for R26, R124 and R132. For R513, the facility failed to ensure that her advanced directive was up to date and accurately filed in the clinical record. Findings include: 1. Review of R132's clinical records revealed: 6/21/23 - R132 was readmitted to the facility. 8/18/23 - Review of R132's record revealed that R132 was cognitively intact. Further review of the record revealed a lack of information related to R132's advance directives status. 8/21/23 12:19 PM - In an interview, R132 stated that he did not have an advance directive. R132 also stated that he can not remember receiving information nor meeting with the Ombudsman to discuss his advance directives options. 8/23/23 3:56 PM - Review of the facility Discharge Planning Admission Assessment, dated 6/28/23, documented that R132 did not have an advanced directive and was not offered information about initiating Advanced Directive document. 8/24/23 9:25 AM - In an interview, E25 (SS) stated that, "... When resident's don't have an advance directive, I will ask them if they are	F 578	F578- Request/Refuse/Discontinue Treatment A. 1. R132 and R513 no longer reside at the facility. 2. R124 and R26 were not adversely affected by this practice. The social worker/designee met with R124 and the resident wishes to complete an advance directive at this time. The social worker contacted the ombudsman to schedule the completion. The social worker met with R26 and presented the ability to have an advance directive. R26 refused to complete an advance directive at this time but was educated to contact social worker if changes his mind. B. All residents have the potential to be affected by this practice. The Social Service department will complete a 100% audit of all residents to ensure an advanced directive is present. If an advance directive is not present, the social service department will provide the resident and/or responsible party with the centers policies governing the implementation of self-determination of rights and provide the opportunity to participate in formulating an advance directive. If they request an advance directive the social work will discuss the options for completion of advance direction and the Ombudsman will be contacted to assist with completion of the	

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F 578	Continued From page 13 interested to have one. If they are interested, I will contact the Ombudsman for assitance in formulating and going over the advance directives process." E25 further confirmed that, "The resident (R132) did not seem to be interested so I did not contact the Ombudsman." 2. Review of R513's clinical records revealed: 8/5/23 - R513 was admitted to the facility. 8/18/23 - Review of R513's record revealed a lack of information related to R513's advance directives status. 8/21/23 11:26 AM - In an interview, R513 stated that she cannot remember if she was asked about her advanced directive. 8/23/23 2:00 PM - Review of the facility Discharge Planning Admission Assessment, dated 8/7/23, documented that R513 had an advanced directive but that the document was not filed in her clinical records. 8/24/23 9:27 AM - During an interview, E25 confirmed that resident (R513) had an advanced directive, but the facility was not able to obtain a copy and update her clinical records on file. 3. Review of R26's clinical record revealed: 6/29/23 - R26 was admitted to the facility with a diagnosis of right fifth toe amputation and a right foot infection, vascular dementia, and bipolar disorder. 8/22/23 11:00 AM - Review of R26's clinical record lacked information for an advanced	F 578	advance directive. C. Root cause was conducted, and results identified the admission department failed to provide a copy of the centers policies governing the implementation of self-determination of rights and the social worker failed to identify missing advance directives and failed to offer the resident an opportunity to create an advance directive. The advance directive process will be initiated/implemented upon admission. Confirmation of Advance directive will be confirmed upon admission and if present, advance directive will be validated with resident/responsible party and providers orders and care plan updated to accurately match directive. If an advance directive is not present, the social service department will provide the resident and/or responsible party with the centers policies governing the implementation of self-determination of rights and provide the opportunity to participate in formulating an advance directive. If they request an advance directive the social work will discuss the options for completion of advance direction and the Ombudsman will be contacted to assist with completion of the advance. During quarterly care plan meetings, the social worker will review the residents advance directive status (in place, does not have one, etc) and determine if they wish to continue with the same advance directive status. Any changes in status will be addressed accordingly (contacting Ombudsman, documenting wish to	

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Continued From page 14
directive.

8/22/23 11:44 AM - During an interview R26 said, "they didn't talk to me about anything, and no one talked to me about what my wishes were."

8/22/23 12:15 PM - Review of R26's Discharge Planning Admission Assessment, dated 7/12/23, documented that R26 does not have an advanced directive. Additionally, the reviewed documentation lacked evidence that an advanced directive had been offered and or that R26 did not want an advanced directive.

8/22/23 12:59 PM - In an interview E25 (SS) stated that, "if a resident had an advanced directive, it would be scanned into the resident's electronic medical record under miscellaneous." In addition, E25 stated, "if the resident doesn't want an advanced directive, I just let it go."

8/22/23 2:13 PM - E25's social services note documented ..."Offered advanced directive information to R26 and gave R26 Ombudsman contact, R26 declined advanced directive option at this time."

8/24/23 9:40 AM - During an interview E25 stated, "Yes, moving forward I will make sure I put in a note that I have offered the resident an advanced directive, if they are interested, I will contact the Ombudsman for assistance in describing the process."

4. Review of R124's clinical record revealed:

6/13/23 - R124 was readmitted to the facility with a diagnosis of right-side paralysis, weakness, and stroke.

F 578

continue without an advance directive, etc). The residents order and care plan will accurately reflect/match the advance directive if present. The administrator/DON will educate the admission and social worker department on providing the resident or POA, if not able, the centers policies governing the implementation of self-determination of rights upon admission and the opportunity to participate in formulating an advanced directive. Any advance directives created will be placed in the medical record. The facility will have an Ombudsman provide education to facility staff on 12/7/23 on advance directives and the advance directive process.
D. The Social Service Department will audit newly admitted residents for evidence of offering the resident to participate in formulating an advance directive and advance directive paperwork in chart (if applicable) weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X months 4 until 100%. The NHA will audit care plan conferences held to verify advance directives were addressed and documented weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100% and then monthly x 4 months until 100%. Results will be brought to QAPI for review and further recommendations. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months.

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Continued From page 15

E. Date of completion: 11/30/2023

7/12/23 4:44 PM - Review of R124's Discharge Planning Admission Assessment dated 7/12/23 documented that R124 had an advanced directive.

8/17/23 3:11 PM - Review of R124's clinical record revealed the lack a copy of the advanced directive.

8/18/23 10:00 AM - During an interview R124 said, "my home was condemned, and I didn't have a copy to give them." In addition, R124 stated, "they didn't ask me if I wanted one, they didn't ask me anything when I was admitted."

8/22/23 12:59 PM - During an interview E25 (SS) revealed, R124 had an advanced directive but R124 did not have a copy of it."

8/22/23 2:00 PM - In another interview E25 revealed, "I spoke with R124 and offered assistance with getting an advanced directive and I informed R124 I would contact the Ombudsman to assist with the process."

8/22/23 3:41 PM - Record review of R124's social services note documented... "Spoke with R124 about getting a copy of the advanced directive R124 had, R124 informed social worker my house was condemned and gone. In addition, E25's note documented... "Offered advanced directive information, R124 interested Ombudsman notified."

8/24/23 9:40 AM - During an interview E25 stated, "Yes, moving forward I will make sure I put in a note that I have offered the resident an advanced directive, if they are interested, I will contact the

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F 578	Continued From page 16 Ombudsman for assistance in articulating the process." 9/8/23 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 578		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		11/30/23

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F 585	Continued From page 17 facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions	F 585		

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F 585	Continued From page 18 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to implement a grievance policy and postings that included a process for residents and families to file anonymous grievances and to identify the grievance official. Findings include: The facility policy on grievances last updated 1/23/20 indicated, "The patient has the right to file grievances/complaints (orally, in writing or anonymously)... The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process." 9/5/23 10:17 AM -10:24 AM - The facility nurses stations on both the first and second floor, the	F 585	F585- Grievances A. No residents were affected by the practice. Grievance mailboxes will be placed at ADA level with proper signage and filing instructions on each nursing unit. B. All residents have the potential to be affected by the deficient practice. Facility audit conducted to confirm all nursing units had anonymous grievance boxes and signage displayed. C. A root cause analysis identified the facility failed to have a process in place to ensure signs were in place for filing grievances and timely/documentation of grievance resolution. The Social Services	

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F 585	Continued From page 19 second floor resident lounge and activity room were observed for signs that informed residents/families of grievance official and process for filing grievances anonymously, none were found. 9/5/23 10:29 AM - 10:34 AM - E1(NHA) accompanied the surveyor on a tour of the aforementioned locations and confirmed the absence of signs informing residents and families of the grievance process and grievance official as well as directions on how to file an anonymous grievance. E1 also acknowledged the absence of a folder/mailbox for anonymous grievances to be placed. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 585	Department will audit grievance signage/mailbox placement monthly and will review grievance resolution weekly with the Administrator. The Administrator/Social service department will review all grievances weekly for completion by the assigned department head. Grievances with outstanding resolutions will be completed by the Social Services Department with direct oversight by the Administrator. The Administrator will educate the Social Services Department on ensuring that residents and family members have the ability to file grievances and that signs are posted instructing how and where to file a grievance(s). The Social Services Department will educate the residents at the facility resident council meeting to inform them on the location of the anonymous grievance box locations, how to file a grievance, and who the grievance officer is. In addition, grievances will be responded to timely and documented for evidence. D. The Social Services Department will audit postings/mailboxes of the grievance instructions to ensure signs outlining the process on filing grievances and timely/documentation of grievance resolution compliance weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months.	

