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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care at Silver Lake **DATE SURVEY COMPLETED: December 9, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	REVISED STATE SURVEY REPORT POST IDR Held on February 7, 2023 F695 removed. **The State report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced Annual and Complaint Survey was conducted at this facility from December 2, 2022 through December 9, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 105. The survey sample totaled 49 residents. Abbreviations/definitions used in this state report are as follows: DON -Director of Nursing; NHA – Nursing Home Administrator; OT – Occupational Therapist		
3201 **3201.1.0**			
3201.1.2	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Sub-part B**	**Personnel/Administrative** 3201.50 5.5.3 5.5.4 5.5.5 5.6 1. Upon notification of employee E18 who was out of compliance with the results of her criminal background check, mandatory drug testing, and adult abuse registry check, the facility investigated this. E18's files were reviewed and her first day in the facility was 3/14/22, date	1/23/23

Provider's Signature [signature] Title NHA Date 2-24-23

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	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.	of drug screen was 1/14/20, and date adult abuse registry results received was 11/8/18. E18 was eligible for employment per her Delaware Background Check Center (BCC) eligibility letter. Complete Care at Silver Lake contacted the company E18 works for (Tender Touch Rehab Services, LLC) and requested a new background check, fingerprints, and drug screen. Tender Touch Rehab Services, LLC, confirmed that E18 was registered with a new Delaware background check (BCC) on 12/21/22 and had fingerprints and a drug screen completed on 1/9/23. E18's eligibility letter from 1/9/23 states that she is eligible for employment.	
3201.5.0		2. Current contract employees have the potential to be affected by this deficient practice. All contract services staff will be audited to ensure compliance with criminal background checks, mandatory drug testing results, and adult abuse registry checks.	
3201.5.5	This requirement is not met as evidenced by the following:	3. The Administrator or designee will educate contract services employees on Title 16 Health and Safety Delaware Administrative Code, 3105 Criminal History and Drug Testing for Nursing and Similar Facilities, as well as the Delaware BCC requirements for background checks, drug screens and registry checks.	
3201.5.5.3	Cross Refer to the CMS 2567-L survey completed 7/25/22: F561, F609, F641, F644,		
3201.5.5.4	F655, F656, F661, F677, F684, F685, F686, F688, F689, F760, F791, F803, F812, F880		
3201.5.5.5	and F943.		
	Personnel/Administrative		
	The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:		
	Results of criminal background check		
	Results of mandatory drug testing		
	Result of Adult Abuse Registry check		
	This requirement was not met as evidenced by:		
	Based on interview and review of facility documentation provided to the Surveyor, it		
3201.5.6	was determined that for one (E18) out of thirteen (13) employees reviewed, the fa-		
3201.5.6.1	cility's personnel records lacked evidence		

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3201.5.6.2	criminal background checks, mandatory drug testing an adult abuse registry check. 12/9/22 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E18's (OT's) first day working in the facility was 3/14/22 and there was lack of evidence of drug testing, adult abuse and child abuse registry check. 12/12/22 4:20 PM – During a telephone interview with E1 (NHA), the above findings were reviewed and confirmed. **Dementia Training** **Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** **The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.**	4. Administrator or designee will audit all new employee files for compliance weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
3105 **3105.9.0**	Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required training on dementia care was	**Dementia Training** 3201.5.6 5.6.1 5.6.2 1. Per the new hire therapist orientation checklist, E17 completed dementia training. E17 was educated on dementia on the first day of orientation (E17's first day in the facility), however this date was not listed on the orientation checklist. E17 was identified to be a contract services employee for Tender Touch Rehab Services, LLC and all other employees audited during this survey were found to be in compliance with required dementia training. No residents were reported to be negatively impacted by this deficient practice.	1/23/23

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3105.9.1	completed for one (E17) out of 13 randomly sampled staff members. Findings include: 7/1/22 - E17's (OT)'s first date in the facility, according to the information submitted by the facility on the Personnel Audit Form. 8/10/22 - E17's (OT's) "New Hire Therapist Orientation Checklist", which included "Dementia" training and only included one date, which was 8/10/22. 12/9/22 1:15 PM - An interview with E1 (NHA) confirmed that E17's first day in the facility was 7/1/22. E1 verbalized that the date of "8/10/22" was the date that all the items on this one page checklist was completed and was unable to provide evidence the actual date that E17 received the new employee training for dementia. Findings were reviewed with E1 (NHA) and E4 (DON) during the exit conference on 12/9/22 at 2:14 PM. **Criminal History and Drug Testing for Nursing and Similar Facilities** **Drug Tests** **The BCC provides an electronic conduit through the Delaware Health Information Network (DHIN) to transmit the results of a drug test from a DHIN participating laboratory to the employer. An employer that chooses not to engage a DHIN-participating laboratory will certify that a drug test has been secured by checking a box in**	2. Current contract services employees have the potential to be affected by this deficient practice. 3. Administrator or designee will in service contract services department managers on the required dementia training for new employees. New contract services employees will be audited for compliance with required education prior to their 1st day in the facility. 4. Administrator or designee will audit all contract services personnel files prior to their first day in the facility. Administrator or designee will audit all new contract services staff files for education compliance weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. **Drug Tests** 3105.9.0 3105.9.1 1. Upon notification of employee E18 who was out of compliance with mandatory drug testing, the facility investigated this. E18's files were reviewed, and E18's first day in the facility was 3/18/22, while her date	1/23/23

