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

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

STATE SURVEY REPORT

NAME OF FACILITY: Promedica Wilmington **DATE SURVEY COMPLETED:** August 10, 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 July 13, 2023 through July 31, 2023. An Extended Survey was also conducted at this facility from August 9, 2023 through August 10, 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 136. The sample totaled 113 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, 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 the following: Cross Refer to the CMS 2567-L survey completed June 31, 2023: F562, F578, F580, F584, F585, F600, F603, F610, F644, F656, F657,	Cross Refer to the CMS 2567-L survey completed June 31, 2023: F562, F578, F580, F584, F585, F600, F603, F610, F644, F656, F657, F677, F684, F685, F686, F688, F689, F690, F692, F695, F697, F725, F756 ,F758, F760, F806, F812, F868, F880, F882, F908, F923, F940, F942, F943, F944, F946, F947, F949	9/25/2023

Provider's Signature Renee Boyer Title NHA Date 9/26/2023

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16 Del. Code, 1121. Residents Rights:	F677, F684, F685, F686, F688, F689, F690, F692, F695, F697, F725, F756 ,F758, F760, F806, F812, F868, F880, F882, F908, F923, F940, F942, F943, F944, F946, F947, F949 **Title 16 – Chapter 11. Long-Term Care Facilities and Services – Sub chapter II. Rights of Residents** **1121. Residents Rights** **(3) After admission, each facility shall submit to the resident or authorized representative, on a monthly basis, a written, itemized statement detailing, in language comprehensible to the ordinary layperson, the charges and expenses the resident incurred during the previous month:** Based on record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to ensure that R87's authorized representative received itemized statements detailing, in language comprehensible to the ordinary layperson, the charges and expenses the resident incurred during the previous month. Findings include: The facility's Admission Packet [undated], included a "Delaware Resident Rights" section that stated, "As a patient of the Center You [sic] have the right to: ... A monthly written, itemized statement detailing in language comprehensible to the ordinary layperson the charges and expenses the patient or resident incurred during the previous month. The statement shall contain a description of	**16 Del. Code, 1121. Residents Rights:** a. E59 explained the itemized breakdown to R87 b. Current residents residing in the facility have the potential of being affected by this practice. The facility will provide itemized breakdown of the monthly charges (room and board and ancillary charges) c. NHA or designee will educate business office manager to itemize monthly charges on invoices d. NHA or designee will conduct audits of itemized bills to be met monthly x 3 until 100% success is met. Results of audits will be forwarded to Quality assurance and Performance Improvement committee for review and action as appropriate until compliance is met. Compliance date 9/25/23	9/25/2023

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	specific services, equipment and supplies received and expenses incurred for each item...". 2/15/22 – R87 was admitted to the facility. 1/1/23 – R87's last billing statement that was itemized. 2/1/23 – Change in management at the facility. 7/13/23 12:49 PM – During an interview, FM2 stated that, "Billing used to be itemized but now [the facility is] bed bundling ... and raised the prices for the rooms...". 7/24/23 12:30 PM – During an interview, E59 (Regional Business Supervisor), stated, "Since the switching of companies, prices went from $327- $360 (per day) ... Room and Board and ancillary charges are inclusive." 7/28/23 08:14 AM – E58 (Assistant BOM/Business Office Manager) confirmed that, "Room and Board prices are bundled and not itemized...Room and Board includes the ancillary charges...I asked E1 (NHA), and she said, 'that's just how it is'...it doesn't have a break down. " Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (Corporate Nurse), and E18 (Vice President of Operations) on 7/31/23, at approximately 2:00 PM.		
3201.5.0 **3201.5.5.1**	**Personnel/Administrative** **-Results of tuberculosis screening.** This requirement was not met as evidenced by:	**16 Del. Code , 3201.5.5.1** a. No residents were affected by this practice. b. Current residents residing in the facility have the potential	9/25/2023

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	Based on interview and review of facility documentation provided to the surveyor, it was determined that for 6 out of 10 employees reviewed, the facility's personnel records lacked evidence of tuberculosis screening results. The following employees was missing evidence of the 2-step tuberculosis screening: -E22 (LPN) -E32 (LPN) -E54 (CNA) -E69 (Dietary Assistant) -E70 (CNA) -E73 (CNA)	of being affected by this practice. The facility will conduct an audit of staff members missing the 2-step tuberculosis screening. c. Root cause analysis completed, resulted that facility failed to follow the new hire TB screening requirement. NHA or designee will educate HR on ensuring to have 2-tep tuberculosis screening d. NHA or designee will conduct audits of HR files on ensuring to have 2-tep tuberculosis screening met daily x 3 days, weekly x 2 weeks, and monthly x 2 until 100% success is met.	
3201.5.5.3 **3201.5.5.4** **3201.5.5.5**	**-Results of criminal background check** **-Results of mandatory drug testing** **-Result of Adult Abuse Registry check.** **This requirement was not met as evidenced by:** Based on interview and review of facility documentation provided to the surveyor, it was determined that for 10 out of 11 employees reviewed, the facility's personnel records lacked evidence of criminal background checks, mandatory drug testing and adult abuse registry checks. Findings include: The following employees were missing evidence of recent criminal background check, and recent adult abuse registry check. 7/27/2023 at 10:00 AM – During an interview, the surveyor requested evidence of	Compliance date 9/25/23 **16 Del. Code , 3201.5.5.5** a. No residents were affected by this practice. b. Current residents residing in the facility have the potential of being affected by this practice. The facility will conduct an audit of staff criminal background check, and adult abuse registry check. c. Root cause analysis completed, resulted in the facility to follow the new hire criminal background and abuse registry check requirement prior to employment. NHA or designee will educate HR on ensuring to have staff criminal	9/25/2023

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	the above information from E16 (HR Director) for the following staff: E9 (Social Services Director) -E22 (LPN) -E32 (LPN) -E53 (Housekeeping) -E54(CNA) -E61 (CNA) -E69 (Dietary Assistant) -E70 (CNA) -E71 (Agency LPN) -E73 (CNA)	background check, and adult abuse registry check d. NHA or designee will conduct audits of HR files on ensuring to have staff criminal background check, and adult abuse registry check met daily x 3 days, weekly x 2 weeks, and monthly x 2 until 100% success is met. Compliance date 9/25/23	
16 Del. code , Chapter 11, Subchapter VII **1162**	**Nursing Staffing** **Minimum Staffing Levels for Residential Health Facilities** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** **RN/LPN CNA*** **Day - 1 nurse per 15 res. 1 aide per 8 res.**	Nursing Facilities must be in compliance with 16 Del. code, Chapter 11, Subchapter VII 1162 Nursing Staffing at all times. It is the intent of this facility to provide minimum staffing of 3.28 hours of direct care per resident per day. A. No residents adversely affected by this practice. B. Current residents residing in the facility have the potential of being affected by this practice. The facility will provide minimum staffing of 3.28	9/25/2023