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F 585	Continued From page 20	F 585	E. Date of completion: 11/30/2023	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R162) out of 15 residents reviewed for abuse, the facility failed to ensure R162 was free from verbal abuse and physical abuse when a nurse called R162 a dumbass and pulled a gown over his head. Findings include: Policies and Procedures Abuse/Neglect/Misappropriation/Crime Prevention/Screening/Training (effective date 1/23/20): "The Administrator promotes the prevention of abuse (including verbal, sexual, mental, physical, corporal punishment, involuntary seclusion, or abuse facilitate or enable through the use of technology) and...	F 600	F600- Free from Abuse and Neglect A. R162 no longer resides at the facility. E75 no longer employed at the facility and was reported to the licensing board and local police department. B. All residents who were in E75 assignment were interviewed/assessed to ensure there was no evidence of abuse and neglect. The administrator/designee will interview all residents who were assigned to E75 to ensure that they had not been abused by identified staff member. If any resident verbalizes abuse the facility will initiate abuse reporting procedure. Any resident who cannot verbalize abuse will have a nursing head	11/30/23

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F 600 (summary statement of deficiencies)

Continued From page 21

6/13/23 - Most recent admission to the facility.

7/23/23 5:30 AM - A progress note documented that R162 was found on the floor.

7/23/23 5:42 PM - An allegation of physical and verbal abuse reported to the State Agency documented at approximately 6:00 AM, R162 was verbal and physically abused. R162 stated "The nurse that took care of me last night physically abused me." This was reported over 11 hours later.

7/24/23 - A facility provided investigation with statements from E32 and E34 (Former CNA's) that documented that R162 was verbally abused by E75 (Former RN). E75 called R162 a "dumbass and to get up off the floor" it was further revealed that when R162 was being resistant to treatment E75 pulled R162's gown over his head. The facility investigation did substantiate the verbal abuse and E75 was terminated from the facility.

8/31/23 11:33 AM - During an interview with E34 (Former CNA) it was confirmed that on that early morning between 6:00 AM and 6:30 AM of 7/23/23 it was witnessed E75 calling R162 a dumbass and pulled R162's gown over his head.

8/31/23 11:53 AM - During an interview with E32 (Former CNA) it was confirmed that on that early morning between 6:00 AM and 6:30 AM of 7/23/23 it was witnessed E75 calling R162 a dumbass and E75 pulled R162's gown over his head.

The facility failed to ensure R162 was free from

F 600 (provider's plan of correction)

to toe assessment completed by the UM or corporate regional nurse in the facility to ensure no sign/symptoms of abuse have occurred.
C. Root cause analysis completed, results identified that staff failed to identify and protect abuse/neglect and failed to report it immediately to their supervisor per facility policy and regulations. If any staff member in any department witnesses abuse or neglect they are to immediately protect the resident from harm by separating the perpetrator from the resident and then they are required to report it to their supervisor immediately. Facility staff in all departments including the Administrator and department heads will be educated by the Regional Director of Clinical Services/SDC on the facility□s abuse policy including the types of abuse/neglect, examples of each type of abuse/neglect, upon witnessing abuse/neglect to immediately protect the resident from harm by separating the perpetrator from the resident, the reporting structure on who to report suspected allegations to and that they must report suspected abuse/neglect immediately to their supervisor. The supervisors will be educated to report any reported abuse/neglect allegations immediately to the DON/NHA. The NHA will be educated by the corporate clinical nurse on ensuring reporting is completed for any abuse/neglect allegations within the required timeframe to the Division of Health Care Quality, local police department (if applicable), responsible party. and provider. Abuse/Neglect

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F 600	Continued From page 22 verbal and physical abuse. 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 600	training will occur during new hire orientation and at least annually thereafter and prn as needed. Corporate regional nurses will be supporting the unit manager on both the first floor and the second floor. These regional nurses will conduct rounds on the units at least 3 times weekly to speak with residents/observe for any signs/symptoms of abuse/neglect. D. Administrator/Social Services Director will interview 5 residents, and those resident unable to be interviewed will be assessed, to identify if any abuse and/or neglect has occurred/reported weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. In addition, 5 employees in various departments will be interviewed on the facility's policy for abuse and neglect weekly x 4 weeks, then every 2 weeks x1 month, then monthly x4 months until 100%. The results will be brought to QAPI for review and further recommendations. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		11/30/23

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§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,

§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.

§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.

§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.

§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview it was determined that the facility policy for abuse failed to include written procedures that ensure that all residents are protected from physical and psychosocial harm during and after the investigation. Findings include:

The facility policy on abuse last updated 1/23/20 indicated, "Any and all suspected or witnessed incidents of patient abuse, neglect, theft and or

F607- Develop/Implement Abuse/Neglect Policies

A. No residents were affected by the deficient practice. The facility developed and implemented a policy that indicates how the facility will protect residents from physical and psychosocial harm during and after investigations. The facility will ensure protection of the resident, such as and not limited to protection from staff,

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F 607	Continued From page 24 exploitation or any reasonable suspicion of a crime against a patient brought to the attention of the centers administration result in an internal investigation, appropriate and timely report to the state survey agency and other legally designated agencies as well as staff corrective action." During an interview on 8/29/23 at 11:00 AM, E1 (NHA) confirmed the policy did not specify actions taken to protect residents from further abuse during investigations. E1 then stated, "It is our process to remove any accused from the building." 9/8/23 at 11:30 AM - Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON).	F 607	other residents, families or other outside personnel if identified as accused, during and after investigations. If staff is the accused perpetrator they will be suspended until the investigation is completed. Depending on the outcome of the investigation additional steps will be taken including mandatory education prior to returning to work, reassignment and/or termination. If another resident is the accused perpetrator, interventions will be either relocated or have frequent monitoring (I.e., every 30-minute check, every 15-minute check, one to one). If a family member or outside visitor is the accused perpetrator, they will have their visiting rights suspended until after the investigation is completed. B. All residents have the potential to be affected by the deficient practice. A review of the abuse policy and procedure was conducted by the facility and revised to address how the facility will protect all residents from physical and psychosocial harm during and after an investigation. The revision included removing the staff person accused from the facility by suspension until the investigation is completed and a determination is made to return the individual back to work with a corrective action and/or termination of employment. If another resident is the accused perpetrator, interventions will be either relocated or have frequent monitoring (I.e., every 30-minute check, every 15-minute check, one to one). If a family member or outside visitor is the accused perpetrator, they will have their visiting rights suspended until after the	

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F 607	Continued From page 25	F 607	investigation is completed. C. A root cause analysis determined the facility□s policy did not include specific verbiage on how the center was going to ensure all residents are protected from physical and psychosocial harm during an investigation, by removing the accused if identified during and after investigations. Facility staff will be educated by the Regional Director of Clinical Services/SDC will on the facility□s revised policy on how to protect residents from physical and psychosocial harm by removing the accused if identified, during and after investigations. Identified staff will be addressed via corrective action, suspension, and/or termination if applicable. If another resident is the accused perpetrator, interventions will be either relocated or have frequent monitoring (I.e., every 30-minute check, every 15-minute check, one to one). If a family member or outside visitor is the accused perpetrator, they will have their visiting rights suspended until after the investigation is completed. D. The Administrator/DON will audit investigations to ensure the resident(s) are protected from physical and psychosocial harm by removing the accused if identified during and after investigations weekly x 4 weeks until 100%, then every 2 weeks x one month or until 100% then monthly x 4months until 100%. All audits conducted by the Administrator/DON will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. All audits will be submitted to the QAA	

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F 607	Continued From page 26	F 607	committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		11/30/23

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F 609

Continued From page 27

This REQUIREMENT is not met as evidenced by:

Based on interview and record review it was determined that for one (R162) out of 15 reviewed for abuse the facility failed to report an allegation of abuse within the required time frames. Findings include:

Policies and Procedures Abuse/Neglect/Misappropriation/Crime Prevention/Screening/Training (effective date 1/23/20):...All employees receive training in orientation and are routinely in-serviced regarding the definitions of abuse, neglect, and misappropriation of property and... their responsibility to immediately report any cases of suspected or witnessed abuse or neglect.

6/13/23 - Most recent admission to the facility.

7/23/23 6:12 AM - A progress note documented that R162 was alert and responsive no acute distress noted. R162 was found on the floor "no visible injuries noted upon assessment. [R162] refused vitals and not compliant with assessment. [R162] state (sic) that I rolled over on the floor because no one came to change me, so I want to go to the hospital."