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	the BCC. If the box is checked, it constitutes a representation that a drug test which complies with statutory requirements, 11 Del.C. 1142, has been secured prior to hiring This requirement was not met as evidenced by: 12/9/22 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E18's (OT's) first day working in the facility was 3/14/22 and there was lack of evidence of drug testing. 12/12/22 4:20 PM – During a telephone Interview with E1 (NHA), the above findings were reviewed and confirmed.	of drug screen was 1/14/20. Complete Care at Silver Lake contacted the company E18 works for (Tender Touch Rehab Services, LLC) and requested a new drug screen. Tender Touch Rehab Services, LLC, confirmed that E18 had a drug screen completed on 1/9/23. 2. Current contract employees have the potential to be affected by this deficient practice. All contract services staff will be audited to ensure compliance with mandatory drug testing requirements. 3. The Administrator or designee will educate contract services employees on Title 16 Health and Safety Delaware Administrative Code, 3105 Criminal History and Drug Testing for Nursing and Similar Facilities, as well as the Delaware BCC requirements for background checks, drug screens and registry checks. 4. Administrator or designee will audit all new employee files for compliance weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	

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	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

(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 Annual and Complaint Survey was conducted at this facility from December 2, 2022 through December 9, 2022. The facility census on the first day of the survey was 105. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS REVISED SURVEY REPORT POST IDR Held on February 7, 2023 F695 removed. An unannounced Annual and Complaint Survey was conducted at this facility from December 2, 2022 through December 9, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 105. The survey sample totaled 49 residents. Abbreviations/definitions used in this report are as follows: ADA - American Diabetes Association; ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact	F 000		

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

Electronically Signed | 01/19/2023

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.

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F 000	Continued From page 1 8-12: Moderately impaired 0- 7: Severe impairment; BM - bowel movement; CE/IC - Corporate Educator/Infection Control; CNA - Certified Nurse Aide; Diaphoretic - profuse sweating; DON - Director of Nursing; Ex. or ex - example; FM - Family Member; Feeding tube - a tube inserted into the abdomen for feeding artificial nutrition and administering medications; LPN - Licensed Practical Nurse; MD - Medical Doctor; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; Nasal cannula- tube placed into nostrils to deliver oxygen; Neurological evaluation (neurocheck) - a series of simple questions and physical tests to determine if the nervous system is impaired; Mg/dl - milligrams per deciliter, a unit of measure that shows the concentration of a substance in a specific amount of fluid, such as glucose; NHA - Nursing Home Administrator; O2 - oxygen; OT - Occupational Therapy; PRN - as needed; PT - Physical Therapy; pt. or pt - patient; RCD - Regional Clinical Director; RD - Registered Dietician; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F 637		1/23/23

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F 637	Continued From page 2 §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R260) out of twenty-eight residents reviewed for comprehensive MDS (minimum data set) assessment, the facility failed to complete a comprehensive MDS assessment upon return from the hospital after being out of the facility from 9/13/22 through 11/4/22 which was longer than the thirty-day requirement and necessitates a comprehensive assessment. In addition, the facility failed to identify that R260 returned to the facility with a Foley catheter and a new feeding tube which were new care needs that would be captured in a comprehensive assessment. Findings include: A facility policy (last revised 10/2019) included: The Interdisciplinary Team must review and update the care plan: -When there has been a significant change in the resident's condition; -When the resident has been readmitted to the facility from a hospital stay.	F 637	F637 1. R260 currently resides in the facility and is stable. R260 was readmitted to facility on 11/4/2022 and comprehensive assessment was completed on 12/5/2022 upon identification. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents who were readmitted within the past 30 days were reviewed as they had the potential of being affected. All residents included in audit were not affected by deficient practice. 3. Nurse Practice Educator/designee will educate all Clinical Reimbursement Coordinator□s (CRC) on Complete Care Management Policy on Comprehensive Assessments. 4. Director of Nursing (DON) or designee	

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F 637	Continued From page 3 7/6/22 - R260 was admitted to the facility. 9/13/22 - R260 was transferred to the hospital related to poor appetite. 9/13/22 - R260's discharge MDS documented that she did not have a Foley catheter and was not receiving tube feeding. 11/4/22 - R260 returned to the facility from the hospital. 11/4/22 - A facility Physician's order included to administer tube feeding for 15 hours a day. Tube feeding was a new care need on readmission to the facility. 11/6/22 - A facility Physician's order included to Perform Foley Catheter Care every day, evening shift and as needed. Having a Foley catheter was a new care need on readmission to the facility. The facility lacked evidence that a significant change MDS assessment was completed upon readmission to the facility related to R260's hospitalization and return with significant new care needs that required a significant change MDS assessment. 12/05/22 1:08 PM - During an interview, E14 (RNAC) confirmed that R260 was out of the facility for greater than 30 days, therefore the facility failed to complete a comprehensive assessment upon return from the hospital after being out of the facility from 9/13/221 through 11/4/22. In addition, the facility failed to identify a change in status related to tube feedings and having a Foley catheter when readmitted to the	F 637	will audit all readmissions for applicability of policy within 14 days to ensure compliance is met. Audit will continue weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	

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F 637	Continued From page 4 facility. 12/9/22 - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference, beginning at 2:14 PM.	F 637		
F 657 SS=D	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- (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 review and interview, It was	F 657	F657	1/23/23