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	Evening 1:23 1:10 **Night 1:40 1:20** *** or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.** This requirement is not met as evidenced by: A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long-Term Care Residents Protection. The facility was found to be noncompliant with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that on the four days reviewed, the facility failed to provide a staffing level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of the Facility Staffing Worksheets, completed and signed by E1 (Nursing Home Administrator) revealed the following: 3/25/23 – PPD = 3.17 4/9/23 – PPD = 3.11 4/10/23 – PPD = 2.96 7/30/23 – PPD 3.05 The facility failed to maintain the minimum PPD staffing requirement of 3.28. 8/14/23 11:19 AM – Findings were communicated in an email correspondence to E1 (NHA) and E3 (RDC).	hours of direct care per resident per day. C. Staff scheduler with VPO, DON and Administer immediately reviewed 7/21/2023, 7/22/2023, 7/23/2023, 7/24/2023 staffing levels of licensed nursing staff to ensure medication administration on 7/21/2023 Staff will call out to supervisor using the number 667-335-5995 Management staff will review licensed nursing staff 2 hours prior to shift change identifying any needs. If the levels fall below 6 licensed nurses on 7-3, 6 licensed nurses on 3-11, 4 licensed nurses on 11-7, the following plan will be initiated: A list of current employed licensed nurse with contact numbers will be provided A list of current agencies utilized by the facility • Trinity • Oculus • Samba • American An Agency orientation package will be place at the nursing stations on each floor that will contain agency orientation check list that will include information on how to obtain PCC login with contact information of HR manager who is available 24/7, if	

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		there is an issue with obtaining login within 15 minutes, and the HR manager, will obtain PCC login Manager will follow the below plan if there are any needs identified: • Notification of on call nurse to come in for staffing need • The manager on duty will place calls to current licensed employees • Then call agencies if needs are not filled • Then call to Administrator and Director of Nursing to have Nurse Management team fill in the needs • Staff will be mandated to stay until relieved • NHA or designee will educate staffing coordinator to maintain direct care ppd at a minimum of 3.28. D. NHA or designee will conduct audits of direct care staffing ppd to ensure minimum requirement of 3.28 is met daily x 3 days, weekly x 2 weeks, and monthly x 2 until 100% success is met. Results of audits will be forwarded to Quality assurance and Performance Improvement committee for review	

Provider's Signature __Renee Boyer_____ Title _____NHA_____ Date _____9/26/2023_____

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		and action as appropriate until compliance is met. Compliance date 9/25/23	

Provider's Signature __Renee Boyer_____ Title _____NHA_____ Date _____9/26/2023_____

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

(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 July 13, 2023 through July 31, 2023. The facility census the first day of the survey was 136. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from July 13, 2023 through July 31, 2023. An Extended Survey was also conducted at this facility from August 9, 2023 through August 10, 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 136. The sample totaled 113 residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RCD - Regional Clinical Director; RN - Registered Nurse;	F 000		

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

Electronically Signed | 09/04/2023

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F 000	Continued From page 1 UM - Unit Manager; VPO -Vice President of Operations; 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; Advanced Life Support (ALS) - Professionals qualified to provide advanced cardiac life support are trained and authorized to administer medication, perform injections, and conduct airway procedures prior to the arrival of the patient at an advanced care facility; AIMS - Abnormal Involuntary Movement Scale; Alzheimer's disease - a degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; AMA - Against Medical Advice; Anemia - low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues which may make you feel tired and weak; Antidepressant - drug to counter depression; Antipsychotic - class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Anxiety - an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth; Arthritis - painful inflammation and stiffness of the joints; AV fistula - the connection of a vein and an artery, usually in the forearm, to allow access to the vascular system for hemodialysis, a procedure that performs the functions of the kidneys in	F 000		

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F 000	Continued From page 2 people whose kidneys have failed; Basic Life Support (BLS) - level of medical skill used to treat victims experiencing life-threatening illnesses or injuries until they can be given full medical care at a hospital. BLS requires knowledge and skills related to CPR, use of AEDs, and relieving airway obstructions; Basic Metabolic Panel (BMP) - set of tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance; Benign Prostatic Hypertrophy (BPH) - enlarged prostate; BID - Twice a day; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions); 08-12: Moderately impaired (decisions poor; cues/supervision required); 13-15: Cognitively intact (decisions consistent/reasonable); Blood glucose - check blood sugar levels; Bowel Movement (BM) - stool; Braden Scale - a standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure injuries; Bruit/Thrill - assessment of sound and sensation indicating that the blood is flowing through the blood vessel and functioning properly; Cardiologist - doctor specializing in finding, treating and the prevention of heart disease and associated blood vessels; Chronic Obstructive Pulmonary Disease (COPD) - a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing; Chronic Respiratory Failure (CRF) - type of	F 000		

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F 000	Continued From page 3	F 000		

breathing disorder that ' s associated with low blood oxygen levels;
Code Blue - announcement to the nursing staff to respond to a life-or-death emergency;
Congestive Heart Failure (CHF) - heart unable to pump enough blood to meet the body's needs;
Contracture - joint limitations with fixed high resistance to passive stretch of muscle;
CPAP - machine for breathing assistance during sleep;
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;
Epithelial- relating to or denoting the thin tissue forming the outer layer of a body's surface and lining the alimentary canal and other hollow structures;
Etiology - cause of disease or condition;
Feces - stool;
Gastroesophageal reflux disease (GERD) - occurs when stomach acid or, occasionally, stomach content, flows back into your food pipe;
Gastrointestinal (GI) bleeding - a symptom of a disorder in your digestive tract. The blood often appears in stool or vomit but isn't always visible, though it may cause the stool to look black or tarry. The level of bleeding can range from mild to severe and can be life-threatening;
Gastroparesis - condition that affects the normal muscle movements of the stomach. This may cause persistent nausea and vomiting;
Gerry sleaves - protects residents' arms and legs against damage caused by friction and shearing;
Glaucoma - group of eye conditions that damage the optic nerve, which can cause blindness. This damage is often caused by an abnormally high

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F 000	Continued From page 4	F 000		

pressure in eye(s);
Grievance - an official statement of a complaint over something believed to be wrong or unfair;
Groin - area where the lower abdominal wall meets the thigh;
Humalog - fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood;
Hyperglycemia - high blood sugar from skipping a dose of insulin or not taking enough of insulin; if it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart;
Hypodermoclysis - Method of administering fluids under the skin;
Hypoglycemia - low blood sugar; may experience symptoms such as sweating, shakiness, pale skin, alteration in mental status and seizures;
Hypothyroidism - under active thyroid gland that includes symptoms such as fatigue, weight gain, muscle weakness, muscle aches, slowed heart rate, memory problems and depression;
IDT - Interdisciplinary team;
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;
Incentive spirometry - respiratory exercise to help clients improve their lung expansion, prevent fluid and mucus from collecting in the lungs, and reduce the risk of developing respiratory complications;
Incontinence - loss of control of bladder &/or

