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: Stonegates

DATE SURVEY COMPLETED: December 5, 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 and Emergency Preparedness Survey was conducted at this facility from November 28, 2023 through December 5, 2023. An Extended Survey was also conducted at this facility on December 5, 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 34 . The sample totaled was 15 residents.	A. The incident was not reported, as the facility as the resident did not leave the premises. B. Incident reports will be audited to determine if any should be reported to the state agency. C. Reportable incidents will be reported in a timely manner. The root cause analysis for lack of reporting is the facility did not report due to resident remaining on the premises. The deficient practice and lack of understanding that the resident was outside of the facility should have been reported per regulation. This will be reviewed with the nursing supervisors and a review of the regulatory requirement will be provided as education for reportable incidents. D. All audits will be reported to the QAPI committee for 3 consecutive quarters or until 100 % compliance is achieved.	
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. 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		Jan 18, 2024

Provider's Signature Michelle Clemmis Title Administrator Date 1/18/24

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	completed December 5, 2023: F580, F635, F641, F655, F657, F689, F730. F883 and F947.		
3201.9.8	**Reportable incidents are as follows:**		
3201.9.8.3	**Resident elopement under the following circumstances:**		
3201.9.8.3.2	**A cognitively impaired resident's whereabouts are unknown to staff and the resident leaves the facility premises.**		
	These requirements are not met as evidenced by:		
	Based on record review and interview, it was determined that for one (R14) out of five residents reviewed for accidents, the facility failed to ensure that R14's elopement on 2/18/23 was reported to the State Agency. Findings include:		
	R14's clinical record revealed:		
	2/18/23 - The facility's incident report documented that R14 exited from the Healthcenter onto the driveway, passing through the employee parking lot.		
	Review of the State Agency's incident reporting system records lacked evidence that R14's elopement was reported as required.		
	12/1/23 at 10:50 AM – During an interview, E1 (NHA) confirmed that the incident was not reported to the State Agency.		
	12/5/23 at 3:00 PM - Findings were reviewed during the Exit Conference with E1, E2 (DON) and E6 (ADON).		

Provider's Signature Michele Dennis Title Administrator Date 1/18/24

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Provider's Signature Michele Dennis Title Administrator Date 1/8/24

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	085026	A. BUILDING _____ B. WING _____	C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATES	4031 KENNETT PIKE GREENVILLE, DE 19807

(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, Complaint, and Emergency Preparedness survey was conducted at this facility from November 28, 2023 through December 5, 2023. The facility census was 34 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, 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 identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from November 28, 2023 through December 5, 2023. An Extended Survey was also conducted at this facility on December 5, 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 34 . The sample totaled was 15 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; PT - Physical Therapist;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/03/2024

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 RN - Registered Nurse; Abatement - end, reduce or terminate; Activities of Daily Living (ADL) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADLs - Activities of Daily Living; Alzheimer's disease - a degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Asymmetrical - has two sides that does not match; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact, 08-12: Moderately impaired, 00-07: Severe impairment; c - with; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; EHR - Electronic Health Record; eMAR - electronic Medication Administration Record; Gait - posture when walking; Garbled - confused or distorted; Grievance - an official statement of a complaint over something believed to be wrong or unfair; Immediate Jeopardy (IJ) - represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death; Incessantly - constantly; Locomotion - movement from one place to another; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Neurocheck - examination that assesses vital signs and oxygen level, level of consciousness (includes verbal response), orientation to person,	F 000		

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F 000	Continued From page 2	F 000		

place and time, ability to open eyes, pupil check, speech, strength in upper and lower limbs and motor responses, such as withdrawal to touch and extension of limb(s);
Neurosurgery - brain surgery;
Occupational Therapy (OT) - form of therapy for those recuperating from physical that encourages rehabilitation through the performance of activities required in daily life;
oob - out of bed;
Orthostatic blood pressure - low blood pressure that happens when you stand up from sitting or lying down;
Palliative - care that helps or comforts a person who is dying, including pain relief, without dealing with the cause of the problem;
Perineal - area of the body that surrounds a person ' s genitals and anal area;
Physical Therapy (PT) - form of therapy used to restore functional movements such as standing, walking;
PointClickCare - cloudbased healthcare software program used in nursing homes;
Pt - patient;
RAI - Resident Assessment Instrument;
Rollator - rolling walker and seat to rest on;
Sepsis - 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;
Shuffling - the action of walking without lifting one's feet fully from the ground;
Supine - lying face upward;
TAR - Treatment Administration Record;
Urinary tract infection (UTI) - bacteria in the urine;
Wanderguard - bracelet worn by residents that are at risk for wandering. Alerts staff with audible alarm when resident is near an alarmed door,

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		1/18/24

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F 580	Continued From page 4 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R38) out of three residents reviewed for hospitalization, the facility failed consult with the resident's physician and notify R38's resident representative of a fall on 10/5/22 which resulted in an injury and had the potential for requiring physician intervention. Findings include: R38's clinical record revealed: 10/5/22 at 10:30 PM - An incident report documented that R38 fell out of bed "head and torso first" and R38 was noted with garbled speech, small skin tear to left elbow and left 5th finger was swollen. Two nurses' statements (E19 and E18) documented that R38's speech was "garbled/unintelligible... Unable to identify names/surroundings ~ (approximately) 50% when asked" and "Her speech was garbled." Review of R38's clinical record and incident report lacked evidence that the physician and family representative were notified of R38's fall that may have needed further evaluation. 12/5/23 at 8:10 AM - During an interview	F 580	A □ The facility is unable to correct as the resident no longer resides in the facility. The family was notified of the fall on 10/6/2022 by the LPN careing for the resident. (Attachment -A) B □ All residents who fell within the last 30-days have had record reviews completed by the Director of Nursing. Any missing notifications have been addressed with the responsible party and attending physician.(Attachment-B) C □ 1. The root cause of notification is due to lack of nursing staff understanding of the requirement of notifying responsible party and physician at the time of a fall. 2.The shift supervisor will review all falls with the nurse filing the incident to ensure the responsible party and physician have been notified of the fall. 3. All Nurses will be educated on the facility policy as well as the regulatory requirement of F-tag 580 Notify of changes. (See attachment C)policy and procedure related to notification and the regulatory requirement which is a part of the policy and procedure. The policy indicates will notify promptly, this means	