7/23/23 5:42 PM - An allegation of abuse and neglect was reported to the State Agency documented at approximately 6:00 AM this morning R162 alleged allegations of abuse and neglect were reported. R162 stated "The nurse that took care of me last night physically abused me." This was reported over 11 hours later.

7/24/23 - A facility provided investigation with statements from E32 and E34 (Former CNA's)

F 609

F609- Reporting of Alleged Violations

A. R162 no longer resides at the facility. E32, E34, and E75 no longer work at the facility and was reported to appropriate organizations.

B. All residents have the potential to be affected by the deficient practice. The administrator/designee will review witness statements for grievances and incident reports to ensure proper and timely reporting occurred within the past 30 days to determine if any abuse/neglect allegations occurred and were not reported. Any identified incidents that require reporting will be reported and investigated by the NHA.

C. Root cause analysis completed, results identified that staff failed to identify abuse/neglect and failed to report it per requirements. If any staff member in any department witnesses abuse or neglect they are to immediately protect the resident from harm by separating the perpetrator from the resident and then they are required to report it to their supervisor immediately. Facility staff in all departments including the Administrator and department heads will be educated by the Regional Director of Clinical Services/SDC on the facility□s abuse policy including the types of abuse/neglect, examples of each type of abuse/neglect, that upon witnessing abuse/neglect to immediately protect the resident from harm by separating the perpetrator from the resident, the reporting structure on who to report

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F 609	Continued From page 28 that documented that R162 was verbally abused by E75 (Former RN). E75 called R162 a "dumbass and to get up off the floor" it was further revealed that when R162 was being resistant to treatment E75 pulled R162's gown over his head. The facility investigation did substantiate the verbal abuse and E75 was terminated from the facility. The witnesses failed to report the incident when the abuse happened. 8/31/23 11:33 AM - During an interview with E34 (Former CNA) it was confirmed that on that early morning between 6:00 AM and 6:30 AM of 7/23/23 it was witnessed E75 calling R162 a dumbass and pulled R162's gown over his head. 8/31/23 11:53 AM - During an interview with E32 (Former CNA) it was confirmed that on that early morning between 6:00 AM and 6:30 AM of 7/23/23 it was witnessed E75 calling R162 a dumbass and E75 pulled R162's gown over his head. The facility failed to report the allegation of abuse . 9/8/23 at 11:30 AM - Findings were reviewed during the E1 (NHA), E2 (RCD) and E3 (DON).	F 609	suspected allegations to (a supervisor) and that they must report suspected abuse/neglect immediately to their supervisor. The supervisors will be educated to report any reported abuse/neglect allegations immediately to the DON/NHA. The NHA will be educated by the corporate clinical nurse on ensuring reporting is completed for any abuse/neglect allegations within the required timeframe to the Division of Health Care Quality, local police department (if applicable), responsible party. and provider. Abuse/Neglect training will occur during new hire orientation and at least annually thereafter and prn as needed. Corporate regional nurses will be supporting the unit manager on both the first floor and the second floor. These regional nurses will conduct rounds on the units at least 3 times weekly to speak with residents/observe for any signs/symptoms of abuse/neglect. D. The Administrator/DON will audit abuse/neglect allegations for compliance weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. In addition, 5 employees in various departments will be interviewed on the facility's policy for abuse and neglect weekly x 4 weeks, then every 2 weeks x1 month, then monthly x4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4	

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F 609	Continued From page 29	F 609	months. E. Date of completion: 11/30/2023	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation as indicated, it was determined that for one (R170) out of fifteen residents reviewed for abuse, the facility failed to investigate, prevent, and/or correct alleged abuse violations. For R170, the facility failed to maintain documentation that appropriate corrective action was taken as a result of R170's alleged violation of abuse. Findings include: 1. Review of R170's clinical record revealed:	F 610	F610-Investigate/Prevent/Correct/Alleged Violation A. R170 no longer resides at the facility. The allegation of abuse was unsubstantiated. E15 is still employed at the facility and was re-educated by the NHA on 8/29/2023. Education was filed in employee's employment record. B. All residents have the potential to be affected by the deficient practice. Audit of	11/30/23

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F 610

Continued From page 30

4/14/23 - R170 was admitted to the facility.

7/12/23 - The facility reported an allegation of abuse made by R170 to the State Agency and began their investigation. E15 (CNA) suspended.

During the facility's investigation, a statement was taken from R170. R170 stated, "Around 2 AM this morning I asked to be changed. She [E15], came in to change me. She flipped me on one side and flipped me to the other. When she flipped me to the left side it hurt because she flipped me hard."

7/13/23 - The facility's incident follow-up determined, "[R170] was noted to have a new open area on the sacrum and incontinent associated with dermatitis. Nystatin powder ordered to bilateral groin ...Due to the resident's comorbidities and skin condition in the groin area caused discomfort during care ...The accusation of physical abuse had been determined to be unsubstantiated. The CNA [E15] received education on abuse and returned to work."

7/18/23 - E15 returned to work at the facility.

8/25 /23 12:42 PM - During review of facility documentation, it was revealed that the facility's documentation related to the investigation was missing evidence of completed abuse education completed by E15, the alleged perpetrator of abuse.

8/29/23 6: 00 AM - The facility provided education on, "Resident Abuse/Neglect/Resident Rights," to E15.

8/29/30 7:56 AM - During email correspondence

F 610

the past 30-day allegations of abuse/neglect that resulted in any necessary employee corrective actions will be completed and verification made that corrective/educative action documentation was completed and filed in the employee file. Any identified missing documentation will be corrected.

C. A root cause analysis determined the facility failed to maintain documentation related to corrective/educative action in alleged abuse case(s). When completing an investigation and corrective action is determined to be warranted the NHA and/or DON are to determine the appropriate education based on the investigation results and situation. Education is to be presented to the staff member and a copy immediately placed in the investigation file and in the staff member's file. To prevent recurrence of this deficient practice the RDCS will educate the Administrator, DON and department heads on maintaining documentation related to corrective/educative action given to employees in the employees file.

D. The Administrator/DON will monitor open incidents of allegations of abuse, neglect, mistreatment, and exploitation incident reports for compliance to ensure necessary corrective actions are filed in employees□ employment record weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will

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F 610	Continued From page 31 with E1 (NHA) she stated, " ... I was unable to locate the original... education for [E15]. The unit manager who... provided the education is no longer with the company, so I... provided education to her." The facility failed to maintain documentation that appropriate corrective/educative action was taken as a result of R170's alleged abuse violation due to lacked evidence that education on abuse was completed by E15 before the employee was allowed to return to the facility.	F 610	determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
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 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.	F 623		11/30/23

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F 623	Continued From page 32 (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: (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	F 623		

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F 623	Continued From page 33 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. §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 and interview, it was determined that for one (R178) out of six residents reviewed for transfer/hospitalization, the facility failed to provide written notice to R178's resident representative regarding the resident's hospital transfer. Findings include:	F 623	F623- Notice Requirements Before Transfer/Discharge A. R178 no longer resides in the facility. B. The DON/SDC will complete a 30-day audit to verify resident/representatives were presented with a written discharge notice upon unplanned discharge,	

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F 623	Continued From page 34 Review of R178's clinical record revealed: 10/5/22 - R178 was admitted to the facility for rehabilitation. 11/25/23 - R178 had an unplanned hospital transfer. 9/6/23 10:00 AM - Review of R178's clinical record revealed a lacked of evidence that R178 and their representative were provided with a written discharge notice. 9/6/23 10:12 AM - An interview with E2 (RDC) confirmed there was no documentation in the clinical record that showed R178's resident representative was notified in writing and was provided the transfer/discharge notification information. Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON) on 9/8/23 beginning at 11:30 AM.	F 623	including the transfer/discharge notification information. Discharge notices identified to not have been presented will be hand delivered if resident(s) continue to reside at the facility. Notices will mailed if resident(s) no longer reside at the facility to residents and/or representatives by the Social Services department. C. A root cause analysis identified the social services staff lacked training on the procedure for providing written notice of discharges and transfer/discharge notification to resident/ representatives. Social Services will be educated by the Regional Director of Clinical services/SDC on the requirement to provide written notice to residents and/or representative regarding unplanned discharge/transfer from facility. The NHA will audit all residents who had an unplanned discharge to ensure that transfer/discharge notification was presented in writing to resident and/or representative. D. The NHA will audit all resident charts for transfer/discharge notification to resident/ representatives upon unplanned discharge compliance weekly x 4 weeks until 100%, then 5 records every 2 weeks x 1 month until 100%, then 5 records monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 record review and interview, it was determined that for four (R92, R103, R160, and R256) out of 76 sampled residents the facility failed to ensure the MDS assessment accurately reflected the residents status. Findings include: 1. Cross refer F760. Review of R160's clinical record revealed: 5/21/23 - R160 was diagnosed with a deep vein thrombosis (DVT/Blood Clot) in her right arm prior to her admission to the facility. 6/16/23 10:54 PM - R160 was admitted to the facility with diagnoses that included stroke, vascular dementia and epilepsy (seizure disorder). 6/19/23 2:56 PM - A verbal order from E28 (MD) was written in the electronic medical record (EMR) for enoxaparin sodium (Lovenox- a blood thinning medication) injection solution 60 mg, inject 60 mg subcutaneously (under the skin) every 12 hours for DVT prevention. 6/27/23 10:17 AM - A review of R160's Minimum Data Set (MDS) assessment documented "no" to deep venous thrombosis (DVT) being the primary reason for admission. R160 was actively being treated for a known right	F 641	F641- Accuracy of Assessments A. 1. R160 is no longer in the facility. MDS was corrected with active diagnosis, submitted and accepted. R92 is still in the facility. MDS was corrected with active diagnosis, transmitted, and accepted. 2. R256 and R103 are no longer in the facility. B. 1. All residents newly admitted have the potential to be affected by the practice. A 30 day look back audit on newly admitted residents with admission documentation to ensure that diagnosis have been coded correctly. 2. All Non-English-speaking residents have the potential to be affected by the practice. MDS/Designee will audit all non-English speaking residents to ensure the use of appropriate language interpretation tools. C. 1. No policy changes are needed. Root cause analysis completed; results identified knowledge deficit in MDS department when coding active diagnosis by reviewing all admission documentation and ensuring coding of diagnosis are correctly. Regional MDS director will educate MDS department on accurate	11/30/23