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F 000	Continued From page 5 bowel function; Inner Cannula - is an inner tube inserted within the main outer cannula of the tracheostomy tube and is useful for individuals who require secretion management; IPCP - Infection Prevention and Control Program; Jackson-Pratt Drain- A Jackson-Pratt drain is a closed-suction medical device that is used to remove fluids that build up in an area of your body after surgery. It consists of a bulb-shaped device connected to a tube that is placed inside the surgical site. The bulb is connected to the end of the tube that comes out through a small cut in your skin. The drain has multiple fluid pathways that allow continuous fluid flow. The drain can help in the healing process and requires proper care; Juven - nutrition powder supplement mixed with fluid; Laxative - stimulates a bowel movement; Liters (L) - unit of volume; MAR - Medication Administration Record; MASD - moisture associated skin damage; MD - Medical Doctor; Milligram - a unit of mass equal to 1/???? gram; Milliliters (mls) - unit of liquid volume; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Multiple Sclerosis - nervous system disease that effects the brain and spinal cord; Necrosis - the death of body tissue due to illness, injury, infection, or lack of blood flow; Neuropathy - disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness or pain; NPH insulin - intermediate-acting insulin given to help control blood sugar levels in people with diabetes; NSS - Normal Saline Solution;	F 000		

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F 000	Continued From page 6 Obstructive Sleep Apnea - disorder that makes you stop breathing repeatedly during sleep, depriving your body and brain of oxygen; Occupational Therapy - a type of rehabilitation that offers practical advice and support to help people carry out their daily activities; Olecranon fracture - a break of the bone that forms the point in the back of your elbow; OOB - out of bed; Orthostatic hypotension - postural hypotension is a form of low blood pressure that happens when you stand up from sitting or lying down; PAINAD - Pain Assessment in Advanced Dementia tool is a pain scale to provide a universal method to access pain experienced in people in late dementia. Total scores range from 6-10 points. 1-3 = mild pain, 4-6= moderate pain, 7-10 = severe pain; Paraplegia - impairment in motor sensory function of the lower extremeities; PCP - Primary Care Physician; Perianal - skin surrounding the anus; Perineal - area between the thighs; PointClickCare - cloudbased healthcare software program used in nursing homes; Pressure Ulcer - injuries to the skin or the soft tissue under the skin. The mildest stage of pressure ulcers is stage 1. Stage 2 ulcers have partial thickness loss of the first two layers of the skin, the epidermis and dermis. Stage 3 ulcers extend into the subcutaneous tissue. Stage 4 ulcers have become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; Prevalon boots - a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure; Psychotropic - any medication capable of affecting the mind, emotions and behavior;	F 000		

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 000	Continued From page 7 Pulse Ox - measures blood oxygen saturation levels; RAI - Resident Assessment Instrument; Reconstitution - mix medication with water; Reprisal - an act of retaliation; Sacrum - large triangular bone at base of spine; Schizophrenia - a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal; Scrotum - the pouch of skin that contains the testes; 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; Skin-Prep - a liquid film-forming dressing that forms a protective film to help reduce friction during removal of tapes and films; Sodium (Na) - a mineral and electrolyte found in salt; blood tests show how much is in blood; Stirrup brace - brace that allows the ankle to bend up and down; Subcutaneously - injection given into the fat layer between the skin and the muscle; Suprapubic Catheter - tube used to drain urine from the bladder; TAR - Treatment Administration Record; Ted stockings - compression stocking to the lower extremities to ensure that there is no pooling of blood in the veins and helps to prevent the formation of blood clots; Urinary tract infection (UTI) - bacteria in the urine; Vascular Dementia - A condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory; Wanderguard - bracelet worn by residents that	F 000		

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F 000	Continued From page 8 are at risk for wandering. Alerts staff with audible alarm when resident is near an alarmed door; Weepy - tearful.	F 000		
F 562 SS=D	Immediate Access to Resident CFR(s): 483.10(f)(4)(i)(A)-(G) §483.10(f)(4)(i) The facility must provide immediate access to any resident by: (A) Any representative of the Secretary, (B) Any representative of the State, (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.), (D) The resident's individual physician, (E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq), (F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and (G) The resident representative. This REQUIREMENT is not met as evidenced by: Based on interviews and reviews of the clinical record and other documentation as indicated, it was determined that for one (R131) out of nine residents reviewed for change of condition, the facility failed to provide immediate access to R131 during the 11:00 PM to 7:00 AM shift on 3/8/23 when 911 was called and both BLS (Basic Life Support) and ALS (Advanced Life Support) crews had difficulty entering the facility in order to	F 562	F562 Immediate Access POC A. Resident R131 no longer resides at the facility no corrective action required. B. All residents have the potential to be affected by this practice. When 911 is called a staff member will be assigned to the front entrance to ensure EM access to the facility. C. Root cause analysis completed	9/25/23

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F 562	Continued From page 9 provide emergent aid to R131. Findings include: Review of R131's clinical record revealed: 9/23/22 - R131 was admitted to the facility. 3/8/23 at 1:29 AM - E49 (RN) documented, "On call NP (Nurse Practitioner) notified of change in mental status with elevated vitals; 173/116 (blood pressure), 136 (heart rate); 30 (respirations); 101.9 (temperature); 94% RA (pulse ox on room air). Increased respiration with periods of shallow breathing noted. Pt. (Patient) unable to respond to verbal commands. Nurse received order from NP to transfer pt to ER (Emergency Room) for evaluation. 911 called. Patient transferred to (name) hospital. Message left for family to call facility." According the Prehospital Care Report, the BLS unit was dispatched on 3/8/23 at 12:56 AM for a patient (R131) with altered mental status of unknown etiology. The BLS unit arrived at the facility at 1:06 AM and at the patient's side at 1:12 AM. The Report documented, "...There was a delay in making pt (patient) contact due to no staff answering the back door or the front door to the building. After about 5 minutes, ALS made entry at the front door from staff letting them in. BLS crew made entry via an unlocked door in the rear of the building... After 911 was called, staff stated that they crushed up some Tylenol into some apple sauce and pour (sic) it into the pt's mouth with the pt not being fully alert...". A statement obtained from ALS, dated 7/28/23, documented, "The BLS and ALS crew arrived at the facility within 2 minutes of each other. The BLS crew contacted the communications center	F 562	results finding that there was not a specific process in place to allow EMS access to the facility after 911 was called. Administrator/designee will re-educate nursing staff on the importance of having staff member assign to the front entrance allowing EMS access to entering the facility when 911 is called. Licensed nursing will be in-serviced on the EMS access to residents when 911 is called by administrator/designee. D. Administrator/designee will audit residents being sent out 911 to ensure that EMS had access to the facility weekly x 2 weeks until 100%, every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. The results will be brought to QAPI for review and further recommendations, E. Date of completion: 9/25/2023	

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F 562	Continued From page 10 and requested a call back to have staff allow them access. The communications center made three (3) call backs to the facility and received no answer...". 7/28/23 at 8:26 AM - The Surveyor left a voicemail for E49 (RN), the assigned nurse for R131 on 3/8/23, requesting a call back. The Surveyor never received a call back from E49. 7/28/23 at 9:55 AM - A combined interview with E1 (NHA), E2 (DON) and E4 (RCD) regarding the incident involving R131 on the 11:00 PM to 7:00 AM shift on 3/7/23 - 3/8/23 revealed that none of them were aware about the incident. There was no evidence that an incident report was completed nor any follow-up as to why there was a delay in providing immediate access to a resident by emergency personnel after 911 was called. 7/31/23 at 2:00 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 562		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		9/25/23