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F 657	Continued From page 5 determined that for one (R26) out of twenty-eight residents reviewed for care plan conferences, the facility lacked evidence that the required members of the interdisciplinary team (IDT) were in attendance at the post-admission care plan conference. Findings include: A facility policy (last revised 10/2019) included: "The IDT includes: a. The Attending Physician; b. A registered nurse who has responsibility for the resident; c. A nurse aide who has responsibility; d. A member of the food and nutrition services staff; e. The resident and the resident's legal representative (to the extent practicable); and f. Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident." Review of R26's clinical record revealed: 10/28/22 - R26 was admitted to the facility with pneumonia and sepsis (a potentially deadly medical condition characterized by a whole-body inflammatory state; symptoms include fever, difficulty breathing low blood pressure, fast heart rate, and mental confusion). 11/3/22 1:00 PM - A progress note regarding the post-admission care plan conference documented: "Summary of Care Plan Review: Include who attended (resident/family, etc): Writer- (E9) SS (Social Services) (E7) UM (Unit Manager) (E17) Therapy Pt. (R260) and her daughter (FM1)	F 657	1. R26 is no longer residing in the facility. R26 was discharged on 12/6/22, prior to identification of the deficient practice. R260 was not in the facility on 11/3/22 (the referenced date of the post-admission care conference) and was readmitted to the center on 11/4/22. We believe R260 to be written in error and the resident referenced to be R26. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents who resided in the facility as of 12/9/22 were reviewed as having the potential for being affected by this deficient practice. 3. Administrator or designee will educate members of interdisciplinary team on the Complete Care Management Policy on comprehensive, person-centered care plans. The Social Service Director will notify required members of the IDT of post-admission care plan conferences for each resident. The Social Services Director will ensure that all required members of the IDT, are included in the development of each post-admission care plan and that input from the physician, a member of food and nutrition services, and a certified nursing assistant (CNA) staff member with responsibility for each resident is included in the development of each post-admission care plan. 4. Administrator or designee will audit all residents with post-admission care plan meetings weekly x 4 for one month, then	

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F 657	Continued From page 6 (E16) BOM (Business Office Manager)." The facility lacked evidence that the post-admission care plan conference attendees included: Physician input, Food and Nutrition Services staff input and CNA (Certified Nursing Aide) input with responsibility for the resident. 12/9/22 - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference, beginning at 2:14 PM.	F 657	every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other documentaion as indicated, it was determined that for one (R211) out of one resident sampled for hospitalization, the facility failed to complete a comprehensive respiratory assessment, monitor, and provide respiratory interventions for a resident recognized as having an acute change in respiratory status. R211 was caused further distress when she remained without supplemental respiratory interventions (oxygen) until EMS (Emergency Medical Services) implemented interventions upon arrival at the facility. For one (R8) out of one resident	F 684	F684 (R211) 1. R211 no longer resides in the facility. E12 reported that a comprehensive respiratory assessment with appropriate interventions were implemented prior to R211□s discharge on 10/1/2022. 2. Current residents as of 12/9/2022, with an acute change in condition which required an unplanned transfer to the hospital were reviewed as having the potential to be affected by same alleged	1/23/23

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F 684	Continued From page 7 reviewed for potential for constipation, the facility failed to assess the residents for signs or symptoms of constipation and administer medications as ordered for no bowel movement (BM) after three (3) days. For one (R34) out of six residents reviewed for unnecessary medications, the facility failed to follow Physician's orders to monitor for sedation with the usage of Melatonin. Additionally, the facility failed to obtain weights as per Physician order for one (R66) out of five residents reviewed for weight loss, which led to uncertainty of when R66's weight loss began. Findings include: A facility policy "Acute Condition Changes - Clinical Protocol", adopted 11/2018 and last updated 10/2019 included: The nurse shall assess and document/report the following baseline information: - Vital signs; - Onset, duration, severity. 1. Review of R211's clinical record revealed: 7/1/21 - R211 was admitted to the facility with a history of a stroke, diabetes, difficulty swallowing, and a peg tube (feeding tube). 10/1/22- Review of the EMS (Emergency Medical Services) Patient Care Report revealed the dispatcher received a call at 3:52 PM from the facility to request an ambulance to transport a patient to the hospital. At 4:03 PM, EMS crew members arrived on scene at the facility and found R211 with a "... room air oxygen saturation of 85% (normal blood oxygen saturation is 95-100%) and a blood glucose of 484 mg/dl (ADA recommendation for someone with diabetes 80-130) upon their contact, the patient is	F 684	deficient practice. No negative resident outcomes were identified. 3. Nurse Practice Educator and/or designee will educate current licensed nursing staff on Complete Care Management Acute Condition Changes - Clinical Protocol Policy and the policy for Pulse Oximetry including but not limited to the nurse will assess and document/report baseline information and obtain pulse oximetry when clinically indicated. 4. Director of Nursing and/or designee will audit all current residents with a change in condition assessments daily x 30 days, weekly x 4 weeks, bimonthly x 4 weeks, then monthly x 3. Results of audits will be presented monthly for 6 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F684 (Other) 1. R8 currently resides in facility and is stable. From 10/1/22 through 11/21/22, R8 refused the bowel protocol on 3 different occasions. During that same time period, R8 refused to attend a scheduled appointment with a gastrointestinal physician. During that same time period, the facility assessed R8 for constipation on 10/6/22, 10/12/22, 10/25/22, 11/8/22, and 11/9/22. R34 currently resides in facility and is stable. R66 currently resides	