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F 641	Continued From page 36 arm blood clot at the time the MDS Assessment was completed. 2. Review of R92's clinical record revealed: 3/31/23 - R92 was admitted to the facility with a broken right leg. 7/5/23 - R92's quarterly MDS assessment documented that R92 had a hip fracture (and not a broken leg) and did not have any surgical wounds. 8/22/23 8:06 AM - A skin and wound note documented: "The patient has a surgical wound. Presence of other specified functional implants (external fixator)." 8/22/23 9:41 AM - During an interview, E64 (MDS Coordinator) confirmed R92's 7/5/23 quarterly MDS assessment did not reflect that R92 had a broken leg and surgical wounds. 3. The following was reviewed in R103's clinical record: 5/4/23 - R103 was admitted to the facility and R103's primary language was Mandarin Chinese. The facility documented use of the telephone translation line for Mandarin language translation three (3) times. 5/10/23 - According to the Speech Language Pathology (SLP) notes, R103's Brief Interview for Mental Status (BIMS) score was 2. This score indicated that the resident had severe cognitive impairments in the areas of memory, safety, and problem solving. There was no evidence of the translation line having been used during R103's	F 641	coding of active diagnoses by reviewing documentation provided. 2. No Policy change needed. A root cause analysis results determined that there was knowledge deficit to MDS department and the provider on where to find interpreter line. The DON/ Designee will educate MDS department and providers on the interpreter line and how to access it. D. 1. Regional Director of MDS/Designee will audit newly admitted resident MDS assessment for accurate coding of active diagnoses by reviewing admission documentation weekly x 2 weeks until 100%, then every week's x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 2. Regional Director of MDS/designee will audit all charts for Non-English-Speaking patients weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 641	Continued From page 37	F 641		

SLP assessment.

5/10/23 - The 5 day MDS Indicated that R103's primary language was Mandarin.

8/21/23 at approximately 11:25 AM - Resident interview in Mandarin language revealed that R103 was able to answer basic questions such as the general times the family visits, what the breakfast was, and that the spouse passed away several years ago.

8/30/23 at approximately 10:30 AM - E1 (NHA) was interviewed about the frequency of the use of the translation line for R103, E1 indicated that R103's "wife frequently visits."

8/30/23 at approximately 11:00 AM, it was revealed that the facility used an iPhone translator application made by Apple Inc. F94 typed the assessment questions for pain in English into the translation app, which translated them into Mandarin. Resident R103 then read the questions and answered them based on the translation. The iPhone translator application is not considered a substitute for a certified Mandarin translator, as it is not as accurate and reliable.

The facility failed to conduct an accurate assessment when a proper Mandarin translator was not utilized for the assessment.

4. The following was reviewed in R256's clinical Record:

9/1/23 - R256 was admitted to facility.

9/3/23 - A progress note documents R256 only

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F 641	Continued From page 38 speaks Mandarin, and the translation line was needed or for help interpreting. 9/4/23 - SLP assessment revealed R256's BIMS was 3, which indicated severe impairment of mental status. 9/4/23 at approximately 9:45 AM - Interview with E71 (Nurse practitioner) revealed that they do not have a translator line for residents who do not speak English. 9/4/23 at approximately 9:49 AM - Interview with R256's son revealed that he had no recollection of the translation service line having been used during R256's facility admission assessment. R256's son revealed that he is not in the medical profession and does not completely understand everything the facility shares to family. 9/4/23 at approximately 10:34 AM - R256 was interviewed in Mandarin witnessed by E1, E3 (DON) and 2 surveyors. According to interview, R256 remembered the day of admission, that she had a fall on day one, and the name of the Mandarin speaking interviewer. 9/4/23 at approximately 10:36 AM - E3 was asked by surveyor if R256 appears to be a BIMS of 3, E3 replied "no". The facility failed to conduct an accurate assessment when a proper Mandarin translator was not utilized for the assessment. Findings were reviewed with E1, E2 (RCD) and E3 on 9/8/23 at 12:30 PM.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments	F 644		11/30/23

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F 644	Continued From page 39 CFR(s): 483.20(e)(1)(2) §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 and record review, it was determined that for one (R75) out of four residents reviewed for PASARR, the facility failed ensure that a referral for a PASARR (Preadmission Screening and Resident Review) screening was completed following a significant change. Findings include: Cross Refer, F758, Example # 2. a. Review of R75's clinical record revealed: 7/6/23 - R75 was admitted to the facility with diagnoses including dementia. An admission Level One PASARR dated 7/6/23	F 644	F644- Coordination of PASARR and Assessments A. R75 still resides at the facility. A new PASARR was completed correctly on 8/28/2023. B. All residents have the potential to be affected by this deficient practice. Social Worker/Designee will audit all residents to verify the PASARR is received and correct. If PASARR was not received or incorrect, it will be corrected. C. The root cause determined that the Admission Department needs to ensure that the appropriate Delaware state PASRR is obtained prior to admission and Social Service Department staff failed to	

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F 644	Continued From page 40 completed for R75 documented no mental health medications. 8/28/23 - A review of R75's physician orders revealed the following active mental health medications ordered: - 7/6/23 Seroquel 25 mg (milligrams) tablet one time a day for bipolar - 8/4/23 Seroquel 50 mg tablet at bedtime for bipolar - 8/10/23 Trazodone 50 mg tablet every 6 hours as needed for agitation 8/28/23 9:43 AM - In an email correspondence, S1 (PASARR State Authority) revealed that, "...The facility should have submitted a status change or another resident review PASARR at that time of or timely discovery that the Level 1 (Notice Date 7/6/23) was not an accurate reflection of (R75's) mental health status (receiving Seroquel since admission). They should have definitely submitted a status change when he was started on Trazodone". 8/28/23 10:16 AM - In an interview, E25 (SW) confirmed that R75 only has the 7/6/23 PASARR assessment on file. E25 stated that she will start working on a follow up PASARR review regarding R75's change in condition. Findings were reviewed with E1 (NHA), E2 (RCD) and E3 (DON) 9/8/23 beginning at 11:30 AM.	F 644	recognize an accurate reflection of a resident□s mental health status and failed to conduct a status change upon a resident□s change in condition. The NHA will educate the admission and social work staff on verifying State specific PASARR accuracy, also identifying a resident□s change in condition would trigger a status change PASARR D. The NHA/Social Service department will audit new admission/change in condition PASARR documentation weekly x 4 until 100% compliance, then every 2 weeks x 1 month until 100% compliance and then monthly x 4 months until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		11/30/23

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F 645	Continued From page 41 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under	F 645		

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F 645	Continued From page 42 paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R125 and R139) out of four residents sampled for PASARR review, the facility failed to provide evidence that a Delaware State PASARR was obtained prior to admission. Findings include: PASSR (Preadmission Screening and Resident Review) - screening of a patient for signs of serious mental illness and/or intellectual disabilities, developmental disabilities, or related conditions so if residing in a nursing home, the resident receives all necessary services for their condition.	F 645	F645- PASARR Screen for MD & ID A. R125 no longer resides at the facility. R139 still resides as the facility and a new PASARR was completed accurately on 9/10/23. B. All residents have the potential to be affected by this deficient practice. SS/Designee will audit all residents to verify a Delaware PASARR was received. If PASARR was not received it will be completed. C. It was determined that the root cause was the Admission Department and Social Services staff failed to identify that a	

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F 645	Continued From page 43	F 645		

F 645 Continued From page 43

1. 6/13/23 - R125 was admitted to the facility with multiple diagnoses including major depressive disorder.