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F 580	Continued From page 5 regarding R38's falls, finding was reviewed with E1 (NHA) and E2 (DON). 12/5/23 at 3:00 PM - Finding was reviewed during the exit conference with E1, E2 and E6 (ADON).	F 580	as soon as necessary depending on the severity of the reason of the notification. 4.The education will be completed by the DON/Designee. D. Weekly audits will be conducted on all residents who fall to ensure notification has been made to resident representative and the attending physician. See attachment A. Audits of notification for residents who fall will be reported to the QAPI committee until 100% compliance is achieved over 3 consecutive quarters. This will be reported by the DON/designee.	
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R38) out of three residents sampled for hospitalization, the facility failed to have an admission order for R38's immediate care of her fractured finger. Findings include: R38's clinical record revealed: 9/10/22 - The hospital discharge instructions stated, "... recommendations for your pinky fracture: Continue with buddy taping, okay to remove tape for cleaning the hand. Would re-apply buddy tape after cleaning...".	F 635	F635 Admission Physician Orders for Immediate Care A - The facility cannot correct the deficient practice due to the resident no longer resides in the facility. B □ All residents admitted to the facility in the last 30-days have had records reviewed by the Director of Nursing to determine if there are any missing orders not included in the admission orders and documented in the clinical record (MAR/TAR). This audit will continue to be done weekly on all newly admitted residents.(Attachment D) C - 1)The root cause of the lack of	1/18/24

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F 635	Continued From page 6 9/10/22 - R38 was admitted to the facility with a diagnosis of a fractured finger on her left hand. Review of R38's physician orders recap report lacked evidence of treatment for her fractured finger. 12/4/23 at 9:20 AM - During an interview, E2 (DON) confirmed the finding. 12/5/23 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E6 (ADON).	F 635	documenting orders related to training on completion of admission orders. 2) All newly admitted residents will have admission orders entered by the admitting nurse (LPN/RN) and then reviewed by the shift supervisor (RN) to determine all orders on admission are included in the clinical record. Both the admitting nurse and shift supervisor will sign off on the review of the orders to determine all orders have been documented. (Attachment S) 3) Licensed staff will be educated on the process of entering and reviewing the admission process. The policy for admitting a resident will be reviewed along with the regulatory requirement. This will be completed by the Director of Nursing/designee. (Attachment E) D □ All newly admitted residents will have the clinical record audited weekly to determine that all admitting orders have been documented in the clinical record. This audit will be completed by the ADON/designee. The audits will be completed weekly until 100% compliance is achieved over three consecutive quarters. This will be reported to the QAPI committee.	
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 interview and record review, it was	F 641	F641 Accuracy of Assessment	1/18/24

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F 641	Continued From page 7 determined that for one (R6) out of seventeen residents reviewed for assessments, the facility failed to ensure the accuracy of R6's Resident Assessment Instrument (RAI). Findings include: Review of R6's clinical record revealed: 8/17/21 - R6 was admitted to the facility with multiple diagnoses including sepsis and dementia, after being hospitalized for the treatment of sepsis (a potentially deadly condition with whole-body inflammation). 8/31/21 -A Physician Admission History and Physical documented revealed that R6 received treatment for sepsis while hospitalized. A review of R6's 10/22/23 quarterly Resident Assessment Instrument (RAI) revealed that septicemia (sepsis) was coded as a current diagnosis. 11/28/23 - A review of R6's current diagnoses in the electronic medical record (EMR) revealed that R6 still had an active diagnosis of sepsis. A review of R6's medications revealed that R6 was not receiving medications for a sepsis infection. A review of R6's 10/22/23 Quarterly Resident Assessment Instrument (RAI) revealed that septicemia (sepsis) was coded as a current diagnosis. 11/30/23 11:45 AM - During an interview, E2 (DON) confirmed that R6's 10/23/23 quarterly MDS listed septicemia (sepsis) as an active diagnosis and that the diagnosis should have	F 641	A □ The accuracy of this assessment was completed at the time of the survey. The DON/ resolved the diagnosis of septicemia on 11/30/23. B □ All resdients have the potential to be affected by the deficient practice. All resident diagnosis will be reviewed for accuracy and any diagnosis no longer active will be resolved. An audit of accuracy of assessment will be completed by the Director of nursing/designee. (Attachment F by 1/18/24) C - 1)The root cause of the diagnosis was an oversight. 2)Diagnosis of residents will be reviewed quarterly during the assessment period of each resident. 3) This will be conducted by the MDS coordinator and reviewed with the IDT. 4) All licensed staff will be educated on active versus inactive diagnosis and the importance of resolving inactive diagnosis per policy by the DON/Designee . (Attachment G) D □ The MDS coordinator will review all diagnosis during the assessment period of each resident to determine if any diagnosis should be resolved. The diagnosis will be monitored quarterly for all residents during the assessment period. This Audit will be conducted and reported to the QAPI committee until 100 % compliance is achieved over 3 consecutive quarters.	

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F 641	Continued From page 8 been removed from the list of current diagnoses when R6 completed her treatment for Sepsis in 2021. Findings were reviewed with E1 (NHA) and E2 (DON).	F 641		
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).	F 655		1/18/24

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F 655	Continued From page 9 §483.21(a)(3) The facility must provide the resident and their representative with a summary 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 record review and interview, it was determined that for one (R38) out of three residents reviewed for hospitalization, the facility failed to develop and implement a baseline care plan for R38's fractured finger. Findings include: R38's clinical record revealed: 9/10/22 - R38 was admitted to the facility from the hospital with a diagnosis of a fractured finger. Review of R38's baseline care plan, dated 9/10/22, lacked evidence of R38's fractured finger diagnosis and the treatment recommended per the hospital discharge instructions. 12/4/23 at 9:20 AM - During an interview, E2 (DON) confirmed the finding. 12/5/23 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 and E6 (ADON).	F 655	F655 Baseline Care plan A □ R-38 baseline care plan cannot be amended due to the resident no longer resides in the facility, B □ All newly admitted residents have the potential to be affected by the deficient practice. All residents admitted in the last 30- days will have baseline care plans reviewed to ensure pertinent diagnosis are documented. This will be completed by 1/18/2023 by the ADON/Designee. (Attachment H) C □ 1)The root cause of the omission of the diagnosis and treatment is due to a lack of understanding of the importance of documenting all pertinent diagnosis that relate to the baseline care plan. 2)Licensed staff will be educated on the policy related to the baseline care plan documentation by the DON/designee. 3)Baseline care plans will be reviewed by the ADON for all new admissions. The shift supervisor(RN)will ensure that the baseline care plan is initiated, and	