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F 684	Continued From page 8 unresponsive, shallowed breathing, warm to the touch" EMS placed a non-rebreather mask (enables delivery of high concentrations of oxygen) on R211. R211's response remained unchanged. 10/1/22 4:07 PM - A nurse progress note by E12 (RN) documented, "Upon start of shift rounds at approx. 3:30 PM, observed patient with rapid respirations, unresponsive and diaphoretic (profuse sweating)." R211's vital signs were as follows: blood pressure 168/77 (normal range for an adult is 120/80, 140/90 is high blood pressure); blood sugar 382 (high) temperature 98.2 Fahrenheit; pulse 144 beats per minute (normal range for an adult pulse is 60-100 beats per minute); respirations 24-28 breaths per minute (normal range for respirations [breathing] is 12-20 breaths per minute at rest). R211's clinical record lacked evidence that an oxygen saturation was obtained. The on-call E8 (NP) was notified and an order was obtained to transfer R211 to the hospital. 10/1/22 4:16 PM - A nursing progress note documented, R211 was transferred to the hospital via EMS. R211 had an abnormal heart beat was unresponsive. The facility lacked evidence of any monitoring or interventions until EMS arrived at the facility and EMS recorded a low oxygen saturation of 85% on room air. 10/1/22 (Untimed) - Hospital documentation included: "... female with complicated past medical history brought to the emergency department by EMS with altered mental status."Patient was found unresponsive at the nursing facility satting (refers to oxygen saturation) at 85% on room air." Enroute to the	F 684	in facility and is stable. R66 had one missing monthly weight in 2022. No negative resident outcomes have been reported because of these deficient practices. 2. Director of Nursing and designee conducted a clinical alert audit report to identify other residents having the potential for being affected by the deficient bowel protocol practice. Director of nursing and/or designee will conduct an audit of all residents receiving Melatonin to identify other residents having the potential for being affected by the deficient practice, and to ensure side effects are being monitored where applicable. Director of Nursing and/or designee will conduct an audit of all residents with a weight order to identify other residents having the potential for being affected by this deficient practice. 3. Nurse Practice Educator will educate all licensed nurses on the Complete Care Management Policy on Bowel Management-Clinical Protocol. Nurse Practice Educator will educate all licensed nurses on the Complete Care Management Policy on Behavioral Assessment, Intervention, and Monitoring, including but not limited to, the nursing staff and the physician will monitor for side effects and complications related to psychoactive medications. Nurse Practice Educator will educate all licensed nurse on the Complete Care Clinical Management policy on Weighing the Resident/Patient including but not limited	

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F 684	Continued From page 9 ED (Emergency Department), EMS personnel attempted to intubate (place a plastic tube into the windpipe to maintain an open airway) R211 without success. Alternately, EMS initiated bag-valve-mask breathing. Upon arrival to the ED, R211 was successfully intubated (a breathing tube was placed), placed on a ventilator (a machine that breathes for you) and was admitted to the ICU (intensive care unit). 10/3/22 - A statement composed by E12 (RN) documented "on September 30, 2022, patient's sister verbalized patient felt warm." E12 documented that R211 was in bed "lying under thick, heavy, personal blanket." 12/8/22 12:50 PM - During an interview via telephone, E12 (RN) stated on the evening of 9/30/22 during her 3:00 PM - 11:00 PM shift, she recalled R211's family member approaching the nurses station and were concerned as R211 was "warm to the touch." E12 stated that she went to assess R211 who was alert, but felt warm. E12 confirmed she did not take R211's temperature at that time and stated, "I had no urgent concern at that time." E12 stated she worked the next day on 10/1/22 on the 3:00 PM-11:00 PM shift. The off going nurse did not report any concerns for R211. E12 confirmed that her observation and assessment of R211 revealed a significant change in condition; rapid respirations and a heart rate in the 140's. E12 stated she could not recall taking an oxygen saturation, but stated that it should have been part of her assessment. She further confirmed that no respiratory interventions were initiated such as supplemental oxygen administration and R211 was "transferred out of the facility by EMS no later than 4:30 pm."	F 684	to weights will be obtained and recorded monthly or more frequently if clinical condition warrants or as ordered by the physician. 4. Director of Nursing or designee will conduct a clinical alert audit to ensure compliance with Complete Care Management Policy on Bowel Management-Clinical Protocol. Director of Nursing or designee will conduct an alert audit to ensure compliance with Complete Care Management Policy on Behavioral Assessment, Intervention, and Monitoring. Director of Nursing or designee will conduct an audit to ensure compliance with Complete Care Clinical Management policy on Weighing the Resident/Patient. These audits will be conducted weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	

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F 684	Continued From page 10 12/9/22 9:14 AM - During an interview, E13 (LPN) confirmed she was assigned to R11 on 10/1/22 7:00 PM - 3:00 PM shift. E13 did not obtain a temperature or a pulse ox. as R211 was alert and "taken her meds. and was at her baseline." 12/9/22 9:40 AM - During an interview, E26 (LPN) confirmed he was assigned to R211 on 9/30/22 11:00 PM - 7:00 AM shift and at 12:41 AM R11's vital signs were as follows: pulse 78, respirations 18, temperature 97.8, pulse ox 96% room air, (no blood pressure documented). 12/9/22 9:48 AM - During an interview, E28 (LPN) confirmed she was assigned to R11 on 9/30/22 7:00 AM - 3:00 PM shift. Documentation lacked evidence of any vital signs obtained during that shift. 12/9/22 10:41 AM - During an interview, E29 (CNA) confirmed she was assigned to R211 on 9/30/22 3:00 PM - 7:00 AM 10/1/22. E29 confirmed that R211 did feel warm but stated " it's always hot in that room because her room mate likes it hot." 12/9/22 11:03 AM - During an interview, E7 (UM) confirmed that per their facility policy following an acute change in condition, a comprehensive set of vital signs would include a pulse ox (same as oxygen saturation). Additionally, the clinical record lacked evidence that R211's pulse ox was obtained. Interviews of facility staff and review of facility documentation lacked evidence of a complete assessment of R211 on 9/30/22 on the evening shift when staff failed to complete a BP until after R211 was identified to have an acute change in	F 684		