6/13/23 - R125's physician's orders included the antidepressant mirtazapine 7.5 mg daily for depression.

A Pennsylvania State PASARR signed and dated 6/13/23 was uploaded into R125's medical records. There was no evidence that a Delaware State PASARR was obtained prior to admission.

8/21/23 9:30 AM - During an interview E25 (Social Worker) confirmed that R125 did not have a Delaware PASARR prior to admission.

2. 7/1/23 - R139 was admitted the facility with multiple diagnoses including schizoaffective disorder and bipolar disorder; R139's medications included apriprazole10 mg daily for bipolar and schizoaffective disorder.

A Maryland State PASARR in chart signed and dated 7/1/23 was uploaded to R139's chart. There was no evidence that a Delaware State PASARR was obtained prior to admission.

8/21/23 10 AM - During a phone interview, P6 (Delaware State PASARR Coordinator) stated, "All residents who are admitted to a Delaware long term care facility must have a Delaware PASARR prior to admission. Delaware does not accept PASAAR from another state."

8/22/23 10:42 PM - The absence of PASARR was confirmed with E2 (Regional Clinical Director, E4 (RN) and E25 (Social Worker.)

F 645 (Plan of Correction)

Delaware PASARR was completed prior to admission. The NHA will educate admission staff on verification of Delaware PASARR prior to admission and Social Services staff to review all new admissions to ensure that a Delaware PASRR has been completed. Those identified as needing a Delaware PASRR will have one completed
D. The Social Service staff will audit new admission PASARR documentation weekly x 4 until 100% compliance, then every 2 weeks x 1 month until 100% compliance and then monthly x 4 until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months.

E. Date of completion: 11/30/2023

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F 645	Continued From page 44 9/8/23 at 12:30 - Findings were reviewed with E1 (NHA), E2 (RCD), and E3 (DON).	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		11/30/23

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F 655	Continued From page 45 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R160 and R182) out of thirteen residents sampled for quality of care, the facility failed to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care. For R182, the facility failed to develop and implement a care plan to address her skin integrity issues upon admission. For R160 the baseline care plan did not include epilepsy including seizure prevention interventions. Findings include: 1. R182's clinical record revealed: 7/3/23 - R182 was admitted to the facility. 7/4/23 at 6:06 AM - A skin and wound note documented that R182 was admitted with an unstageable pressure ulcer on the sacrum (bone at the base of the spine) and open lesions on the left medial malleoulus (ankle bone), right shin and left forearm. R182's clinical record lacked evidence of a baseline care plan to address and treat her skin integrity issues.	F 655	F655- Baseline Care Plan A. R160 and R182 no longer reside in the facility. B. All residents have the potential to be affected by the deficient practice. The Regional Director of MDS will complete a 14 day look back of baseline care plans of all new admissions from 10/23/23 to ensure compliance. C. A root cause analysis identified the EHR program admission assessment was not configured to trigger a high-risk medical condition and/or skin integrity baseline care plan. In addition, the admission chart review was not completed to verify baseline care plan was accurate and in place. Upon admission the nurse will complete the nursing admission assessment. This assessment has been reprogrammed to develop care plans based on responses to certain questions within the assessment. If additional conditions, care or medications exist that are not captured during the nursing admission assessment they will be entered manually into the resident's care plan. Each admission will	

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F 655	Continued From page 46 8/31/23 at 12:10 PM - During a combined interview with E3 (Interim DON) and E4 (RN/UM), R182's skin integrity issues were reviewed. E3 and E4 acknowledged the lack of a baseline care plan for R182's skin integrity issues. No further information was provided to the Surveyor. 2. Cross refer F760. Review of R160's clinical record revealed: 6/16/23 10:54 PM - R160 was admitted to the facility with diagnoses that included stroke, vascular dementia and epilepsy (seizure disorder). 6/16/23 - R160's baseline care plan did not have an epilepsy and/or a seizure disorder problem with care interventions or initial goals for epilepsy management. 6/16/23 10:57 PM - R160's EMR included physician orders two oral anti-seizure medications to control the resident's seizure disorder. 9/8/23 11:30 AM - Findings were reviewed E1 (NHA), E2 (RCD) and E3 (DON).	F 655	have a new admission chart review completed by the DON/designee within 48 hours after admission. This chart review will serve as a second check to verify pertinent care is care planned appropriate. The Staff Development Coordinator/Designee will educate the nursing staff on the triggering of baseline care plans for the initial goals of the patient, current pertinent medications, dietary instructions and any services/treatments. Licensed nurses will be educated on how to develop a baseline care plan through EHR assessment and/or manual entry. D. The MDS Coordinator/Designee will audit newly admitted resident baseline care plans for compliance weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		11/30/23

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F 656	Continued From page 47 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F 656		

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F 656	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R163 and R172) out of seventy-six residents reviewed for investigations, the facility failed to develop and implement comprehensive resident centered care plans for identified care areas. Findings include: 1. Review of R163's clinical record revealed: 6/24/22 - R163 was admitted to the facility with multiple diagnosis including urinary retention. 3/5/23 - A physician's order was written for R163 to have a bladder scan every shift and to straight catheterize if more than 400 ml of urine was present in the bladder. 3/29/23 - A quarterly MDS assesment documented that R163 had a urinary catheter. 4/10/23 - An order was written for R163 to have a Foley catheter inserted for urinary retention. 4/19/23 - A care plan was developed for R163's Foley urinary catheter related to urinary retention. The care plan included interventions for Foley catheter care to be provided each shift. This care plan was developed greater than thirty days after R163's straight cath order and nine days after R163's Foley catheter order. During an interview on 9/1/23 at 10:54 AM E58 (RNAC) confirmed the finding and stated that a care plan for catheter care "Should have been initiated when the catheter was began". 2. Cross refer F684, example 1	F 656	F656- Develop/Implement Comprehensive Care Plan A. R163 and R172is no longer in the facility. B. All residents with Foley Catheters and with wound care have the potential to be affected by the practice. MDS department will audit all residents with foley catheters and wound care to ensure a comprehensive care plan has been developed to identify care needs. C. No policy changes are needed. Root cause analysis completed; results identified MDS department failed to accurately create/update care plans timely. When a resident is admitted or has a change in plan of care (new order, new diagnosis, change in treatments, etc) the care plan will be created, reviewed and/or updated to match the clinical/psychosocial need of the resident. MDS staff will be educated by the Regional Director of MDS on and timely creation/updating of care plans via the daily clinical meeting discussions, reviewing the order recap, review of the MDS CAA□s when applicable, review of the clinical dashboard in the EHR, review of the resident progress notes (24 hr. report), etc. D. MDS/Designee will audit new resident and residents with new/updated/discontinued orders, new diagnosis, or any changes to plan of care to ensure care plan has been created/updated promptly weekly x 4	

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F 656	Continued From page 49 R172's clinical record revealed: 5/10/22 - R172 was admitted to the facility with multiple diagnosis including a recent (4/2022) left foot surgical toe amputation. 5/11/22 - A physician's order was written for R172's wound care to "cleanse with NSS apply providine - iodine, ABD and secure with ACE wrap, one time a day for wound care". 5/11/22 - R172's comprehensive care plan for skin/wound included the following: -Problem: "at risk for alteration in skin integrity related to:..recent surgery Left Tarsal amputation ...". -Interventions: .... "Administer treatment per physician orders ...". 5/19/22 - The facility Admission Collection Tool revealed "left foot two toes missing, which is the big and the second toe, warm to touch surgical incision in place". 5/20/22 - Comprehensive care plan intervention: "Provide preventative skin care routinely and prn". The facility failed to identify a care plan for R172's skin/wound issues.	F 656	weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		11/30/23

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F 657	Continued From page 50 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for nine (R26, R49, R92, R110, R121, R147, R173, R182 and R509) out of seventy-six residents reviewed for comprehensive care plan timing and revision, that for R49, R92, R110 and R147, the facility failed to have the required interdisciplinary (IDT) team members at the resident's care conferences. For R26, R121, R173, R182 and R509 the facility failed to revise the care plan when a change in care needs was identified. Findings include: A facility policy and procedure titled "Care	F 657	F657- Care Plan Timing and Revision A. 1. R92, R173, R182, R26 and R509 no longer reside in the facility. R49, R110, R147, and R121 still reside in the facility and will have care conferences scheduled with the required interdisciplinary (IDT) team members in participation and care plans updated to reflect their current plan of care. B. 1. All residents have the potential to be affected by the deficient practice. Social worker/designee will conduct a	