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F 578	Continued From page 11 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure that two (R75 and R579) out of 30 residents in the investigative sample were offered the opportunity to formulate an advance directive. Findings include: The facility's Admission Packet [undated], included a "Skilled Nursing Rehabilitation Centers	F 578	F578 Request/Refuse Treatment A. R75 no longer resides in the facility. R579 no longer resides in the facility. B. SW/ designee completed a 100% audit of all residents to ensure advance directive was present/ offered. Residents that were without advanced directives, were offered and documented. C. To prevent recurrence of this deficient	

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F 578	Continued From page 12 Patient Information Handbook," n.d. stated, "Advance Directives: You have the right to make decisions about your own health ...should you be unable to communicate your wishes. You have the right to make an advance directive, such as a living will or durable power of attorney for health care ...If you would like more information about advance directives, please contact our Social Services Department." 1. Review of R75's clinical record revealed: 6/9/23 - R75 was admitted to the facility. 6/15/23 - R75's Admission Minimum Data Set (MDS) assessed resident to have a BIMS (Brief Interview for Mental Status) of 15. (Scores of 13-15 mean cognitively intact). 6/21/23 - R75 started Hospice services. 7/13/23 - During an interview, R75 was unaware of what an advance directive meant. 7/14/23 9:15 AM - During R75's record review it was revealed that there was no evidence of the facility offering the resident the opportunity to create an advance directive. 7/17/23 8:42 AM - E9 (Social Services Director) confirmed the absence of documentation from the facility offering R75 the ability to create an advance directive. 2. Review of R579's clinical record revealed: 7/3/23 - R579 was admitted to the facility. 7/9/23 - R579's Admission Minimum Data Set	F 578	practice the Regional SW/ designee will educate the social worker on Focus on F-Tag 578 and offering advance directives upon admission. It was determined the root cause of the deficient practice was the lack of knowledge of the regulation of F578 and failure to offer advance directives if not present. D. The SW/ designee will monitor all advance directives daily x 3 days, with the goal of meeting 100% success consecutively. All advance directives will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. E. Date of completion: 9/25/2023	

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F 578	Continued From page 13 (MDS) assessed resident to have a BIMS (Brief Interview for Mental Status) of 13. (Scores of 13-15 mean cognitively intact). 7/13/23 - During an interview, R579 did not recall the facility offering the opportunity to create an advance directive. 7/14/23 9:17 AM - During R579's record review it was revealed that there was no evidence of the facility offering the resident the opportunity to create an advance directive. 7/17/23 8:42 AM - During an interview with E9, it was stated, "Usually admissions handle this, the places I would normally check it's not there." 7/17/23 8:59 AM - E33 (Admissions Coordinator Assistant) confirmed that the facility lacked evidence of an advance directive being offered to R579. E33 stated, "Sometimes we ask the family or resident if they have it ... if they say no, they just don't have it." Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (Corporate Nurse), and E18 (Vice President of Operations) on 7/31/23, at approximately 2:00 PM.	F 578		
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	F 580		9/25/23

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F 580	Continued From page 14 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). §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	F 580		

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F 580	Continued From page 15 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 (R113) out of one resident reviewed for notification of change in condition the facility failed to consult with the resident's physician in a timely manner. Findings include: A policy and procedure titled "Significant Change of Condition" documented...All staff members shall communicate any information about patient status change to appropriate licensed personnel immediately upon observation...3. This assessment shall be reported to primary physician or designated alternate...4. Responsible party will also be notiifed of a change of condition. Review of R113's clinical record revealed: 1/6/23 - R113 was admitted with a diagnosis of Dementia and Osteoarthritis. 2/11/23 11:53 AM - A progress note documented..."noted bruise light/blue/purple and swelling to the right upper arm."...Complained of pain, as needed Tylenol given, (E3 MD) made aware, new order for X-ray two views to arm (E64 RP) present and aware of bruise/swelling and new order." 2/11/23 11:17 PM - A progress note documented...X-ray provider called and stated, "they were unable to perform the patient's right humerus (upper arm) x-ray today because of staffing issues and would do the x-ray in the AM	F 580	F580 Notify of Changes A. R113 still resides in the facility. R113 was sent to ER by facility/ MD for Tx on 2/14/23. B. DON/ designee completed a 100% audit of all residents that received X Ray orders in the last 30 days for MD notification of results in a timely manner. If no notification was provided DON/designee will notify MD of X Ray results. C. To prevent recurrence of this deficient practice the DON/ designee will educate the licensed nursing staff on Focus on F-Tag 580 and MD notification of change in condition. It was determined the root cause of the deficient practice was the lack of knowledge of the regulation of F580 and failure to notify MD in a timely manner of resident change in condition and x ray results. D. The DON/ designee will monitor all change in condition assessments and x ray results for completed MD notification in a timely manner daily x 3 days, with the goal of meeting 100% success consecutively. All change in condition and x ray results will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly 100% of change in condition assessments and x ray results until the facility reaches 100% success for two consecutive months. The results of these	

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F 580	Continued From page 16 (morning). MD (Medical Doctor) and family aware." 2/12/23 11:30 AM - R113's x-ray had been completed. 2/12/23 12:16 PM - R113's x-ray of the right right upper arm results documented..."there is a shoulder joint dislocation with a fracture of the upper right arm, likely chronic...Conclusion shoulder joint dislocation with a bony defect at the head of the right upper arm." 2/14/23 8:38 AM - A progress note documented..."notified by staff that the resident's right upper arm was swollen and had a purple bruise, resident complained of pain with ROM (range of motion) (E57 RN) called the x-ray provider...x-ray results revealed resident had a dislocation on the upper arm per report...(E3 MD) made aware gave order to put a sling on the right arm and send the patient to the emergency room... (E64 RP) made aware." 7/19/23 10:39 AM - During an interview E24 (ADON) revealed, "R113's x-ray results were reported to the physician on 2/14/23, I'm not sure why it wasn't addressed on 2/12/23." 7/19/23 12:44 PM - An interview with E22 (LPN) revealed, "the evening shift Supervisor prints off the faxes for x-rays and then puts them in (E3's MD) book, all critical reports are called in to the facility to a nurse." 7/19/23 12:49 PM - A brief interview with E31 (LPN) revealed, "all the nurses are responsible to pull the reports for any pending x-ray results and if it had been critical the nurse is supposed to	F 580	audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion: 9/25/2023	

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F 580	Continued From page 17 notify the physician right away." 7/26/23 12:14 PM - During an interview E1 (NHA) said, "I can't tell you why R113's x-ray results were not reported until 2/14/23." R113 had a change in condition. An x-ray had been ordered on 2/11/23 and completed on 2/12/23. X-ray results revealed there was a dislocation of the resident's right shoulder and a nondisplaced fracture to the upper right arm. The physician had not been consulted until 2/14/23, two days after results had been received by the facility. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (Corporate Nurse), and E18 (Vice President of Operations) on 7/31/23, at approximately 2:00 PM.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		9/25/23