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F 684	Continued From page 11 respiratory status and EMS arrived on 10/1/22. The facility also lacked evidence of appropriate respiratory assessments and necessary interventions including the application of oxygen from when R211 was found at approximately 3:30 PM with rapid respirations, unresponsive and diaphoretic until the arrival of EMS at 4:03 PM. 12/9/22 - Findings were reviewed with E1 (NHA) and E4 (DON) during the Exit Conference, beginning at 2:14 PM. 2. Review of R8's clinical records revealed: 7/19/21- R8 was admitted to the facility. 8/13/21 - The following Physician's orders were written for three laxative medications: - Milk of Magnesia (MOM) every 24 hours as needed for constipation to be given at bedtime if no BM in 3 days. - Dulcolax suppository every 24 hours as needed if no BM from MOM by the next shift. - Fleet Enema every 24 hours as needed if no BM Ducolax suppository within 2 hours. If no BM from Fleet enema, call MD/APP (Advanced Practice Providers) for further orders. 8/13/21 - A care plan for at risk for constipation related to decreased mobility was developed and implemented with a goal that R8 would have a normal BM every 3 days. The interventions included to follow the bowel protocol which included to monitor, document, and report signs and symptoms of constipation; monitor for change in mental status, including new onset of confusion and sleepiness; abdominal distention, vomiting, small loose stool, fecal smearing, bowel	F 684		

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F 684	Continued From page 12 sounds, abdominal tenderness, fecal impaction; and to record BM pattern each day including the amount and consistency. 10/1/22 through 12/5/22 - The Bowel Report revealed there were a total of three (3) periods of time in which R8 did not have BM for greater than 3 days (more than 9 shifts) and there was lack of evidence that the facility assessed for signs or symptoms of constipation and/or administered medications as follows: - 10/2/22 night shift through 10/6/22 evening shift for total of 15 shifts. - 11/4/22 night shift through 11/9/22 night shift total of 16 shifts. - 11/15/22 evening shift through 11/21/22 day shift for total of 17 shifts. 12/7/22 1:59 PM - An interview with E5 (ADON) was conducted and the above findings were reviewed with E5 and confirmed. 3. Review of R34's clinical record revealed the following: 9/17/22 - R34 was readmitted from the hospital to the facility with a hip fracture. 9/17/22 - R34's Significant Change MDS Assessment revealed that R34's cognition was intact. 9/17/22 - R34 had a Physician's order for Melatonin (naturally occurring hormone/dietary supplement that helps promote sleep) 3 mg tablet at bedtime for insomnia, hold for sedation and	F 684		

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F 684	Continued From page 13 notify the NP (Nurse Practitioner) if held twice. 9/20/22 - R34 was care planned for the use of Melatonin related to insomnia. Interventions included to monitor and document side effects and effectiveness every shift. 12/7/22 - Review of R34's September 2022 through November 2022 MAR (Medication Administration Record) lacked evidence that R34 was monitored for sedation. Further review of R34's MAR revealed that it was initiated on 12/6/22 that R34 had a Physician's order to monitor side effects for the use of Melatonin with targeted behaviors including sedation. 12/8/22 4:00 PM - In an interview, E6 (IP) stated that R34 went to the hospital for a right hip fracture. E6 confirmed that on readmission, E34 was still receiving Melatonin 3 mg but the Physician's order for side effect monitoring including sedation was not put in the EMR (Electronic Medical Record) until 12/6/22. 4. Review of R66's clinical record revealed the following: The facility policy titled, "Weighing the Resident/Patient", last revised 5/2021, documented, "...Weights will be recorded...Protocol...C....either monthly or more frequently...as ordered by the physician...". 2/1/22 - R66 was admitted to the facility. 2/7/22 (revised 8/15/22) - R66 had a care plan developed for potential nutritional problem related to significant weight loss, therapeutic diet and variable intake of meals with interventions,	F 684		

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F 684	Continued From page 14 including weight as per policy (2/7/22) and RD (Registered Dietitian) to evaluate and make diet changes and recommendations PRN (as needed) or when necessary (2/7/22). 3/3/22 - R66 had an active Physician's order for monthly weights. 5/10/22 - R66's quarterly MDS assessment revealed that R66 was able to eat and drink independently with set up help. R66 was receiving a diuretic medication (helps reduce the amount of water/excess fluid in the body) and had a weight of 205 lbs with no known weight loss. 5/10/22 - The facility's Nutritional Assessment, completed by E24 (RD), documented R66's weight obtained on 4/3/22 as 205.2 lbs. (pounds). E24 noted R66's nutrition evaluation as "...Stable weight since admission with meals and outside sources...rec (recommend) 75%-100% of most meals to meet needs...maintain stable weight or allow for gradual weight loss...no nutrition problem." Review of R66's weight records from April 2022 through June 2022 revealed that on 4/3/22, R66 weighed 205.2 lbs. On 6/1/22, R66 weighed 186.2 pounds which was a 9.26 % significant weight loss. There was a lack of evidence that R66's May 2022 weight was obtained. 12/8/22 10:32 AM - When asked whether R66's weight information of 205.2 lbs on 4/3/22 was the same information documented on the 5/10/22 Nutritional and MDS Assessments, E24 (RD) confirmed and stated that R66's weight was not obtained in May 2022. E24 stated that the facility was not able to determine the time frame in May	F 684		

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F 684	Continued From page 15 2022 when R66 started losing weight. 12/9/22 9:30 AM - During an interview, E4 (DON) confirmed that R66's Physician's order for monthly weights was not done in May 2022. The facility failed to follow the Physician's order to obtain R66's weight for the month of May 2022. 12/9/22 - Findings were reviewed with E1 (NHA) and E4 (DON) during the Exit Conference, beginning at 2:14 PM.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined that for one (R39) out of two residents sampled for ROM (Range of	F 688	F688 1. As of 12/22/2022, R39 no longer	1/23/23