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F 657	Continued From page 51 Planning" policy number 2602 dated 11/01/19 documented ... Procedure ... 6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment. 1. Review of R49's clinical record revealed: 3/28/23 - R49 was admitted to the facility with diabetes and kidney disease requiring dialysis. 4/14/23 - R49 attended a scheduled care plan conference. Review of the attendees at the care conference revealed that only a social worker, an occupational therapy assistant, and a registered nurse attended the care conference. The facility lacked evidence that R49's attending Physician, a CNA and a member of food and nutrition services staff attended or had input into R49's care conference. 8/22/23 4:21 PM - During an interview, E25 (Social Services) confirmed that the facility lacked evidence that the required IDT members had attended or provided input at R49's scheduled care conference. 2. Review of R92's clinical record revealed: 3/31/23 - R92 was admitted to the facility with a broken right leg. 4/17/23 - R92 attended a scheduled care plan conference. Review of the attendees at the care conference revealed that only an LPN, a dietician, a physical therapy assistant, an occupational therapy assistant and a social worker attended the care conference. The facility lacked evidence	F 657	30-day look back audit to ensure all required IDT members participated in the care conference. If the required IDT members were not present, then another care plan conference will be held with the required members. 2. A review of all residents' care plans will be completed to ensure the care plan matches the residents current clinical and psychosocial needs. Those care plans found not accurately reflecting the current clinical and psychosocial needs will be corrected. Residents receiving hospice services will have their coordination of care reviewed to ensure it matches. Any discrepancies will be corrected. C. 1. A root cause analysis identified the facility failed to ensure all required members of the IDT Team were participating in care conferences due to meeting location changes with no notification and the provider not having enough notice of the upcoming care plans. The social workers office was relocated within the facility which created a meeting space that all care plans will be held. Care plan meetings are now sent out via a calendar to all members of the IDT team that include the details of the meeting and are updated if any changes happen so all parties are aware. The social worker will send scheduled care conferences to the provider. If the provider is unable to attend in person, the social worker will contact the provider and obtain their input on the resident's plan of care prior to the meeting. This discussion will be reviewed at the care conference	

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F 657	Continued From page 52 that R92's attending physician, a registered nurse and a CNA attended or had input into R92's care conference. 8/22/23 4:21 PM - During an interview, E25 (Social Services) confirmed that the facility lacked evidence that the required IDT members had attended or provided input at R92's scheduled care conference. 3. Review of R110's clinical record revealed: 5/25/23 - R110 was admitted to the facility with cerebral palsy and an injured right ankle. 6/7/23 - Review of a facility utilized care plan conference template revealed that only R110 had signed the form. The facility lacked evidence that any of the required IDT members attended the care conference. 8/22/23 4:21 PM - During an interview, E25 (Social Services) confirmed that the facility lacked evidence that the required IDT members had attended or provided input at R110's scheduled care conference. 4. Review of R147's clinical record revealed: 7/19/23 - R147 was admitted to the facility with musculoskeletal issues. 8/1/23 - R147 attended a scheduled care plan conference. Review of the attendees at the care conference revealed that only a registered nurse, a social worker, a physical therapy assistant and an occupational therapy assistant attended the care conference. The facility lacked evidence that R147's attending physician, a CNA and a member	F 657	meeting and will be reflected in the meeting minutes. The Administrator will educate the Social Services Department in ensuring all required members participate in resident care plan conferences, putting all care plan conferences on the calendar and ensuring the provider has been notified of upcoming care plan conferences so they can schedule to attend. 2. Root cause analysis completed; results identified MDS department failed to timely review and update care plans. When a resident has a change in plan of care (new order, new diagnosis, change in treatments, etc) the care plan will be reviewed and updated to match the change in plan of care by the appropriate discipline. In daily clinical meetings the MDS staff will verify care plans were updated accurately based on the clinical report given during this meeting. MDS staff will be educated by the Regional Director of MDS on timely updating of care plans via the daily clinical meeting discussions, reviewing the order recap, review of the clinical dashboard in the EHR, review of the resident progress notes (24 hr. report), etc. MDS will attend the daily clinical meeting 5x weekly and update the care plans based on discussions and review of the EHR. D. 1. The Social Services Director/Designee will audit 5 resident care plan conferences for compliance weekly x 4 weeks until 100%, then every 4 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be	

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F 657	Continued From page 53 of food and nutrition services attended or had input in the care conference. Further review of the care conference template revealed that a staff member documented "patient refused to sign". 8/22/23 4:21 PM - During an interview, E25 (Social Services) confirmed that the facility lacked evidence that the required IDT members had attended or provided input at R147's scheduled care conference. 5. Cross refer F684, example 4 R182's clinical record revealed: 7/14/23 - A physician's order stated, "Fluid Restriction 1500 ml/day (milliliters per day)." R182's comprehensive care plan lacked evidence of the 7/14/23 physician's order for fluid restriction. 8/31/23 at 12:10 PM - During a combined interview with E3 (Interim DON) and E4 (RN/UM), finding was reviewed and acknowledged. No further information was provided to the Surveyor. 6. R121's clinical record revealed: 5/18/23 - Admitted to the facility with a history including cancer and colitis. 5/18/23 - A care plan last revised on 7/10/23 included a risk for constipation related to medication use and lack of exercise. The care plan for nutrition mentioned a diagnosis of IBS. The care plan lacked evidence of the chronic loose stools/diarrhea that R121 was experiencing frequently.	F 657	submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 2. MDS/Designee will audit care plans on residents with any changes in plan (new/updated orders, refusal of care, etc) of care and ensure care plans are accurate weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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5/19/23 - A History and Physical documented R121's stage III metastatic melanoma...inflammatory bowel disease and colitis.

6/30/23 - Admitted to hospice care.

A care plan last updated on 7/10/23 lacked evidence of a hospice diagnosis, hospice status, interventions or reflect coordination between the hospice and the nursing home.

8/28/23 - A discussion with E1 (NHA) and E2 (Corporate Nurse) the Surveyor shared that R121's care plan does not address diarrhea/loose stools or hospice care and collaboration. E1 and E2 stated they would follow up right away.

7. Review of R26's clinical record revealed:

6/29/23 - R26 was admitted to the facility with a diagnosis of a right forefoot amputation, a right foot infection, bipolar disorder, and vascular dementia.

7/25/23 - Review of R26's wound assessment report documented...1. Wound status is stable... 2. Wound edges are sutured... 3. Peri-wound is intact.

8/15/23 - Review of R26's wound assessment report documented...1. Wound status is worsening.

8/22/23 - Review of R26's wound assessment report documented...1. Wound status is worsening... 2. Wound edges unattached.

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F 657	Continued From page 55 8/23/23 1:00 PM - Review of R26's care plan for "Surgical Wound" revised 8/9/23 documented ...Resident has a surgical wound to the right foot and is at risk for infection and complications...1. The resident's surgical wound will heal through the review period without complications... 2. Treatment as ordered. 8/25/23 12:26 PM - An interview with E59 (LPN) revealed, R26 refused to allow E59 to change the dressing on 8/24/23. Further review of E59's progress note revealed the LPN had not documented R26 refused wound care. 8/30/23 11:40 AM - During a phone interview P10 (NP) stated, "R26 had refused treatment on wound rounds and P10 had documented R26's refusals." In addition, P10 said that "R26 had refused to allow other staff nurses to do the dressing changes and thought that nursing staff had documented R26's refusal of the treatment." 8/30/23 1:20 PM - A second interview with P10 revealed "R26 refused treatment to the right foot frequently." The facility failed to review and update R26's care plan for refusal of wound care. 8. The following was reviewed in R173's clinical record: 4/11/22 - R173 was admitted to the facility with dementia. 4/11/22 - R173 was care planned for alteration in musculoskeletal status with interventions including but not limited to: monitoring for risk of falls, educating the resident, family/caregivers on	F 657		

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F 657	Continued From page 56 safety measures to reduce risk of falls (9/18/22), bed in low position (4/12/22); educate resident on calling for help prior to reaching for nightstand (2/6/23); have commonly used articles within easy reach (4/12/22), educate resident on use of reacher and calling for help (2/2/23); and encourage to transfer and change positions slowly (4/12/22). 4/24/22 - Per the facility's investigation report at approximately 4:57 AM, the resident was found lying on the floor and the socks were off on the floor near R173's feet. 5/3/22 - An incident report documented that at approximately 7:50 PM, R173 was in a wheelchair with a call bell within reach wrapped around the arm rest of the wheelchair. At about 8:30 PM, the resident was heard yelling, was noted sliding down in the wheelchair and holding onto the wheelchair arm for support. R173 was repositioned in the chair by facility staff. 4/12/23 - The annual assessment MDS documented a BIMS score of 12 suggesting moderate cognitive impairment; bed mobility showed extensive assist for self-performance and one person physical assist for support; transfer showed limited assistance for self-performance and one person physical assist for support; eating with supervision for self-performance and one-person physical assist for support; and toilet use with extensive assistance for self-performance and one person physical assist for support. There was a failure to incorporate new interventions such prevent falls or slipping from the wheelchair.	F 657		

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9. Cross Refer F684, Example # 9 a & b
Review of R509's clinical records revealed:

8/10/23 - R509 was admitted to the facility with diagnoses including malnutrition (lack of sufficient nutrients in the body) and unstageable pressure ulcer of the sacrum.