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PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 584	Continued From page 18 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and observation of four out of four units toured, it was determined that the facility failed to provide a safe, clean, and homelike environment. Findings include: 1. 7/19/23 11:04 AM - During an observation of the Heritage unit, room 204A was observed with ant traps around the room brought in by the resident's family, also the room had wallpaper peeling off the wall. It was observed that room 208A also had wallpaper peeling from the wall. Room 210A had dirty floors and one area of the floor had what appeared to be dried, crusted	F 584	F584 Safe/Clean/Comfortable Environment A. Resident 204A and 208A no longer reside in the facility. Room 210A and 218A were previously self-identified of peeling wallpaper. Bathroom floors were cleaned, and new linens have been purchased. B. 238A the floors were cleaned. New wardrobe closets have been purchased to replace. The toilet lid has been replaced. Resident in 243B was not affected. Resident is a LTC resident who alert x3	

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F 584	Continued From page 19 liquid that was white in color, stuck to floor. Room 218A's bathroom floor was filthy with brown grime and dirt on the floor tiles around the bottom of the toilet. Also, the walls in the room had peeled wallpaper and the bed had been made with dirty linen with holes. Furthermore, the carpet in the Heritage unit's hallway was dirty, dingy in color and sticky in some areas. 2. 7/19/23 11:17 AM - During an observation of the Dover unit, room 238A resident area and bathroom floors dirty/sticky. 238B the closet door initially broken off and missing. The toilet's back lid was off and sitting on the floor in the bathroom. It was observed that room 243A also had a missing door for the closet and 243B there was a clear bag of dirty clothes sitting on top of a locked box near the window. It was observed that room 244A had a filthy privacy curtain that was partially hanging from the curtain's rod and the room had dirty walls. At the end of the Dover unit's hallway, the window was full of dust, dirt, debris, and cobwebs. 3. 7/19/23 11:23 AM - During an observation of the New Castle unit, it was observed that room 129A's privacy curtain was filthy and partially hanging off the curtain's rod. It was observed that room 139B had dirty bed linen, a dirty privacy curtain, and peeling wallpaper throughout the room, with high/uncomfortable water pressure coming out of the faucet in the bathroom sink. Also, it was observed room 140B had apple cores and food left in room from dinner the night prior, gnats filled the area of the room with the expired food, and the bathroom floor was dirty, and a leaky faucet in the bathroom sink. 4. 7/19/23 11:30 AM - During an observation of	F 584	manages his own clothing and places clothing per his preference. Resident in 244A had the privacy curtain removed and replaced. Walls have been cleaned. Screen removed and window cleaned. C. Privacy curtain for room 129A was taken removed and replaced. Privacy curtain was removed and clean one hung up. Resident in 139B received new linens. Facility had self-identified peeling wallpaper. A. Traps in room 204A were removed and wallpaper that was peeling off was repaired. Wallpaper in room 208A that was peeling off was repaired. Room 210A floors have been cleaned and debris has been removed. Room 218A bathroom floors were mopped and cleaned grime and dirt on floor tiles around toilet have been removed. Peeled wallpaper was repaired. Linen on bed were replaced with clean linen. Carpet in heritage unit was washed and shampooed. 238A room and bathroom floor mopped and cleaned. 238B closet repaired and good working condition. Toilet back lid restored in bathroom room 238. Room 243A closet door repaired and in good working condition, bag of dirty	

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F 584	Continued From page 20 the Arcadia unit, (the facility's locked Dementia unit), there was inadequate ventilation resulting in hot humid air, pungent suffocating odors, and the carpet throughout the unit's hallway was filthy and discolored. Also, it was observed that some areas of the carpet were sticky which caused residents' feet to stick to the floor. Room 121A and 121B had not been finished being painted revealing old and dingy floral wallpaper underneath the paint. Additionally, room 121B's privacy curtain was missing with the curtain's rod partially hanging off from the ceiling. 7/19/23 11:40 AM - E38 (Director of Housekeeping & Laundry) and E39 (Director of Maintenance) confirmed findings. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (Corporate Nurse), and E18 (Vice President of Operations) on 7/31/23, at approximately 2:00 PM.	F 584	clothes in 243B removed off the lock box 244A privacy curtain replaced with clean curtain and hanging in good working condition, walls were cleaned as well. The window at the end of Dover unit□s hallway was cleaned and cleared from dust, debris, dirt and cobwebs. Room 129A privacy curtain was cleaned and properly hung onto the rod. 139B linen was replaced with clean linen, clean privacy curtain and wallpaper that was peeling off was repaired. Water faucet in bathroom 139 was fixed to lower highwater pressure. 140B dinner tray was removed with expired foods, bathroom floor was cleaned, and leaky faucet was fixed. Mobile Air Condition Units were installed for adequate ventilation. Carpet in unit was washed and shampooed. Room 121A and 121B was finished painting so no wallpaper was revealed. 121B privacy curtain was replaced with clean curtain and hung up properly on curtain rod. B. All residents have the potential to be affected. The Administrator has provided education to staff in each Department on the importance of maintaining cleanliness within the facility. Maintenance issues must be entered into TELs upon finding. Facility was not conducting routine environmental rounds, nor utilizing the facility maintenance program effectively.	

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F 584	Continued From page 21	F 584	C. Root cause analysis conducted results were that the the did not conduct routine environment rounds, nor utilize the facility maintenance program effectively. The facility has hired a new Maintenance director to ensure the facility maintenance program will be utilized effectively and frequently environmental rounds occur with maintenance concerns addressed timely. The Administrator, Maintenance Director, and Housekeeping Director will round the facility in unison weekly to observe for any environmental issues that require immediate attention. Maintenance Director will check TELs daily and make necessary repairs within 72hrs. D. The administrator/designee will audit the environment rounds checklist with necessary corrective actions weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. Results will be brought to QAPI committee for review and further recommendations E. Date of completion: 9/25/2023	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		9/25/23

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F 585	Continued From page 22 furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 585		

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F 585	Continued From page 23 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

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F 585	Continued From page 24 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and reviews of a clinical record and facility documentation, it was determined that the facility failed to ensure that information on how to file a grievance/concern was available to the residents/resident representatives on two out of two resident floors. Additionally for R129, the facility failed to ensure that concerns received by the facility included prompt efforts to resolve the resident's problems. Findings include: The facility's Service Concerns/Grievances policy and procedure, dated 1/23/20, stated: "Policy: The patient has the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal... Procedure: 1. ...The Administrator will make every reasonable effort to resolve grievances/complaints regarding the rights of the patient as promptly as possible. The review process by the Administrator is anticipated to be complete no later than five (5) business days from the Administrator receiving the filed grievance. 2. The... Grievance Form will be completed by the Administrator. The patient will be provided a written response from the Administrator regarding his or her grievance via the completed... Grievance Form...". 1. Observations in the facility on 7/20/23 revealed:	F 585	F585 Grievances A. Resident R129 no longer resides in the facility. By end of business, mailboxes were placed at ADA level with proper signage on each unit. R129 no longer resides in the facility. B. All residents have the potential to be affected, mailboxes were placed at ADA level with proper signage on each unit. By end of business, mailboxes were placed at ADA level with proper signage on each unit. C. Root cause analysis completed, resulted in that the facility failed to have a procedure in place to ensure that signs that address outlining the process on filing grievances and timely/documentation of grievance resolution. Social Service/designee will audit grievance signage placement monthly and will review grievance resolution weekly with the administrator. The administrator/designee will review all grievances weekly for completion by the assigned department head, any grievances with outstanding resolutions will completed with direct oversight by the administrator. Administrator re-educated Social Services Department on ensuring	