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F 655	Continued From page 10	F 655	pertinent diagnosis/information is documented. (Attachment I) D - Audits of baseline care plans will occur weekly by the ADON/designee for all newly admitted residents. All results of audits will be submitted to the QAPI committee until 100 % compliance is achieved for 3 consecutive quarters.	
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.	F 657		1/18/24

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F 657	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for one (R2) out of one resident sampled for pressure ulcers and one (R38) out of three residents sampled for hospitalizations, the facility failed to revise each residents' care plan. Findings include: Review of R2's clinical record revealed: 1/11/19 - R2 was admitted to the facility with multiple diagnosis including depression and peripheral vascular disease (disease of arteries and veins with reduced blood flow to arms/legs). 11/7/23 - A Physician order was written for wound care for R2's right foot heel: to apply skin prep (dressing for intact skin to form protective film) to the right heel every day shift. 11/22/23 - A Physician order was written to clean the wounds on right and left lower legs daily and as needed until healed; to apply Vaseline gauze, and to cover with a protective pad and then to wrap the legs in rolled gauze. 11/28/23 - A review of R2's care plan revealed the lack of evidence of a care plan problem, interventions or goals for R2's right and left lower leg and right foot heel wound. 11/29/23 1:45 PM - During an interview E4 (RN) confirmed that R2's care plan did not contain the above care plan elements. 2. R38's clinical record revealed: 9/18/22 at 8:01 PM - The incident report	F 657	F657 A □ R2□s care plan was updated at the time of the survey by the DON to reflect current treatment intervention on 11/29/23 by the Charge nurse. B □ All residents with pressure ulcers have potentila to be affected by the deficient practice. All residents with current pressure ulcers will have care plans reviewed for appropriate interventions related to wound care. (Attachment J) C □ A wound care plan was in place for residents, it was not updated to reflect the current treatment, yet the treatment was included in the TAR. Nursing staff will be educated regarding updating care plans with new orders and interventions necessary for all residents with wound care plans. The policy of updating care plans will be reviewed with licensed staff. Audits of residents with wound care care plans will be audited monthly for current treatment and interventions. (Attachment K) D □ Audits of wound care plans will be submitted to the QAPI committee for review of findings. Reports will be submitted for three consecutive quarters or until compliance is achieved at 100%. A The care plan cannot be amended as R38 no longer resides in the facility B All residents have the potential to be affected by the deficient practice. An audit of fall care plans will be completed by the DON/designee to ensure all interventions	

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F 657	Continued From page 12 documented that R38 fell and in response an intervention was initiated for a chair alarm. 10/5/22 at 10:30 PM - The incident report documented that a nurse supervisor observed R38 fall out of bed by watching a (baby) monitor positioned in the nurse's station that was being used in R38's room. Review of R38's comprehensive care plan lacked evidence of the two new interventions: chair alarm and (baby) monitor. The facility failed to revise R38's care plan. 12/4/23 at 9:20 AM - During an interview, findings were briefly discussed with E2 (DON). 12/5/23 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 and E6 (ADON).	F 657	are added this will be completed by 1/18/24(Attachment B) C 1)The root cause analysis determined that the care plan was not updated to reflect the interventions related to the falls which is related to the lack of understanding of the importance of revising care plan interventions. 2) All licensed staff will be educated on the policy and procedure of updating care plans by the DON/Designee 3) All falls will be reviewed daily to determine interventions are added to the care plan. This will be completed by the ADON/designee by 1/18/2024. D Completed audits will be submitted to the QAPI committee for review of findings. Reports will be submitted for three consecutive quarters until compliance is achieved.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Revised post IDR Based on interview and record review, it was determined that for two (R14 and R38) out of two residents reviewed for accidents, the facility failed	F 689	F689 Free of Accidents Hazards/Supervision/Devices Elopment/Wandering □ R14 A □ The resident directly involved had a wander guard added to the wheelchair	1/18/24

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F 689	Continued From page 13 to ensure residents received adequate supervision and assistive devices to prevent accidents. R14, a cognitively impaired resident with dementia and identified as high risk for wandering, eloped from the building on 2/18/23 and was found outside on the community grounds by a bystander. R14 was at risk of a severe adverse outcome. An IJ (immediate jeopardy) was identified on 12/4/23 at 2:17 PM and abated on 12/4/23 at 11:59 PM. For R38, a cognitively impaired resident who was at high risk for falls upon admission, the facility failed to implement appropriate person-centered fall interventions taking into consideration her continued impulsivity, lack of safety awareness and her diagnosis of a urinary tract infection (UTI). R38 had four falls (9/18/22, 10/5/22, 10/6/22 and 10/8/22). After each fall, the facility failed to reassess the effectiveness of the fall interventions. R38's fourth fall on 10/8/22 resulted in her being emergently transferred to the hospital where she was diagnosed with a right-sided subdural hematoma. As a result of the facility's failure, R38 was harmed. Findings included: The facility's policy and procedure on Elopements and Wandering Residents, policy explanation and compliance guidelines dated 2023 stated, "The facility is equipped with wander guard system to help avoid elopements; residents will be assessed for risk of elopement and unsafe monitoring upon admission and throughout their stay by the interdisciplinary care plan team; and adequate supervision will be provided to help prevent accidents or elopements." 1. Review of R14's clinical record revealed: 9/10/22 - R14 was admitted to the facility with	F 689	and the intervention of the wander guard was added to the care plan on 2/18/2023. This was completed by the RN supervisor on duty 2/18/2023. B □ All residents had new wandering assessments completed and care plans reviewed by the DON to determine other residents who could be affected by the deficient practice. (Attachment L-5) 12/4/2023 C □ 1)The root cause analysis of the deficeint practice is that the residents initial wandering assessment identified R14 as a wandering risk and the facility did not implement a wandering risk care plan with appropriate interventions. This is a result of lack of knowledge of the staff on the policy and procedures to ensure wandering risk scores are reviewed and appropriate care plans and interventions are put into place. 2)All licensed staff were educated on the risk of wandering, elopement, and care planning by the ADON.(Attachment L-2) 12/4/2023. D □ Audits for wandering risk and care plans for wandering risk will be completed monthly by DON/designee. Findings will be submitted to the QAPI committee for three consecutive quarters until compliance is achieved. (Abatement attachments L through L-6) F689 Free of Accidents Hazards/Supervision/Device/Fall □ R38 A-The resident directly involved in the facility no longer resides in the facility and the care plan could not be updated.	