8/10/23 - R509 had a physicians order for wound consult as needed, activity as tolerated and to limit sitting intervals to a maximum of two (2) hours.

a. 9/21/23 9:30 AM - Review of R509's skin and wound notes by P10 (Wound Nurse NP) from August 2023 through September 20, 2023 revealed a recommendation for " ... Preventive Measures: ...Recommend ...turning and reposition schedule per protocol for pressure prevention. Position patient side to side as tolerated ..."

9/21/23 9:45 AM - Further review of R509's records revealed a lack of evidence that R509's turning and repositioning was being monitored.

9/21/23 2:45 PM - In an interview, E59 (LPN) stated that resident (R509) had a behavior for refusing to be turned and repositioned. E59 also stated, "You have to be patient and careful with her ...Maybe come back at a later time to do her care."

9/21/23 2:50 PM - In an interview, E48 (CNA) stated that, "Resident (R509) did not want us to move her a lot because of her wound. We have to be gentle with her. Sometimes she refused to be turned and repositioned."

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9/21/23 2:55 PM - During an interview, R509 stated, "I don't want to be moved and repositioned because it's very uncomfortable."

9/21/23 3:10 PM - In an interview, E9 (LPN) confirmed and stated " ...There's no document for nursing staff to sign off to record R509's turning and repositioning compliance."

The facility failed to revise R509's person centered care plan to address an identified need when
R509 refused to be turned and repositioned for pressure ulcer care and management.

9/25/23 8:45 AM - Findings were discussed with E1 (NHA).

b. 8/14/23 - R509 was care planned for actual and potential nutritional problem with interventions including obtaining weights as ordered.

9/6/23 1:08 PM - A dietary note by E38 (RD) documented, "Resident has a hx (history) of refusing daily wts (weights) that are (sic) ordered. Will continue to monitor weights that resident complies with."

9/21/23 2:20 PM - Review of R509's Weights Summary from August 11, 2023 through September 11, 2023 revealed that out of 31 opportunities, R509's weights were obtained only 19 times.

9/21/23 3:10 PM - In an interview, E9 (LPN) confirmed and stated that from time to time resident (R509) refuses to be weighed.

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F 657	Continued From page 59 The facility failed to revise R509's person centered care plan to address an identified need when R509 refused to be weighed for nutrition and weight monitoring. 9/8/23 at 12:30 - Findings were reviewed with E1 (Nursing Home Administrator), E2 (Regional Clinical Director), and E3 (Director of Nursing). 9/25/23 8:45 AM - Additional findings were discussed with E1 (NHA).	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interview and record reviews, it was determined that for eight (R121, R92, R110, R147, R108, R113, R606, and R407) out of thirteen residents reviewed for activities of daily living (ADLs), the facility failed to ensure that residents who are unable to carry out ADLs received the necessary services to maintain good nutrition, grooming and personal hygiene. For R121 the facility failed to provide grooming; for R92, R110 and R147 the facility lacked evidence of showers being given; for R108, R113 and R606 the facility failed to provide toileting care to the dependent residents, and for R407, the facility failed to provide grooming and personal hygiene care. Findings include:	F 677	F677- ADL Care Provided for Dependent Residents A. 1. R121, R92, R110, R108, R147, R113, and R407 still at the facility, and are receiving all ADL care not able to carry out to maintain good grooming and necessary hygiene. R606 is no longer at the facility. B. All residents who are unable to carry out ADL□s have the potential to be affected by this practice. DON/UM/Supervisor will conduct daily resident observation for all residents to ensure that they are receiving the appropriate level of care, to maintain good grooming and necessary hygiene.	11/30/23

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F 677	Continued From page 60 1. 5/18/23 - Admission to the facility. 6/28/23 - A significant change MDS documented R121 as needing one person extensive assistance with grooming. A care plan last revised on 7/10/23 only mentions that R121 will maintain or improve their ADL's with interventions of PT, OT and speech. For falls the intervention is to use call bell to request assistance for ADL's. 8/17/23 11:16 AM - During an interview and observation, R121 stated that he has asked to be shaved and for a haircut. "It has not been done since I came to the facility." 8/23/23 11:12 AM - During and observation of R121 was unshaven and in a follow up interview R121 stated he would like to be shaved. The hair is long but combed. 8/23/23 1:28 PM - During an interview with E39 (CNA) revealed that providing care to a resident included shaving. E39 added the use an electric razor for shaving. 8/25/23 1:39 PM - During an interview E47 (CNA) revealed that shaving was part of providing care. Despite shaving being a part of providing grooming to a resident, R121 was not shaved. 8/29/23 in the afternoon - During a discussion with the E1 (NHA) it was revealed that R121 needed to be shaved and wanted a hair trim. 2. Review of R92' clinical record revealed:	F 677	C. No policy changes are needed. It was determined the root cause of the deficient practice was the lack of knowledge of identifying residents□ need for assistance with personal hygiene care. DON/SDC/UM/Supervisor will educate nursing staff on providing ADL care to ensure residents are receiving necessary services to maintain good grooming, necessary hygiene and to locate that information on the Kardex feature in POC and to conduct purposeful rounding by CNA□s that will include observation and speaking with residents to identify needs. Unit Managers/Supervisors will perform daily rounds to include interviews with residents/family to ensure residents are receiving necessary services to maintain good grooming and necessary hygiene. D. The DON/administrative nurse will observe and interview 10 residents receiving ADL care to ensure good grooming and necessary hygiene are maintained weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then monthly X 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of completion: 11/30/2023	

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F 677	Continued From page 61 3/21/23 - R92 was admitted to the facility with a broken right leg. 7/5/23 - A quarterly MDS assessment documented that R92 was cognitively intact, dependent and required assistance of two staff members for bathing/showers. 8/17/23 8:06 AM - During a screening interview, R92 stated that she was not receiving her showers or getting her hair washed. During the interview R92's hair appeared dirty and unkempt. Review of R92's CNA task documentation for showers revealed that the facility lacked evidence of R92 receiving her showers on Wednesday and Friday on any shift on 8/5, 8/12 and 8/19/23. 8/22/23 12:33 PM - During an interview E3 (DON) confirmed that R92 was not receiving her scheduled showers. 3. Review of R110's clinical record revealed: 5/25/23 - R110 was admitted to the facility with cerebral palsy and a laceration (cut/tear in skin) of his right ankle. 5/31/23 - The admission MDS assessment documented that R110 was cognitively intact and required extensive assistance for bathing/showers. 8/17/23 12:09 PM - During a random screening interview, R110 expressed not been getting showers. Review of R110's August 2023 CNA task documentation lacked evidence that R110 was	F 677		

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F 677	Continued From page 62 receiving showers on Wednesday and Friday on any shift on 8/1, 8/4, 8/8, 8/11, 8/15 and 8/18/23. The facility lacked evidence that R110 received any showers during the month of August other than 8/14/23. 8/24/23 11:27 AM - During an interview, E2 (Regional Clinical Director) confirmed the facility's lack of evidence of R110 receiving his showers. 4. Review of R147's clinical record revealed: 7/19/23 - R147 was admitted to the facility with a musculoskeletal issue. 7/25/23 - R147's admission MDS assessment documented that R147 was cognitively intact and required extensive assistance of one staff member for bathing/showers. 8/17/23 1:00 PM - During a random interview during screening, R147 revealed not receiving showers. Review of R147's CNA task sheet documentation revealed that R147 was supposed to have her showers on 8/2, 8/5, 8/9, 8/12, 8/16 and 8/19/23. The facility lacked evidence that R147 had received her showers in the month of August on any date (up until the date of 8/19/23). 8/24/23 11:27 AM - During an interview, E2 (Regional Clinical Director) confirmed the facility lacked evidence of R147 receiving her showers. 5. Review of R108' clinical record revealed: 7/23/23 - R108 was admitted to the facility with Parkinson's disease.	F 677		

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Review of R108's August 2023 CNA task documentation lacked evidence of facility staff providing toileting or incontinence care on the following dates and times:

day shift - 8/5, 8/13 and 8/15/23.
evening shift - 8/7, 8/8, 8/9, 8/10, 8/13 and 8/15/23.
night shift - 8/2, 8/3, 8/14, 8/15, 8/17 and 8/18/23.

8/24/23 11:27 AM - During an interview, E2 (Regional Clinical Director) confirmed the lack of evidence that R147 was toileted or provided incontinence care on the aforementioned dates and times.

6. Review of R 113's clinical record revealed:

7/8/23 - R113 was admitted to the facility with multiple diagnoses including a stroke, that resulted in loss of movement to one sided of his body.