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F 585	Continued From page 25 At 10:30 AM - Observed a locked black "mailbox" hanging on the wall at a standing height next to the receptionist desk across from the Administrator's office in the front lobby. On the lid of the mailbox, a small printed label stated "Concerns/grievances". There were no other signs posted nor any forms to fill out. At 10:32 AM - During the tour of the Heritage and Dover Units on the second floor and two nurse's stations revealed no signs/postings on how to file grievances in the facility. At 10:40 AM - During the tour of the New Castle and Arcadia Units on the first floor and two nurse's stations revealed no signs/postings on how to file grievances in the facility. 7/20/23 at 4:29 PM - Findings were reviewed and confirmed with E1 (NHA). 2. Review of R129's clinical record revealed: 8/18/21 - R129 was admitted to the facility. 11/29/21 - A review of facility grievance log revealed that R129's responsible party filed a grievance related to R129's care. 7/27/23 - A review of R129's concern form from the grievance (11/29/21) revealed the facility lacked evidence of a response to the concern. An interview with E4 (Corporate Consultant) confirmed the facility lacked evidence of a response to the grievance. 7/27/23 2:45 PM - Findings reviewed with E1 (NHA) and E4 (RCD).	F 585	that residents and family members have the ability to file grievances and that signs are posted on how to file grievances in addition grievances need to be responded timely and documented for evidence. D. Administrator will audit postings of grievance instruction to ensure they are visible to the public and grievance log on a weekly x 2 weeks until 100%, then every 2 weeks x one month or until 100% then monthly x 2 months until 100%. The administrator will review 5 grievances for resolution completion weekly x 2 weeks until 100%, every 2 weeks for 2 months until 100%, then monthly x 2 months until 100%. Data collected from the audit will be presented to the QAPI team for review. E. Date of completion : 9/25/2023	

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F 585	Continued From page 26 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1, E2 (DON), E4 and E18 (VPO).	F 585		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that the facility failed to protect the residents' rights to be free from physical abuse for one (R26) out of 14 sampled residents reviewed for abuse. R26 physically abused seven (7) (R480, R35, R481, R41, R117, R95 and R116) residents over a fifteen month period. Findings include: The facility's policy and procedure titled Abuse/Neglect/Misappropriation/Crime Administrative reference Guide, dated 1/23/20, stated, "...Physical Abuse - a. Striking the patient with a part of the body or with an object...shoving,	F 600	F600 Free from Abuse F600 A. R26 still resides in the facility on 1:1 supervision, R35 still resides in the facility, R41 still resides in the facility, R117 still resides in the facility, R95 still resides in the facility, R116 still resides in the facility, R480 no longer resides in the facility, and R481 no longer resides in the facility. B. DON/ designee completed a 100% audit of all residents with aggressive combative behaviors that have the potential to be affected by this deficient practice of inadequate supervision and	9/25/23

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F 600	Continued From page 27 pushing...b. Physical contact intentionally or through recklessness that results in ...physical injury, pain...". Review of R26's clinical record and the facility's incident report documentation revealed: 9/9/20 - R26 was first admitted to the facility. 9/9/20 (revised 9/22/22) - A care plan was developed for R26's risk for behavior symptoms related to depressive disorder, bipolar disorder, constantly pacing up and down the hallways stating he can't stop walking...attempting to push other residents and staff to get them out of his way or out of the chairs, smacking other resident and staff, hitting other residents in the stomach, kicking staff, slapping door, becomes agitated, aggressive, hitting, kicking who directed him not to lay down on roommate's bed, punching, scratching, attempting to kick other resident...". R26's interventions included but not limited to providing comfort by reassuring resident, rubbing resident's back and redirecting resident to take rest periods. 6/28/21 (revised 3/31/23) - A care plan was developed for R26's disruptive/compulsive, verbal/physical agitation/aggressive, can be physically aggressive towards other residents, verbally abusive to staff, slams laptop non med cart, putting trash on top of med cart, grabbing and pushing staff, confrontational with peer/staff, roaming into other rooms, smacked another resident on the head, aggressive, hitting, kicking staff who is redirecting him not to sleep in roommate's bed related to cognitive impairment, bipolar - type schizoaffective disorder, pushing another resident unprovoked. R26's interventions	F 600	physical abuse. C. It was determined the root cause of the deficient practice the facility failed provide adequate supervision due to staff lack of understanding for resident with aggressive/ combative behaviors requiring 1:1. DON/designee will educate staff on 1:1 supervision for residents with aggressive/combative behaviors. D. The DON/ designee will monitor all residents with aggressive/combative behaviors daily to ensure appropriate interventions are in place x 3 days, with the goal of meeting 100% success consecutively. All residents with aggressive combative behaviors will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly 100% of all residents with aggressive combative behaviors until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion: 9/25/2023	

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F 600	Continued From page 28	F 600		

included but not limited to 1:1 supervision (one staff person assigned direct supervision of a resident) for safety (created 6/15/22 revised 2/16/23).

10/7/21 - R26 was admitted to (behavioral health hospital) for abnormal behaviors and aggression.

10/24/21 - R26 was readmitted to the facility with new diagnoses including extrapyramidal (drug induced) movement disorders. schizoaffective disorders, Alzheimer's disease with late onset and delusional disorders.

11/22/21 (revised 1/13/23) - R26 was care planned for use of antianxiety, antipsychotic therapy to treat anxiety, psychosis: at risk for extrapyramidal movements. R26's interventions included: educate/review current medication, reason for use and administration needs with patient and/or family and to report signs and symptoms of adverse reactions.

1/3/22 11:21 PM - A nurse progress note documented that "...resident was noted walking around and wandering in other residents' rooms, multiple attempts to redirect was unsuccessful, will continue to redirect".

1/5/22 7:29 AM - A nurse progress note documented that "Resident was wandering all night into other resident (sic) room, causing some residents to be afraid and was (sic) yelling for help multiple times. Resident was redirected...".

1/30/22 - Review of R26's quarterly MDS (Minimum Data Set- standardized assessment forms used in nursing homes) revealed that R26 had an impaired cognition, inattentive and was

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F 600	Continued From page 29	F 600		

not able to complete the interview, had a wandering behavior occurring daily which intruded the privacy and activities of the other residents during the review period. R26 had behavior symptoms such as hitting and pacing. R26 required limited assistance with 1-person staff member for transfer and in addition, R26 required supervision with 1 person staff member with walking and locomotion on and off unit.

2/15/22 4:11 PM - A physician's progress note documented that R26 was seen for insomnia with new order to increase Seroquel from 25 mg 1 tablet by mouth at bedtime to 50 mg and to follow up appointment with neurology on 3/24/22.

1. 2/15/22 4:22 PM - A facility incident report documented that R480 was seen by NP (Nurse Practitioner) for ongoing right elbow pain and swelling. R480 stated that his left elbow was bothering him because a month ago, a resident (R26) sat on his elbow.

2. 2/15/23 4:37 PM - A facility incident report documented that R26 wandered into R35's room about a month ago and sat on his legs in bed. "It caused a scab on my leg".