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F 689	Continued From page 14 dementia and history of stroke. 9/10/22 - The Wandering Risk Assessment score was 14 indicating high risk. The Wandering Risk Assessment also documented R14 was a "known wanderer/history of wandering." 9/16/22 - The admission MDS for R14 documented a BIMS score of 8. A score of 8 to 12 suggests a moderate cognitive impairment. The was no evidence of a care plan to address the risk of wandering. 12/14/22 - The quarterly MDS documented a BIMS score of 8. 12/22/22 - R14 had a readmission to the facility from the hospital. 12/23/22 - A Wandering Risk Assessment incorrectly scored a 5 indicating moderate risk. The assessment did not include the diagnoses of dementia and history of wandering. 12/29/22 - R14's discharge MDS documented a memory problem and some diffculty in new situations only. 1/1/23 - R14 was readmitted to the facility from the hospital. 1/4/23 - A Wandering Risk Assessment was conducted that incorrectly scored a 8 indicating moderate risk. The assessment did not include the diagnoses of dementia and history of wandering. 2/18/23 - During an interview with E2 (DON) it	F 689	B □ All residents at risk for falls will have their care plans audited for appropriate person-centered care interventions by the DON/designee. (Attachment B) C □ 1)The root cause analysis of the deficient practice is that the residents care plan was not reviewed and updated timely with each fall. This is a result of lack of knowledge of the staff onthe policy and precudres related to falls and updating the care plan timely and implemeting person centered interventions. 2)The IDT will review resident falls and reassess the effectiveness of the intervention with any subsequent falls at the time of the fall through the post fall analysis. 3)Residents who fall will be reviewed for appropriate interventions and care plans will have new interventions added if indicated. A weekly audit will be completed by the DON/designee to ensure appropriate interventions and care plans have been updated. 4) All nurses will be educated on the fall risk assessment policy and fall prevention program by DON/designee(attachment M and N) D □ Care plan audits for fall interventions will be submitted to the QAPI Committee for three consecutive quarters until compliance is achieved.	

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was revealed that while self-propelling in a wheelchair, R14 eloped from the facility and staff did not appear to know that he was gone.

2/18/23 - A statement from E5 (RN, supervisor) documents that when F1 (family member of resident) was notified of the elopement, F1 stated (R14) had done it multiple times at the condominium and (F1) wasn't surprised. Per the Statement Form, E5 notes a Wander Guard was placed on (R14's) wheelchair. Per the facility's documentation of the incident report and staff statements, at 3:30 PM, R14 exited from the Health Center onto the driveway, passing through the employee parking lot. R14 was found by a bystander (I1) and brought to the main entrance of the community where Health Center staff were notified that R14 was at the receptionist's desk.

2/18/23 - The temperature was approximately 38 degrees at 2:51 PM and 39 degrees at 3:51 PM, according to www.timeanddate.com.

2/18/23 - An order obtained from E3 (Medical Director) to ensure the Wander Guard was in place on patient wheelchair every shift due to the outside wandering incident.

2/20/23 - A review by E25 (former NHA) dated 2/20/23 about R14's 2/18/23 incident identified the following results: "supervisors should not leave desk uncovered unless responding to an emergency, meeting with family concerned about incident, to be included, and consider wander guard on all wheelchairs that resident can self-propel in an effort to avoid any resident attempting to navigate the hill in a chair."

2/20/23 - The facility's findings of R14's exit from

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the Health Center documented that the receptionist in the main lobby "asked something about how did you get here, [R14] replied, I am bored, and my hands are cold." The facility's conclusion of findings revealed E1 (NHA) viewed the cameras on 2/20/23. "The camera indicated that [R14] exited the Health Center by wheeling himself in his wheelchair through the main entrance of the Health Center at 3:30 PM. The camera then indicated [I1] (independent living resident) pushing [R14] up the ramp to the main entrance of Stonegates. They were coming from the employee parking location." [I1] (independent living resident) confirmed picking up [R14] at the garage. He was pushed past the employee entrance and towards the main entrance to Stonegates. "The Health Center was notified that [R14] was in the lobby and the Health Center responded and assisted [R14] back to his room in the Health Center. A wander guard was placed on [R14's] wheelchair to prevent him from exiting the Health Center."

3/13/23 - R14's quarterly Wandering Risk Assessment score was 12 indicating high risk for wandering.

11/30/23 10:45 AM - An interview with E2 (DON) revealed the elopement occurred on Saturday 2/18/23 on the evening shift. R14 was in a self-propelled wheelchair and went out the door. The nurse on duty saw [R14] coming down the hall. The nurse was stopped by someone or something, continued to pursue the resident but R14 had turned down the hall in a different direction. R14 had gone outside and another resident who was outside walking saw [R14] who was then wheeled to the front reception area and the receptionist called staff. When asked what

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interventions were in place prior to the elopement, E2 replied, "No he wasn't known to be a wanderer." When asked what interventions were put in place after the elopement E2 stated, "Wander Guard was placed on [R14's] wheelchair and it alarms at the door and at the nurse's station."

12/1/23 10:35 AM - During an interview with E5 regarding the elopement, on 2/18/23 revealed R14 was sitting in the wheelchair talking with staff. Staff then began attending to other residents then E5 (RN, supervisor) asked where was R14. "We started looking for him. Then I got a call from the front office saying [R14] was here. I was out looking near where our cars are parked. Wander guard was placed as soon as we brought [R14] in".

12/1/23 12:51 PM - E7 (RN) was interviewed and stated that (R14) "was out in the hall in his wheelchair. [E7] found [R14] in the hall and asked [R14] 'do you know what you're doing?'. [R14] didn't answer." E7 then answered a call light and other staff were talking to a family, then E7 answered another call bell. E7 had not seen R14 for a while then they received a call from the main entrance saying R14 was there and to come get him.

12/1/23 1:24 PM - An interview with E8 (RN) revealed the incident "....happened around 3:30 PM and .....he was outside for about 15 minutes."