7/14/23 - R113's admission Minimum Data Set (MDS) revealed that R113 was cognitively intact. For Activities of Daily Living, the MDS revealed that R113 needed one person assistance for toilet use and that R113's always lacked control of bowel and bladder (incontinence).

9/1/23 - A review of a 9/1/23 8:00 AM facility incident report for R113 revealed that R113 stated to facility staff that he had not had toileting care throughout the previous night (8/31/23) until 9/1/23 at 6:00 AM.

9/1/23 11:45 AM - During an interview with R113, it was confirmed that care was not provided until

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F 677	Continued From page 64 6:00 AM and R113 sat in his urine. 9/1/23 - A review of R113's bowel and bladder log from 8/1/23 thru 9/6/23 revealed that on 8/31/23, R113's last episode of care for toileting from facility staff was at 4:02 PM. R113's next episode of care for toileting was documented as being on 9/1/23 at 12:37 PM. 7. Review of R606's clinical record revealed: 8/21/23 - R606 was admitted to the facility with multiple diagnoses including heart failure and a stroke that resulted in loss of movement to one sided of his body. 9/16/23 - R606's admission Minimum Data Set (MDS) revealed that R606 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated that R606 was moderately impaired cognitively. For Activities of Daily Living, the MDS revealed that R606 needed one person assistance for toilet use and that R606's always lacked control of bowel and bladder (incontinence). 9/1/23 - A review of a 9/1/23 8:00 AM facility incident report for R606 revealed that R606 stated to facility staff that he had not had toileting care during the night (8/31/23) into 9/1/23 early morning when the next staff shift arrived for duty. 9/1/23 - A review of R606's bowel and bladder log for 8/1/23 thru 9/6/23 revealed that on 8/31/23, R606's last episode of care for incontinence/toileting care from facility staff was at 7:21 PM. R606's next episode of care for incontinence was not documented by facility staff for the rest of 8/31/23 into 9/1/23 because R606	F 677		

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was sent to the hospital on the morning of 9/1/23 for respiratory distress related to Covid 19.

8. Review of R407's clinical record revealed:

5/12/23 - R407 was admitted to the facility with diagnoses including but not limited to encephalopathy (brain disease), urinary tract infection, hemiplegia (right half of the body paralyzed) and aphasia (neurological condition affecting language.)

5/19/23 - A care plan documented that R407 required an indwelling urinary catheter (a small tube used to drain urine from the bladder) with interventions to provide catheter care every shift, check, and change briefs frequently as needed every shift. Provide oral care and supplies as needed. R407 required extensive assist of two persons for turning and repositioning in bed.

8/16/23 12:10 PM - R407 was observed in bed lying on her back wearing a hospital gown. A strong smell of urine was noted in the room and the hallway. R407's hair appeared greasy looking, and her mouth and tongue were coated with a whitish substance. The surveyor was unable to locate oral care supplies in the room.

8/16/23 2:30 PM - R407 was observed lying on her back in the same position as earlier. Her hair continued to appear hair was greasy and, there was no evidence that oral care was performed. The strong smell of urine
continued to be present in the room and hallway.

8/17/23 8:30 AM - R407 was observed lying in the bed on her back. R407's hair was greasy looking, and her mouth and tongue were coated with a

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whitish substance. There was a strong smell of urine in the room and the hallway. The surveyor was unable to locate oral care supplies in the room.

8/17/23 11:30 AM - R407 was observed lying in the in bed on her back, there was no evidence that oral care provided. The room and hallway continued to have a strong smell of urine.

8/17/23 2:30 PM - R407 continued to be observed lying on her back in the bed, her hair was still greasy, and the room and hallway continued to have a strong smell of urine.

8/18/23 8:25 AM - R407 was observed lying on her back in the bed. Her hair was greasy looking, and her mouth and tongue lacked evidence that oral care was provided. A strong smell of urine was present in the room and hallway. The surveyor was unable to locate oral care supplies in the room. A review of R407's care sheets revealed documentation of a shower on 8/17/23 at 8:07 PM by E62 (Certified Nursing Assistant.)

8/18/23 10:40 - R407 was observed lying on her back in the bed, there was no evidence that assistance with washing, dressing or oral care was provided. The strong urine smell of urine continued to be present in the room and hallway.

8/18/23 2: 30 PM - R407's lack of personal hygiene and the smell of urine in the room and hallway confirmed with E4 (RN). E4 stated, "I will (get) someone to clean her (R407) up and we will change the mattress on the bed."

The facility failed to provide the necessary services to maintain grooming, and personal and

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oral hygiene for R407.

9. A review of 411's clinical record revealed:

7/20/23 - R411 was admitted to the facility with diagnoses including but not limited to traumatic brain injury, schizophrenia (mental disorder with false beliefs, confused thinking and bizarre thoughts), C-diff (bacteria that attack the lining of the intestines causing diarrhea), and depression.

8/23/23 - R411's comprehensive MDS documented, "Incontinent of bowel and totally dependent on staff for incontinent care."

8/24/23 7:00 AM - The facility submitted an incident report to the State that documented, "R411 reported the CNA (Certified Nursing Assistant) assigned to her on 8/19/23 on the 7-3 shift did not give her any care. R411 laid in stool for three hours. CNA suspended and investigation in progress."

A review of R411's last documentation in the bowel movement records was completed at 8/19/23 6:29 AM. The 7-3 shift documentation did not have evidence that activities of daily living, bowel movements or incontinent care was provided. E67(CNA) documented, "Incontinent" of bowels at 11:30 PM and "received care".

9/1/23 - During an interview, R411 confirmed that care was not provided on 8/19//23 on the 7-3 shift, but care was provided at 3:45 PM (3-11 shift), and then later that evening. During an interview, E67 stated that R411 was provided with incontinent care at 3:45 PM, "Because she had a bowel movement when I came to check on her". A review of R411's clinical records failed to show

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F 677	Continued From page 68 evidence of a care-plan for refusal of care, or evidence that care was offered and refused. 9/1/23 12:30 PM - During a phone interview, P7 (R411's daughter) stated that her mother called her on 8/19/23 at approximately 3;30 PM, and complained that she, "laid in stool for 3 hours". 9/6/23 10:30 AM - During an interview with E69 (7-3 CNA assigned to R411 on 8/19/23), stated, "I had the resident on my assignment, but it changed after breakfast." E69 was unable to state why care was not provided or documented in R411's medical records. 9/7/23 1:30 PM: A review of the investigation completed by the facility revealed while the complaint of the lack of care occurred on the 7-3 shift, the 3-11 CNA (E67) was suspended. The facility failed to provide incontinent care which caused R411 to lay in stool for 3 hours. 9/8/23 at 12:30 - Findings were reviewed with E1 (Nursing Home Administrator), E2 (Regional Clinical Director), and E3 (Director of Nursing).	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		11/30/23

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PIKE CREEK NURSING & REHABILITATION CENTER	5651 LIMESTONE ROAD WILMINGTON, DE 19808

(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 679	Continued From page 69 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R103) out of one resident reviewed for activities the facility failed to implement resident centered activities programs that incorporates the resident's interests, hobbies, and cultural preferences. R103 was Mandarin speaking. Findings include: 5/4/23 - R103 was admitted to the facility. Date - The MDS indicated that the resident's primary language is Mandarin. 5/10/23 - According to the speech therapy notes, R103 was assessed using the BIMS, which scored a 2. This indicates that the resident has severe cognitive impairments in the areas of memory, safety, and problem solving. 5/9/23 - The careplan stated that R103 will participate in "self-directed activities such as watching the news/tv in patient language" which was Mandarin. 8/21/23 - Interview with R103's son at approximately 11:50 AM stated that the facility does not provide culturally relevant activities or tv/news in Mandarin. 8/21/23 - Observation on from 1:30 PM through 2:46 PM observed R103's TV only playing English programming. Findings were reviewed with E1 (NHA), E2 (Regional Clinical Director) and E3 (DON) on	F 679	F679- Activities Meet Interest/Needs Each Resident A. R103 no longer resides in the facility. B. All residents have the potential to be affected by the deficient practice. A 100% audit will be completed by the Activities Director/Designee on resident's plan of care to ensure that activities are resident-centered and incorporate the residents□ interests, hobbies, language needs, and cultural preferences. C. A root cause analysis identified the Activities Director did not follow the plan of care for resident-centered activities based on the resident's comprehensive assessment. The Administrator will educate the Activities Director on providing activities that are driven by the plan of care for the resident (in their preferred language) and resources available including but not limited to the language line to ensure accurate assessment of the residents' interests/hobbies. D. The Administrator/Designee will audit 5 residents to ensure activities are resident-centered that incorporates the residents□ interests, hobbies, cultural preferences, language needs, and care planned accordingly weekly x 4 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 4 months until 100%. All audits will be submitted to the QAA committee monthly. The results of	