2/15/22 4:51 PM - A facility incident report filed in the State incident reporting agency documented that on 2/15/22 at 4:00 PM, 2 residents (R480 and R35) on long term care unit reported that about a month ago, another man entered their room and attempted to sit on their beds and in turn sat on them".

3. 5/25/22 7:08 PM - A facility incident report filed in the State incident reporting agency documented that on 5/25/22 at 4:00 PM, "resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 600	Continued From page 30 (R26) with dementia smacked another resident (R41) on the head. Resident (R26) was immediately redirected and placed 1:1 supervision...". Care Plan changes indicated R26's updated "to reflect incident and interventions implemented including 1:1 supervision, labs and psych consult". 6/15/22 (revised 2/16/23) - 1:1 supervision for safety was added to R26's care plan interventions for "disruptive/compulsive, verbal/physical agitation/aggressive, can be physically aggressive towards other residents, verbally abusive to staff, slams laptop non (sic) med cart, putting trash on top of med cart, grabbing and pushing staff, confrontational with peers/staff, roaming into other rooms, smacked another resident on the head, aggressive, hitting, kicking staff who is redirecting him no to sleep in roommate's bed related to cognitive impairment, bipolar schizoaffective disorder and pushing another resident unprovoked. 7/14/22 - Review of R26's quarterly MDS assessment revealed that R26 had a severely impaired cognition, had a wandering behavior occurring daily during the review period. R26 had behavior symptoms such as hitting and pacing. R26 required limited assistance with 1-person staff member for transfer, walking and locomotion on and off unit. 7/27/22 5:41 PM - A behavior nurse note documented that, "Resident (R26) has not had any aggressive behaviors in the last 24 hours. IDT (Interdisciplinary Team) discussed removal of 1:1. IDT feels at this time 1:1 can be removed. Medical Director notified and agrees with decision".	F 600		

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 600	Continued From page 31 7/28/22 10:21 AM - A nurse progress note documented, "...continuously ambulating throughout unit and in and out other residents' room, frequently attempting to take/eat other residents breakfast this am (morning)...". 4. 7/28/22 2:21 PM - A facility incident report filed in the State incident reporting agency documented that on 7/28/22 at 11:30 AM, "Resident (R26) was walking around the unit. Resident (R481) was in her room. Staff heard yelling from (R481) room. They (staff) started to head toward the room and saw resident (R26) coming out of the room. They (staff) went into the room and resident (R481) stated, 'That man hit on me'. Staff took resident (R26) into his room...placed on 1:1...". Review of the facility's incident follow up summary documented that R26 was sent to the (hospital) for evaluation, referred to psychiatry for medication review on 7/29/22. A new order was obtained to discontinue morning dose of Seroquel 25 mg, start Seroquel 50 mg two times a day and continue with bedtime dose. R26 was already careplanned for 1:1 supervision for safety since 6/15/22. The facility failed to ensure that R26 received the 1:1 safety supervision. 5. 8/25/22 1:03 AM - A facility incident report filed in the State incident reporting agency documented that on 8/24/22 at 11:40 AM, "Resident (R26) with dementia was witnessed slapping another resident (R41) on her forehead". Review of the facility's incident follow up	F 600		

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 32	F 600		

summary documented that R26 was referred to (behavior hospital); R26's behaviors reviewed with in-house psychiatrist. New orders obtained to start Ativan gel 0.5 mg two times a day routinely. R26 was continued on 1:1 until IDT determines R26 is no longer a risk to others. Due to resident (R26) becoming agitated when 1:1 is present, staff keeps space between them and resident (R26)".

8/25/22 7:42 AM - A nurse progress note documented, "...informed of a patient to patient altercation around 23:40 (11:40 PM) in the hallway while patient was ambulating in the hallway. Patient (R26) was witnessed slapping another resident (R41) as the patient was sitting in the chair in front of her room...".

8/25/22 12:35 PM - A nurse progress noted documented, "Received return call from (behavior hospital). they are unable to accept due to (R26) having 0 psych and 0 hospital days available".

1/6/23 - Review of R26's quarterly MDS assessment revealed that R26 had a moderately impaired cognition, had a wandering behavior occurring daily during the review period. R26 had behavior symptoms such as hitting and pacing. R26 required limited assistance with 1-person staff member for transfer and walking in room. R26 required supervision with 1-person staff member for walking in corridor and locomotion on and off unit.

6. 2/4/23 2:40 PM - A facility incident report documented, "Resident (R26) stroke (sic) another resident (R841) without warning sign, while walking down the hallway with staff member assigned".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 600	Continued From page 33 2/4/23 3:25 PM - A nurse progress note documented, "Staff member assigned to do 1:1 on resident reported that while going down the hallway, beside resident (sic) noted when he strikes another resident (R481) without any warning sign, hitting her across her neck...". 2/4/23 8:23 PM - A facility incident report filed in the State incident reporting agency documented that on 2/2/23 (correct date 2/4/23) at 2:40 PM, "Patient (R26) with dementia was observed slapping another patient (R481) in the hallway...". Review of the facility's incident follow up summary documented, "Resident (R26) has a history of verbal and physical aggression with care plan in place. Interventions include redirecting resident to take rest periods, psyche referrals, numerous medication adjustments...1:1 supervision in place for safety... a psychosocial assessment was conducted for both residents involved as well as trauma informed care assessment." Resident (R26) was seen by the facility psychiatrist with new order to increase Seroquel from 25 mg BID (twice a day) to 50 mg BID. R26's care plan was updated to include "...encouraging resident to ambulate in less populated hallways within the facility when wandering behavior occurs...". 7. 2/26/23 2:33 PM - A nurse note documented that, "TNA (Temporary Nurse Assistant) doing 1:1 with resident (R26) reported, she was sitting with the resident (R26) in the hallway when another female resident (R117) was propelling self in the wheelchair, resident (R26) slapped her on her head...Stated, 'It happened so fast', the TNA could not intervene.".	F 600		

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 600	Continued From page 34 2/26/23 6:26 PM - A facility incident report filed in the State incident reporting agency documented that on 2/26/23 at 1:30 PM, Patient (R26) observed slapping another patient (R117) on her left cheek in the hallway while walking past each other...". Review of the facility's incident follow up summary documented,"...Resident (R26) continues on 1:1 supervision...". 8. 3/22/23 1:00 AM - A physician encounter note documented, "Patient (R26)...in memory unit...apparently pushed another resident in the hallway and it was witnessed and the other resident did fall to the ground and family was notified of the incident...". 3/22/23 1:31 PM - A facility incident report filed in the State incident reporting agency documented that on 3/22/23 8:15 AM, "A resident (R26) with dementia pushed another resident with dementia". Review of the facility's incident follow up summary documented, "...The patient (R26) was being supervised in the hallways by nurse on duty and was noted ambulating up and down the hallway with no noted behaviors. Patient (R95) ambulated out into the hallway and went to the end of the hallway and was looking out of the window. The patient (R26) then walked to the end of the hallway where he spontaneously and unprovoked, walked up to the patient (R95) and pushed him before the nurse was able to intervene. The patient (R95) went into the wall and then fell to the floor. He sustained a skin tear to the right side of his head...". "...Referrals for	F 600		