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F 688	Continued From page 16 Motion), the facility failed to ensure appropriate treatment to prevent further decrease in range of motion was provided when R39's left elbow splint was not applied. Findings include: Review of R39's clinical record revealed the following: 11/24/19 - R39 was admitted to the facility. 7/28/22 - A Physician's Order was written to utilize a left hand splint every shift as tolerated and to remove for personal hygiene care as well as to check the skin every shift. 7/28/22 (Initial development and implementation date of 11/29/21) - R39 had a care plan for ROM with interventions for passive ROM to bilateral upper and lower extremities twice a day for 15 minutes with care and left hand and left elbow splints every shift as tolerated. 8/10/22 - The Annual ROM Assessment documented that R39 had moderate contractures of the left shoulder, elbow, and wrist. No contractures of the right shoulder, elbow, and wrist were identified. In addition, the left hip had minimal contracture, knee with severe contracture, and minimal ankle contracture. The right hip had minimal contracture, knee with severe contracture, and minimal contracture of the ankle. 11/30/22 - A Physician's Order was written to utilize a left elbow splint daily as tolerated. The splint was to be removed for skin inspection every shift, as well as during ROM and personal hygiene.	F 688	resides in the facility. Attempt made to apply the left elbow splint upon identification and R39 refused. E20 was educated by E11 regarding splint application. The order for the splint was written as tolerated. No negative resident outcome has been reported as a result of this deficient practice. 2. Director of Nursing and designee will audit orders for all current residents to identify other residents who have the potential to be affected by the same deficient practice. All current and new splint orders identified will be added to the respective residents' electronic medical record. 3. Nurse Practice Educator/NPE will educate all licensed and non-licensed nursing staff on Complete Care Management Policy on Charting and Documentation and Complete Care Management Clinical Operations Policy on Contractures, Preventative Care and Treatment. NPE will also educate licensed nursing staff to add orders to respective residents' electronic medical chart. 4. Director of Nursing or designee will audit all current residents with splint orders weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and	

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F 688	Continued From page 17 12/5/22 11:10 AM - An observation of R39 in bed revealed no splint devices to the left upper extremity (LUE) including hand or elbow. . 12/5/22 2:28 PM - R39 in bed with no splint devices on LUE. 12/5/22 2:42 PM - An interview with E21 (CNA) confirmed that R39's LUE was applied by staff of the therapy department and E21 does not apply the splint. 12/5/22 2:57 PM - The Surveyor inquired with E20 (Agency RN) if R39 was to have splint on her left upper extremities as no splint was observed by the Surveyor today, during day shift. E20 obtained a splint located on R39's night stand and proceeded to apply the splint to R39's hand and elbow, however, E20 had difficulty and left the room. 12/5/22 3:07 PM - The Surveyor observed E11 (RN) and E20 (Agency RN) in R39's room. E11 located a different splint and attempted to apply the elbow splint on R39, however, R39 refused. An interview with E20 confirmed that she was not aware that there was another splint for the elbow, thus, the elbow splint was not applied during day shift on 12/5/22. 12/5/22 3:15 PM - An interview with E19 (OT) revealed that the left elbow splint was to be applied and removed by nursing staff. 12/6/22 10:30 AM - An interview with E4 (DON) revealed that the intervention for the elbow splint application was on the Medication Administration Record and confirmed it was the responsibility of the licensed Nurse to ensure the implementation	F 688	sustainability of plan.	

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F 688	Continued From page 18 of the left elbow splint. E4 did not dispute that E20 (Agency RN) failed to apply R39's left elbow splint during the observation on 12/5/22 when E20 incorrectly attempted to apply the hand splint to R39's hand and the arm as E20 was unaware there was a separate elbow splint until E20 (Agency RN) inquired with E11 (RN). Findings were reviewed with E1 (NHA) and E4 (DON) during the exit conference on 12/9/22 at 2:14 PM.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

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F 693	Continued From page 19 Based on observation and interview, it was determined that for one (R61) out of one resident reviewed for medication administration through a feeding tube, the facility failed to correctly verify feeding tube placement prior to administering medication. Findings include: The undated facility policy for enteral (feeding tube) medication administration, indicated that in preparation for administration of medication staff "...measure the tube from point of entry into the skin to the end of the tube to determine whether the catheter has migrated (if length of tube significantly changed, do not administer medication)." Review of R61's clinical record revealed: 7/12/22- R61 was admitted to the facility. 7/12/22 - A Physician's order was written for staff to check placement and tube length in centimeters every shift. Check tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube and as needed. 7/12/22 - A care plan for tube feeding was created and last reviewed on 10/23/22. The care plan included an intervention to check the tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube and as needed. 12/8/22 10:50 AM - During an observation of medication administration through the feeding tube, E10 (RN) was observed checking for placement of R61's feeding tube by injecting air via a syringe connected to the feeding tube while	F 693	F693 1. R61 currently resides in facility and is stable. The enteral feed order for R61 included to verify feeding tube placement prior to medication administration by measuring the tube from point of entry into the skin to the end of the tube to check for migration. E10 measured the tube length at the beginning of the shift. E10 was immediately educated on how and when to measure a tube for a resident receiving enteral nutrition. The orders for R61 were written to ensure clarity of when and how tube placement must be verified. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents with enteral feeding orders have the potential to be affected. All current residents with enteral feeding orders will be reviewed and rewritten such that when and how tube placement is verified is clear. Audits of MARS/TARS will be reviewed for documentation that records tube length prior to medication administration for all residents with enteral feeding orders. 3. Nurse Practice Educator/NPE will educate all licensed nursing staff on the Complete Care Management Policy on Medication Administration: Enteral. Nurse Practice Educator/Designee will educate licensed nurses on how the orders should be written for new enteral feeding orders to ensure documentation of how and	

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COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