12/4/23 2:17 PM - During an interview with E1 (NHA) and E2 were advised that R14's admission Wandering Risk Assessment had identified him as being high risk and the lack of interventions to

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F 689	Continued From page 18 ensure the prevention of R14's elopement was an Immediate Jeopardy. 12/4/23 4:03 PM - The facility's abatement plan included: 1. All residents will be audited for wandering. This will be completed by 12/4/23 at 11:59 PM. 2. All residents identified during the audit with a score representing wandering potential will have interventions and care planning in place by 12/4/23 at 11:59 PM. 3. Education of all nurses on wandering assessment for accuracy and completion, to include care planning implementation of interventions and documentation of exit seeking behaviors will be completed by 12/4/23 at 11:59 PM. 12/5/23 - Reviewed list of audit findings. The facility census was 35 with 7 residents identified as risks for wandering. The interventions and care planning were documented. 12/5/23 - Reviewed list of RN and LPN staff who received education on Wandering/Elopement Assessment and Care Planning conducted with staff on 12/4/23 in-person, or via phone call or via text message. Training content included: Wandering assessments should be completed on admission, quarterly and with any significant change; the assessment must be accurate and complete; any resident with a score that represents wandering should have interventions and care plan in place; notify immediate supervisor of any resident whose score indicates at risk for wandering; assessments must be completed timely; and document any exit seeking behaviors.	F 689		

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F 689	Continued From page 19 12/5/23 10:56 AM - Interviewed E6 (ADON) regarding in-service 12/4/23 on the Wandering Risk Assessment, and care planning. Per E6 (DON), "The training reviewed elopement, wandering and scoring, to make sure we're doing accurate and complete assessments. Making sure it's looked at. If a resident is at risk then making sure interventions are put into place. Would update the care plan if interventions are put into place. If there's any score at all you need to do a care plan. Would decide as a team what to do with interventions. For high risk, would do hourly checks. A care plan is in place if at risk at all. At least wander guard is needed if at moderate risk. 12/5/23 - The abatement plan was validated with staff interviews, and review of care plans and interventions for those residents identified as a risk for elopement/wandering during auditing. 12/5/23 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E6 (ADON). 2. Review of facility's Fall policies and procedures revealed: The facility's policy entitled Fall Prevention Program, (undated) stated, "... 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. 4. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining	F 689		

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F 689	Continued From page 20 primary interventions... 6. High Risk Protocols: a. Implement interventions from Low/Moderate Risk Protocols. b. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. c. Provide additional interventions as directed by the resident's assessment, including but not limited to:... Assistive devices... Increased frequency of rounds... Fall alarms (chair, bed, or clip alarm)... Fall mat... Sitter, if indicated... Medication regimen review... Low bed... Alternate call system access... Scheduled ambulation or toileting assistance... Family/caregiver or resident education... Therapy services referral... 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statement in the case of injury." The facility's Fall Risk Assessment policy, dated 2023, stated, "... 2. The risk assessment will contain the following components: a. Identify environmental hazards and individual risk, including the need for supervision. b. Evaluate and analyze hazards and risks. 3. An 'At Risk for Falls' care plan will be completed for each resident to address each item identified on the	F 689		

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risk assessment and will be updated accordingly. 4. The 'At Risk for Falls' care plan will include interventions, including adequate supervision, consistent with a resident's needs, goals, and current standards of practice in order to reduce the risk of an accident. 5. Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice."

R38's clinical record revealed:

9/10/22 - R38 was admitted to the facility from the hospital after a fall where she sustained a cervical (neck) fracture requiring a neck brace, right-sided subarachnoid hemorrhage (bleeding in the space that surrounds the brain) and a fracture of the left hand fifth finger.

9/10/22 - The baseline care plan documented, "... History of falls: fall... (neck) fx (fracture)... Alarm: bed alarm once available... mild confusion/early dementia. Admitted for a fall resulting in (neck) fx and subarachnoid hemorrhage (stable)... Res (resident) able to transfer in bed independently & (and) an assist of walker to walk, transfer to BR (bathroom). Res is a fall risk and proper bed alarms/fall mats to be placed when available...".

9/10/22 at 4:10 PM - The Morse Fall Scale assessment score was 85, which identified R38 as a high risk for falling upon admission to the facility.

Nurse's notes documented the following:
- 9/11/22 at 1:03 AM - R38 was a fall risk and "will have a fall alarm mat and bed alarm placed."
- 9/11/22 at 9:01 PM - R38 was "... confused... She continues to get out of bed without using the

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F 689	Continued From page 22 call bell which in reach... has been redirected to use call bell when she has to get up to use the restroom or if she needs help with anything... states that she understands but, she is very forgetful. Clip alarm in place and fall mat with alarm next to bed... was seen by CNA taking her clip alarm off. Supervisor continue to educate her on the importance of using the call bell system due to her having her C-collar (neck brace) in place and how she needs to be very careful not to fall again. Supervisor will alert oncoming shift about her behavior at this time." - 9/12/22 at 2:19 AM - R38 was "... confused, continues to get oob (out of bed) unassisted without ringing. staff alerted by fall mat alarm...". - 9/13/22 at 1:32 AM - R38 was "... confused, continues to get frequently oob (out of bed) unassisted and not ringing prior to getting up...". 9/13/22 - An occupational therapy daily note documented "... Pt (Patient) displayed (decreased) safety awareness while with COTA (Certified Occupational Therapy Assistant). Pt attempted to walk to bathroom c (with) pants down. COTA explained fall risk to Pt. Pt reluctantly pulled pants up to walk to bathroom. Poor rollator safety c mod (moderate) v/c (verbal cues) for placement and locking of brakes." 9/14/22 at 3:33 AM - A nurse's note documented that R38 "continues to get oob unassisted without ringing. also removing her clip alarm. reminded to ring prior to getting up. resident expressed understanding." 9/14/22 - A physical therapy note documented that R38 "... Advised Pt that she should always ask for assistance as she is high risk for falls. Pt will need continued reminders, also spoke to nsg	F 689		

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F 689	Continued From page 23 (nursing) re (regarding) Pt is getting up by herself in room... Pt requires almost constant cues to decrease shuffling and increase foot floor clearance." 9/15/22 at 11:05 PM - A nurse's note documented that R38 and R14 (husband) "have very short memories are very forgetful." 9/16/22 - The admission MDS assessment documented R38 as having a BIMS (Brief Interview for Mental Status) score of 4, which identified R38 as cognitively impaired. In addition, the assessment documented that R38 required supervision with one staff person assist for transfers, walking in the room/corridor and toileting; and limited assistance with one staff person assist for dressing. R38's first fall on 9/18/22 at 8:01 PM: - The incident report documented: "CNA called nurse reporting resident (R38) was on the floor sitting cross-legged." A chair alarm was implemented as an immediate intervention. - 9/18/22 at 8:49 PM - A nursing note documented that R38 "was found to be seated on the ground outside of her bathroom by CNA... Spoke with pt (patient) and husband they both stated that she did not hit her head, neck or back. After the pt was toileted Nurse completed a skin check and neuro check found pt to be WNL (within normal limits). Spoke with (family) and (physician). He (physician) had no new orders and just asked us to keep him posted if (sic) any changes. Will continue to monitor pt closely." While a chair alarm was implemented after the 9/18/22 fall, this intervention was never added to R38's care plan nor was it captured in R38's	F 689		

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F 689	Continued From page 24 clinical record where nursing staff were required to sign off that it was consistently in place and check the alarm functioning every shift during her time in the facility. In addition, the facility failed to complete a Post-Fall assessment as per their policy and procedure. 9/19/22 - R38's comprehensive care plan for at risk for falls related to dementia, deconditioning, gait/balance problems listed the following interventions: - "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. - Ensure bed exit alarm is in place. - Ensure fall mat is at bedside at bedtime. - Ensure that the resident is wearing appropriate footwear shoes/non-skid socks when ambulating or transferring. -PT (physical therapy) evaluate and treat as ordered or PRN (as needed)." Nursing notes documented the following: - 9/19/22 at 11:09 AM - "... Alert and oriented to name and place only. Resident did not remember falling yesterday. Ambulates to the BR (bathroom) with stand-by assist... Keep reminding resident to use call bell for staff assists when getting up. Resident has a chair alarm on now and call bell in reach...". - 9/19/22 at 10:15 PM - R38 was "reminded to use call bell when ambulating." 9/20/22 - An Occupational Therapy Screen documented that R38 was currently receiving OT/PT at this time with encouragement to use rollator in room. In addition, "resident has bed & (and) chair alarms placed on furniture in room to	F 689		

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F 689	Continued From page 25 (increase) safety alert when resident getting up to move." Nursing notes documented the following: - 9/20/22 at 1:44 PM - "... Resident still gets up without calling for help, however chair and bed alarms in use and call bell within reach...". - 9/21/22 at 3:06 PM - "... Ambulating around the room and to the bathroom without ringing. Chair and bed alarm in place with call light in reach." - 9/22/22 at 10:45 PM - "Resident non-compliant with call bell use. Continuously ambulating to BR (bathroom) unassisted, forgets to use call bell, alarms in place...". - 9/24/22 at 3:13 AM - "Resident up most of the night, transferring from bed to recliner x (times) 4. Forgetful of call bell use when needing any assistance...". R38's eMAR revealed the following documented notes by nursing under the fall intervention to "Ensure fall mat in place every evening and night shift for safety. Make sure fall mat is in place at bedtime." - 9/24/22 at 11:15 PM - "Unable to locate mat at this time." - 9/25/22 at 9:56 PM - "No fall mat in patient room." - 9/26/22 at 2:35 AM - "not in use." 9/26/22 at 3:40 AM - The physician order for "Ensure fall mat in place every evening and night shift for safety..." was discontinued with the reason being "not in use." Review of R38's clinical record lacked evidence of a progress note as to why the fall mat was not being used and discontinued. 10/1/22 - A physician order was obtained to	F 689		

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F 689	Continued From page 26 perform a urine analysis to determine if R38 had a urinary tract infection (UTI). 10/2/22 - R38's at risk for falls care plan was revised to remove the intervention: "Ensure fall mat is at bedside at bedtime." The facility never implemented placement of a fall mat as an intervention after discontinuing it on 9/26/22. 10/5/22 - R38's urine analysis was positive for a UTI and she was ordered an antibiotic. 10/5/22 - An occupational therapy note documented, "... Pt required v/c (verbal cues) to pull her pants down closer to toilet as pt started to pull pants down in doorway to bathroom. Pt was able to toilet self... again required v/c to pull pants all the way up. Pt walked away from toilet c (with) pants 1/2 down. Pt did not notice pants were not up all the way...". R38's second fall on 10/5/22 at 10:30 PM: - The incident report documented: "Nurse supervisor was at the desk watching the monitor in the (resident's) room... I was at the desk and saw (R38) was lying on her right side and went to reach for something on the floor with her left hand and then she slid out of the bed head and torso first. Then her legs and feet followed. I immediately made the nurses around me aware she fell and we ran into the room. We saw her laying on her left side on the floor next to her bed. Her head never made contact with the floor. Myself, and 3 other staff members were in the room and got her back onto a seated position on the bed. Pts (Patient's) speech was garbled and she was very confused. She had a small skin tear to left elbow and left 5th finger was swollen... Pt went to bathroom... Assisted back to bed but	F 689		

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preferred to be in chair. Safety measures in place, clip alarm on. Speech improved. Will continue to monitor." Handwritten at the bottom of the report was "... Just Dx (diagnosed) c (with) UTI on 10/5/22 and started antibiotics. Fall was witnessed & (and) safety measures in place. Would not have prevented fall." There was no evidence in the clinical record that R38's family and the physician were notified of this fall and informed of R38's change of condition, including the garbled speech and injuries that may have needed further evaluation. In addition, there was no evidence in R38's clinical record and care plan that a monitor was being used in the resident's room to observe her.

- 10/5/22 - While R38's at risk for falls care plan was revised with interventions for "request for concave mattress bed with 1/4 side rails for mobility and transfers" were added, these interventions were never implemented on R38's bed.

- 10/6/22 at 12:05 AM - A Post Fall Analysis form for R38's second fall documented,
"... 3. Ask the resident OR DETERMINE what was different this time? n/a (not applicable)... Was the resident incontinent, was the visibility poor? yes and yes... What was the floor like? (checked) shiny... Was a safety alarm in place? if so, which alarm and was it sounding at the time of the fall? (checked) bed (alarm)... Additional information: pt has no side rails on bed.

Despite R38's fall out of bed on to the laminate floor which was witnessed by a staff member watching the monitor from the nurse's station at a distance and an clip alarm on, the facility failed to reassess the effectiveness of the current

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interventions and implement person-centered interventions taking into consideration R38's impaired cognitive status, her impulsivity and the current diagnosis of a UTI requiring her to use the bathroom frequently and urgently.

Nurse's notes documented the following:
- 10/6/22 at 1:50 PM - "... Resident continues to up and down oob (out of bed) every 5 minutes ambulating in room. Going in and out of the bathroom into hallway. Resident redirectable with short lasting effects. Remains on (antibiotic) for UTI...".
- 10/6/22 at 4:38 PM - R38's family "expressed concern regarding (R38's) right knee, resident expressed discomfort with ambulation... pain resolved at rest." The facility lacked evidence of a follow-up assessment of R38's right knee pain.

R38's third fall on 10/6/22 at 7:30 PM:
- 10/6/22 at 8:40 PM - A Post Fall Analysis for R38's third fall documented,
"... 2. Ask the resident, what were trying to do? go to the bathroom... 3. Ask the resident OR DETERMINE what was different this time? n/a (not applicable)... 11. Was a safety alarm in place?... (checked) chair... 12. Additional information: resident will not use call bell or walker."