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F 693	Continued From page 20 listening with a stethoscope to R61's abdomen, then pulling back the plunger of the syringe to look for the presence of stomach contents. E10 (RN) stated, "That's how I usually do it", when asked by the Surveyor E10's method for checking tube placement. 12/8/22 10:56 AM - E10 (RN) reviewed R61's Physicians orders for checking placement and stated, "I already measured the length about 9 this morning. Once the length is the same it's still in place, I check it again by doing air bolus." E10 then confirmed that air bolus was not the ordered method for checking placement of R61's feeding tube prior to medication administration. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 12/9/22 at 2:14 PM.	F 693	when tube length should be measured to verify placement. 4. Director of Nursing or designee will randomly audit all current residents MARs/TARs with enteral orders weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 21 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that medications were stored and labeled properly in two out of two medication carts reviewed. Finding's include: 1. 12/9/22 11:49 AM - During a medication storage review of Station One the following was observed inside the back hall medication cart: - One opened insulin pen without an opened date- the manufacturer's instructions stated to discard 28 days after opening. - One unopened insulin pen with manufacturer's instructions to store in refrigerator until opened. 12/9/22 11:55 AM - E13 (LPN) confirmed the findings. 2. 12/9/22 11:58 AM - During a medication storage review of Station Two, an undated and opened insulin pen was observed on the top drawer medication cart. 12/9/22 11:59 AM - Findings were discussed and confirmed by E25 (LPN). 12/9/22 12:03 PM - In an interview, E6 (IP) stated	F 761	F761 1. No negative resident outcomes have been reported as a result of this deficient practice. All insulin pens that were not dated and opened were discarded and replaced by the pharmacy. All unopened insulin medications were removed from the medication carts, discarded, and replaced by the pharmacy. All unopened insulin products will be stored per package inserts. 2. All medication carts will be inspected for opened insulin medications to ensure all are dated. All medication carts will be inspected for unopened insulin medications to ensure all are being stored in accordance with package inserts. 3. Nurse Practice Educator will educate all licensed nurses on proper storage and handling of insulin medications according to Complete Care Management Policy on Administering Medication. 4. Director of Nursing or designee will conduct a medication cart inspection on	

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	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 22 that the nurse who opened the insulin pen first was supposed to date the pen and discard after 28 days. Findings were reveiwed with E1 (NHA) and E2 (DON) during the exit conference on 12/9/22 at 2:14 PM.	F 761	all medication carts weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make	F 803		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 803	Continued From page 23 personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that residents received the selected food from the menu for one (R40) out two sampled residents for food investigation. Findings include: 12/5/22 12:30 PM - During a random dining observation of R40's lunch tray, the meal ticket did not match and R40 did not receive cranberry juice and a bowl of baked beans. 12/5/22 12:35 PM - An interview with E22 (Dietary Aide) confirmed that R40 was not provided cranberry juice and a bowl of baked beans on the tray. 12/5/22 12:40 PM - The Surveyor observed E22 providing R40 a container of cranberry juice and a bowl of baked beans. Findings were reviewed with E1 (NHA) and E4 (DON) during the exit conference on 12/9/22 at 2:14 PM.	F 803	F803 1. Dietary staff member E22 immediately corrected this deficient practice by providing resident R40 with food items missing from her tray. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents have the potential of being affected by this deficient practice. 3. Food Service Director or designee will in-service dietary staff on tray ticket accuracy and selective menu choices. Food Service Director or designee will assess tray tickets for compliance by completing tray accuracy audits during tray line. 4. The Food Service Director or designee will perform 3 tray line audits weekly for one month, then 2 tray line audits weekly for one month, then 1 tray line audit weekly x 1 month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		1/23/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

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F 812	Continued From page 24 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to prevent the occurrence of mold in high moisture areas, ensure safe storage of food and beverages, and maintain the correct concentration of sanitizing solution. Findings include: - 12/2/22 - 8:44 AM - During the initial tour of the kitchen, the Surveyor observed a large area of black staining that appeared to be mold behind a pan drying rack adjacent to the three -compartment sink. - 12/2/22 - 9:35 AM - During a tour of the kitchen, the Surveyor observed three (3) red sanitizer buckets containing sanitizing solution. When E15 (Food Service Director) tested the sanitizing solution in each bucket, the test strips indicated that the level of chemical concentration in the buckets was not sufficient to provide proper	F 812	F812 1. Upon identification of a stain on the wall in the kitchen, the Food Service Director (E15) immediately performed a thorough cleaning and sanitizing of that area, ensuring no further evidence of the stain. Upon identification of low concentration of sanitizer solution, E15 immediately filled the sanitizer buckets with the proper chemical concentration of sanitizer. Upon identification of opened containers of thickened fruit juice and applesauce with no dates or labels, E15 discarded these items and ensured there were no other food/beverage items without dates or labels in the kitchen refrigerators. Upon identification of thickened juice, a wrapped peanut butter and jelly sandwich,	

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	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 25 sanitization. - 12/2/22 - 9:39 AM - During a tour of the kitchen, the Surveyor observed six (6) opened containers of thickened fruit juice labeled with the incorrect discard date and an opened jar of applesauce with no date label indicating when the product should be discarded. - 12/2/22 - 9:55 AM - During a tour of the unit nourishment area between the Dover and Rehoboth units, the Surveyor observed the refrigerator contained three (3) opened containers of thickened fruit juice with no date labels indicating when the product should be discarded. - 12/2/22 - 10:25 AM - During a tour of the nourishment area shared by the Newark and Wilmington units, the Surveyor observed the refrigerator contained a wrapped peanut butter and jelly sandwich and an opened chocolate bar with no date labels indicating when the products should be discarded. 12/2/22- 1:17 PM - E1 (NHA) and E15 (Food Service Director) confirmed all findings.	F 812	and an opened chocolate bar with no date or labels in the nourishment rooms, the Administrator (E1) discarded these items and ensured there were no other undated/labeled food or beverage items in the nourishment room refrigerators. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents have the potential to be affected. 3. The Food Service Director or Designee will ensure all walls in the kitchen are clean and free of stains on a frequent basis. The Food Service Director will monitor all food/beverage items in the kitchen for proper labeling and dating to ensure compliance. The Administrator or designee will audit the nourishment rooms to ensure proper dating and labeling of food/beverage items. The Food Service Director or designee will educate dietary staff on cleaning in the kitchen, the proper use of sanitizer buckets containing sanitizer solution, and proper dating/labeling of food/beverages according to Health Care Services Group policy. The Administrator or designee will educate nursing staff on the storage, dating, and labeling of food and beverage items within the nourishment room refrigerators per Healthcare Services Group Refrigerator/Freezer Policy. 4. Food Service Director or designee will monitor the walls in the kitchen for cleanliness, the sanitizer bucket solution	