- 10/6/22 at 8:49 PM - An incident note documented that "Pt was found by staff member sitting on the floor in front of her recliner her feet out in front of her and one hand by side the other was holding her husbands hand. Husband was seated in the recliner right next to the pts (patients)... Pt stated she was trying to go to the bathroom and she slipped. Fall was unwitnessed. Pt offered no complaints of pain and no injuries

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F 689	Continued From page 29 noted. Family called and... is looking into a sitter for the pt due to the fact she will not use walker or call bell for assistance and continues to fall... Chair and bed alarms in place. Clip alarms in room but pt (R38) removes them herself. Will continue to monitor and coach pt to use walker and call bell." R38's at risk for falls care plan was revised and an intervention for "Orthostatic BP (blood pressure) x3 days" was added. Despite implementing orthostatic BP monitoring, the facility failed failed to reassess the effectiveness of the current fall interventions and implement person-centered interventions taking into consideration R38's continued impaired cognitive status, her impulsivity and the current diagnosis of a UTI requiring her to use the bathroom frequently and urgently. 10/7/22 at 1:51 AM - A nurse's note documented that R38 "continues on (antibiotic) for UTI... Continues with frequency and urgency. Up and down oob every 10 minute (sic) to go into the bathroom." 10/7/22 at 1:45 PM - A nurse's note documented that R38 "... at baseline with using the walker and walking to the bathroom frequently. Continue to be supervision (sic)." This was the only nurse's note that mentioned supervision, but lacked details regarding what supervision was being performed. 10/7/22 at 3:34 PM - A physical therapy (PT) note documented that R38 "ambulated to and from bathroom with rollator x (times) 5 SBA (stand by assist), shuffling type gait with BLE (bilateral lower extremities) externally rotated worsening... falls in the last two days-fall screens completed.	F 689		

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F 689	Continued From page 30 PT discussed these issues with family." Nurse's notes documented the following: - 10/7/22 at 10:53 PM - "... incessantly gets up to use restroom...". - 10/8/22 at 1:00 AM - "... continues to ambulate self to the toilet intermittently this shift... One of (sic) one activity was provided by nurse and nurse educated on the importance of more fluid intake to help with UTI and to practice safe perineal hygiene when toileting by wiping front to back to prevent further UTI infections from occurring...". - 10/8/22 at 6:10 AM - "... Resident is constantly ambulating from bed to the bathroom this shift. Resident... is incontinent with multiple brief changes this shift... Safety checks in place bed at the lowest position with call bell and belongings within reach. Assistive device walker is close to bed. Nurse observed resident using assistive device walker incorrectly and educated resident on how to properly use the walker when walking...". R38's fourth fall on 10/8/22 at 8:00 AM: - A nurse's note (10:39 AM) documented, "Residents (sic) call bell activated and husband was coming toward the doorway to hall to alert staff that his wife was on the floor. Staff responded, including this nurse who found resident to be laying in supine position next to her bed. She was alert and responsive. Denied any pain or discomfort. She had on gripper socks and she was wearing her (neck brace). She was able to move all extremities without any pain or discomfort. Resident stated that she was unsure how she fell. She stated 'I don't know what happened, i just ended up on the floor.' States that she was trying to go sit on her husband's bed	F 689		

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F 689	Continued From page 31 (she was laying next to her bed, not her husbands). Asked if she hit her head and she stated 'Im (sic) not sure' and then when asked again she stated 'I think so.' No obvious visible injuries to her head noted. Sat resident up for a few minutes and tolerated well, then assisted to her feet with x 2 assist. Resident able to stand and bear weight without difficulties. Resident did note with unsteady gait, more than her baseline. Upon further assessment, resident noted with right sided weakness, including decreased strength to right arm and leg, smile asymmetrical and tongue not midline. Speech was clear and appropriate, no drooling noted. Residents (family)... made aware. Placed call to (physician)... 911 called and resident transported to... ER (emergency room)." - 10/8/22 at 10:58 AM - A Post Fall Analysis for R38's fourth fall documented: "... What was the floor like? (unanswered)... Was the resident using an assistive device? (checked) N/A... Additional information: call bell activated from chair alarm...". 10/8/22 - An occupational therapy discharge note documented "... Resident has not met goals (secondary) to reluctance to participate in therapy. Status unchanged from original eval as of last being seen on 10/5/22. Resident having difficulty carrying out any safety measures (... use of RW [rolling walker]) due to impulsivity." 10/8/22 at 7:09 PM - The hospital record documented that R38 was diagnosed with a acute on chronic left-sided subdural hematoma measuring 1.1 cm with 0.6 cm midline shift and admitted to surgical ICU (Intensive Care Unit) for close monitoring and evaluation pending family	F 689		

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F 689	Continued From page 32 discussion with neurosurgery and determination of next steps. 10/13/22 at 11:58 AM - The hospital discharge summary documented that neurosurgery was consulted and recommended nonoperative/conservative management. Palliative care was consulted and family decided to pursue hospice services. 12/1/23 - In response to the Surveyor's request about grievances involving R38, E1 (NHA) provided a typed note from E25 (former NHA) regarding communications with R38's family, which stated: "Date 10/7/22 at 11:00 a.m. 1) Discussed private duty suggestions. Concern regarding falls... (R38) non-compliant with using call bell...". 12/1/23 at 1:36 PM - During an interview, E24 (CNA) stated that the facility had three CNAs during the day shift on 10/8/22 as one CNA called out. E24 stated that she remembered it was breakfast time when R38 fell. E24 also stated that she responded to the room and the nurses were already in the room. 12/1/23 at 3:40 PM - During an interview, E22 (PT) stated that R38 was not participating in therapy. When asked about supervision, E22 stated that supervision of residents occurred at the nurses station or in the living room with activities and this could be done even at night. The facility failed: - to implement appropriate person-centered fall interventions and reassess the effectiveness of the current interventions for a cognitively impaired resident who was at high risk for falls upon	F 689		

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F 689	Continued From page 33 admission and had four falls in the facility within six weeks; and - to take into consideration R38's continued impaired cognitive status, her impulsivity and the current diagnosis of a UTI requiring her to use the bathroom frequently and urgently. 12/5/23 at 8:10 AM - Finding was reviewed and discussed with E1 (NHA) and E2 (DON) that this would be brought forth as a harm. 12/5/23 at 3:00 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E6 (ADON). No additional information was provided to the Surveyor.	F 689		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (E27 and E28) out of five CNAs reviewed for performance reviews, the facility failed to ensure each CNA had an annual performance review. Findings include: 1. E27 was hired on 10/2/18. The facility lacked evidence of a recently completed performance evaluation of E27. 2. E28 was hired on 5/9/18. The last performance	F 730	F730 Nurse Aide Performance Review 12 hr/yr In-service A □ Performance evaluations have been completed for both E27 and E28 B □ All C.N.A. personnel records have been audited for compliance and are up to date. (Attachment O) C □ 1) Root cause analysis of the incompletion of yearly review were due to an oversight. 2)The Human Resources Director will	1/18/24

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F 730	Continued From page 34 evaluation of E28 was dated 4/18/22. The facility lacked evidence of a recently completed performance evaluation. 12/5/23 - During an interview, E1 (NHA) confirmed the findings. 12/5/23 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E6 (ADON).	F 730	complete audits of C.N.A. performance evaluations and report to NHA for compliance on a monthly basis. 3)Any outstanding C.N.A. performance evaluations will be completed and reviewed with the nurse aide and submitted to the human resource department for their personnel file. D- Audits of C.N.A. performance evaluations will be submitted to the QAPI committee for review of findings. Reports will be submitted monthly to the QAPI committee, for three consecutive quarters or until !00% compliance is achieved.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		1/18/24

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	085026	A. BUILDING _____ B. WING _____	C 12/05/2023

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F 883	Continued From page 35 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R26) out of five residents reviewed for immunizations the facility failed to offer the recommended pneumococcal vaccine. Findings include:	F 883	F883 Influenza and Pneumococcal immunizations A □ Resident 26, was offered the PCV20 ON 12/15/2023 B □ An audit was conducted for all health care residents to determine who eligible to	

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F 883	Continued From page 36 "Pneumococcal Vaccine Timing for Adults- Adults >/= 65 years old Complete pneumococcal vaccine schedules ... PCV13 only at any age- Option A: >/= 1 year, give PCV20, Option B: >/= 1 year, give PPSV23." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. "Pneumococcal Vaccine (Series) Policy: Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized ... The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. A pneumococcal vaccination is recommended for all adults 65 years' and older and based on the following recommendations: ... For adults 65 years' or older who have only received PCV13: give PPSV23 as previously recommended ..." (Stonegates policy dated 9/9/22) Review of R26's clinical record revealed: 12/15/21 - R26, aged 94 years, admitted to the facility with diagnoses of dementia and atrial fibrillation. Review of R26's electronic medical record "Immunization" tab revealed that R26 had received pneumococcal conjugate vaccine (PCV13) on 1/1/93 and 4/18/16. 11/19/23 - R26's annual Minimum Data Set (MDS) assessment documented a Basic Inventory of Mental Status (BIMS) score of 3, which was indicative of severe cognitive	F 883	receive the appropriate pneumococcal vaccine. (Attachment P) C □ 1) the root cause analysis is due to lack of knowledge by the facility of the change in policy for the pneumococcal immunizations 2)Residents eligible to receive the pneumococcal vaccine were offered and both the consents or declinations were completed. 3)Licensed staff will be educated by the DON/designee on the importance of offering immunizations along with review of the policy and procedure, education of resident representative and/or resident, and consent and declination forms. Audits will be competed monthly and include all new admissions to ensure residents have been offered appropriate vaccines. (Attachment Q) 4)A new informed consent form will be utilized when offering pneumococcal vaccines for all newly admitted residents (Attachment T) D- Audit reports will be submitted to the QAPI committee for three consecutive quarters or until 100% compliance is achieved.	

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F 883	Continued From page 37 impairment. 12/1/23 8:05 AM - During an interview, E1 (NHA) confirmed that the facility lacked evidence that R26 had ever received the pneumococcal 20 valent conjugate vaccine (PCV20) or pneumococcal polysaccharide vaccine (PPSV23) vaccine to complete the pneumococcal vaccine series. E1 confirmed there was no evidence that R26 or his representative person was offered the opportunity to consent and obtain either the PCV20 or PPSV23 vaccine to complete the pneumococcal vaccine series. There was no evidence of R26 receiving a PCV20 or PPSV23 vaccine in DelVAX, the State electronic vaccination record. 12/1/23 3:29 PM - During an interview, E1 stated that the facility did not have declination paperwork from R26 or his representative person stating that he had been educated about and offered the PCV20 vaccine and that he had refused it. E1 stated that the facility is having a vaccine clinic in February 24 and that the pneumococcal vaccines will be added to it.	F 883		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management	F 947		1/18/24

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F 947	Continued From page 38 training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (E13, E21, E26 and E27) out of seven Certified Nursing Assistants (CNAs) reviewed for in-service education, the facility failed to ensure each CNA received at least twelve hours of in-service training per year. Findings included: 1. E13 had a hire date of 11/21/22. A course transcript list was not available. Review of her course certificate of completion on abuse, neglect and exploitation was dated 12/1/23 and revealed she received 0.75 hours of in-service training. E2 verified E13 had not received 12 hours of in-service training in the last year of her employment. 2. E21 had a hire date of 11/3/22. Review of her course transcript list revealed 8.5 hours of in-service training. E2 verified E21 had not received 12 hours of in-service training in the last year of her employment. 3. E26's hire date was 8/17/19. The facility lacked evidence of E26's most recently completed 12 hours of in-service education.	F 947	F947 Required in-service training for Nurse Aides A □ Nurse aide□s E 13, E21, E26 and E 27 training is in the process of being completed B □ All nurse aid□s Relias accounts are being audited by the NHA to determine what courses were outstanding. (Attachment R-1) C □ 1) Root cause analysis is staff did not understand importance of completing courses timely. 2)All outstanding Relias education identified as incomplete will be completed. 3)Audits on Relias training will be completed monthly, by the HR director. Findings will be reported to the DON/NHA. 4)Nurse aides who are not compliant with education will be notified and required to complete the educations as soon as possible. 5) Courses will be provided on a monthly basis to equal 12-hours annually. D □ Audits of the nurse aid training will be submitted to the QAPI committee for three consecutive quarters or until 100%	

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F 947	Continued From page 39 4. E27's hire date was 10/2/18. Review of E27's recently completed in-service education provided by the facility revealed that she only completed 2.75 hours. 12/5/23 - During an interview with E1 (NHA), findings were confirmed with E1 (NHA). 12/5/23 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E6 (ADON).	F 947	compliance is achieved.	