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	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

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COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

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F 812	Continued From page 26	F 812	for proper chemical concentration, and dating/labeling of food and beverage items in the refrigerators 3x per week for one month, then 2x per week for one month, then monthly x 1 for one month until 100% compliance has been achieved. The Administrator or designee will monitor food and beverage labeling and dating within the nourishment room refrigerators 3x per week for one month, then 2x per week for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committed for further evaluation, recommendations, and sustainability of plan.	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain essential kitchen equipment in safe operating condition. Findings include: - 12/2/22 - 11:32 AM - During a tour of the kitchen, the Surveyor observed the walk in freezer in the kitchen and the walk in freezer in the dry storage room both had numerous large pieces of ice on the floor indicating that the temperature in each of the freezers was warm enough to melt existing ice particles and refreeze	F 908	F908 1. Temperature logs within the freezers were verified to be within acceptable parameters. The Food Service Director immediately removed all ice from the affected area at the entrance of the freezer units. The ice was located on the bottom left hand corner of the freezer in front of the door where no food is stored. The Food Service Director took a temperature of this specific area (left hand	1/23/23

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	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

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F 908	Continued From page 27 forming large pieces of ice. - 12/2/22 - 12:18 PM - During a tour of the kitchen, the Surveyor observed the bottom left side of the walk-in freezer door was significantly damaged, which allowed cold air to escape from the freezer and room temperature air to leak into the freezer. 12/2/22- 1:17 PM - E1 (Administrator) and E15 (Food Service Director) confirmed findings.	F 908	corner inside the freezer by the door) and the temperature read -1 degrees farenheight. The food service director and Administrator have been monitoring the temperature of this area consistently and it remains within -2 and 5 degrees farenheight. The temperatures within the freezer remain below freezing and within acceptable parameters on a daily basis, as indicated in the temperature logs. There are 3 thermometers being used: one on the outside of the freezer door, one on the back wall of the freezer, and an infrared thermometer gun being used to spot check. We added another thermometer inside the freezer on the left hand corner by the door. In addition, the maintenance team replaced and reinforced the gasket on the freezer door and placed a seal around the perimeter of the door opening to ensure a tight close. The other freezer door on the walk-in freezer within the dry storage area was inspected and there were no breaks in the seal and no cool air was felt coming out of the door. All temperature readings are within the acceptable parameters as per the daily temperature logs. No residents were reported to be negatively impacted as a result of this deficient practice. 2. Current residents have the potential of being affected. 3. The facility maintenance team has replaced and reinforced the freezer door gasket as well as placed a rubber seal around the perimeter of the opening of the freezer door to ensure a tight close. Food	

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	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

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F 908	Continued From page 28	F 908	Service Director or designee will educate dietary staff on ensuring both freezer doors are fully closed and seated correctly after each use. 4. The Food Service Director or designee will monitor freezer units 3x per week for 1 month, 2x per week for 1 month, and 1x per week for one month to ensure safe operating conditions and will report any negative findings to the administrator or designee.	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and the facility's policy, it was determined that for one (E17) out of 13 sampled staff members, the facility failed to ensure that the required training on abuse, neglect, and exploitation was	F 943	F943 1. Per the new hire therapist orientation checklist, E17 was educated on abuse, neglect, and exploitation. E17 was	1/23/23

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F 943	Continued From page 29 completed. Findings include: The facility policy on Abuse Prohibition Program, with a revision date of 3/21 revealed, "...4. Require staff training/orientation programs that include topics as abuse prevention, identification, and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior...". 7/1/22 - E17's (OT) first date in the facility according to the information submitted by the facility on the Personnel Audit Form. 8/10/22 - E17's (OT) "New Hire Therapist Orientation Checklist", which included "Abuse Prevention" only included one date, which was 8/10/22. 12/9/22 1:15 PM - An interview with E1 (NHA) confirmed that E17's first day in the facility was 7/1/22. E1 verbalized that the date of "8/10/22" was the date that all the items on this one page checklist were completed and was unable to provide evidence of the actual date that E17 received the new employee training for abuse, neglect and exploitation. Findings were reveiwed with E1 (NHA) and E4 (DON) during the exit conference on 12/9/22 at 2:14 PM.	F 943	educated on these topics on the first day of orientation, however this date was not listed on the orientation checklist. E17 was identified to be a contract services employee for Tender Touch Rehab Services, LLC and all other employees audited during this survey were found to be in compliance with required abuse, neglect, and exploitation training. No negative resident outcome was reported as a result of this deficient practice. 2. Current contract services employees have the potential to be affected by this deficient practice. 3. Administrator or designee will in service contract services department managers on the required abuse, neglect, and exploitation education for employees per federal and state regulations. New contract services employees will be audited for compliance with required education prior to or on their 1st day in the facility. 4. Administrator or designee will audit all contract services personnel files prior to their first day in the facility. Administrator or designee will audit all new contract services staff files for education compliance weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. BUILDING _____ B. WING _____	C 12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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