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 600	Continued From page 35 R26 were made for psychiatric centers to follow up for evaluation and medication regimen review. Multiple attempts made with difficulty finding pt (Patient/R26) placement at this time... PCP (Primary Care Physician) assessed and psyche continues to follow. Will continue 1:1 as staffing permits." 3/22/23 1:54 PM - A Social Worker note documented that intake coordinator of (psyche hospital) stated that since R26 was on hospice services, R26 could not be accepted at that time. 9. 5/20/23 12:30 PM - A nurse progress note documented, "Resident (R26) was witnessed slap another resident (R116) in the face...". 5/20/23 6:46 PM - A facility incident report filed in the State incident reporting agency documented that on 5/20/23 at 11:09 AM, "Patient (R26) observed slapping another patient on her cheek while walking past the patient in the hallway. Patients separated and redirected...". Review of the facility's incident follow up summary documented,"...Psyche services to be consulted...". 7/17/23 11:41 AM - An interview with E8 (TNA) revealed that she was the assigned regular 1:1 staff for E26 on the 7-3 shift. E8 also stated that R26 was very difficult to take care with because of his aggressive behaviors including hitting staff and residents. 7/20/23 9:07 AM - An interview with E5 (CNA) revealed that R26 really need a 1:1 supervision by staff as resident has tendency to hit people.	F 600		

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F 600	Continued From page 36 7/20/23 9:25 AM - An interview with E6 (CNA) revealed that sometimes there is no 1:1 staff assigned for R26 and that the staff in the unit will have to take turns watching R26. The facility failed to provide adequate supervision resulting in R26 physically abusing R480, R35, R481, R41, R117, R95 and R116 for a total of nine times while residing in the facility from February 2022 to May 2023. R481 and R41 were physically abused two times by R26. 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). Findings were reviewed during the Exit Conference with E1, E2, and E4 on 7/31/23, at approximately 2:00 PM.	F 600		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 603	Past noncompliance: no plan of	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

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F 603	Continued From page 37 other facility documentation it was determined that the facility failed to ensure that two (R45 and R41) out of 14 sampled for abuse were free from involuntary seclusion. R41 and R45's room door had been secured closed with an elastic stocking on the night shift. Findings include: A facility policy titled, "Patient Protection" effective date 1/23/20 documented, "There is a zero tolerance for mistreatment, abuse, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center." 1. Patients of the Center have the legal right to be free from ... involuntary seclusion ... except in an emergency and/or authorized in writing by a physician." 1. R45's clinical record revealed: 3/29/19 - R45 was admitted to the facility with a diagnosis of Stroke, Anxiety, and Vascular Dementia. 4/4/19 - Review of R45's care plan for "Place self on floor off chair, while ambulating refuses to wear socks or shoes related to cognitive impairment, and poor safety awareness documented 1. Keep busy with desirable activities such as listening to music. 4/5/19 - Review of R45's care plan for "Wandering pacing on unit, knocking, and tapping in other residents' rooms related to cognitive impairment, restlessness and anxiety revised 7/13/23 documented 1. Allow to wander on unit and redirect as needed. 2. Encourage and assist resident to wander at night within the boundaries of the hallway and common areas. 3. If patient is	F 603	correction required.	

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F 603	Continued From page 38	F 603		

wandering at night, ambulate with patient on the unit, offer snacks, drinks ad redirect to bed rest."

10/4/22 - A quarterly MDS Assessment documented R45 was severly cognitively impaired and required, extensive assist with one-person physical assist for bed mobility, limited assist with one-person physical assist for transfers, supervision with one-person physical assist ambulating in the room, and extensive assist with one-person physical assist for toileting.

10/4/22 - R45's quarterly MDS Assessment documented R45 is severly cognitively impaired.

11/30/22 4:30 PM - A review of the facility investigation report included E34 (Former DON) had been informed the night before R45's door had been secured closed by E32 (RN). In addition, E1 (NHA) had been notified.

11/30/22 4:45 PM - A facility investigation report documented E35 (TNA) stated," she had seen the tie on R45's door and had not thought it was to restrain anyone."

11/30/22 5:00 PM - A witness statement had been obtained from E32 revealed, "the nurse had secured R45's door to allow the resident to wander safely in her room.". E32 was suspended pending a facility investigation. Additionally, E3 (MD) had been notified of the allegation.

11/30/22 - A facility investigation report documented a head-to-toe assessment had been completed for R45 and all other residents on the Arcadia unit and had not revealed any new findings by E34. In addition, education had been

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 603	Continued From page 39 provided to the 3-11 and the 11-7 scheduled staff on Patient Protection guidelines. A review of the facility Event Summary for 11/30/22 7:42 PM revealed "that a staff person secured the door of R45's room a resident that had a history of unsafe wandering to discourage R45 from wandering unsafely out of the room". 12/1/22 - Education had been provided to the days shift on the Patient Protection guidelines for abuse and neglect by E42 (RN). 12/1/22 10;00 AM - E34 educated all Department Managers on Patient Protection guidelines. 12/1/22 11:00 AM - R45's family had been notified of the allegation. 12/1/22 12:55 PM - The Delaware State Police had been notified and a report had been filed. 12/1/22 1:00 PM - E34 documented residents were reviewed with unsafe wandering behaviors to validate care plans had been updated for current interventions for unsafe wandering. 12/1/22 - Further review of the facility investigation documented all current staff had been educated on Patient Protection guidelines and abuse and neglect. 12/7/22 - A five day follow up submitted to the State Agency included: Root cause, staff member secured the door of a resident with a history of unsafe wandering, the door was secured to prevent the unsafe wandering and allow the resident to wander freely within the boundaries of her room.	F 603		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 603	Continued From page 40	F 603		

12/9/22 - E32 had been terminated from employment and reported to the State of Delaware's Division of Professional Regulation.

The facility failed to ensure R45 a resident with dementia was free from being confined in her room, in addition reviewed documentation had not provided any evidence of unsafe wandering in R45's progress notes or interventions used during the 11-7 shift. The physician had not been notified of any concerns on the 11/29/22 or 11/30/22 for behaviors R45 may have had.

2. R41's clinical record revealed:

2/9/22 - R41 was admitted to the facility with a diagnosis of High blood pressure and had later been diagnosed with Dementia and problems that affect blood flow to the blood vessels and brain.

11/18/22 - A quarterly MDS Assessment documented R41 was severly cognitively impaired.

11/18/22 - A quarterly MDS Assessment documented R41 required, extensive assist with one-person physical assist for bed mobility, transfers, walking in the room, toileting, personal hygiene, and total assist for bathing.

11/30/22 4:30 PM - A review of documentation included E34 (Former DON) had been informed the night before R41's door had been secured closed by E32 (RN). In addition, E1 (NHA) had been notified.

11/30/22 4:45 PM - A facility investigation report documented E35 (TNA) stated," she had seen

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F 603	Continued From page 41 the tie on R41's door and had not thought it was to restrain anyone." 11/30/22 5:00 PM - A witness statement obtained from E32 revealed, "the nurse had secured R41's door to allow the resident to wander safely in her room.". E32 was suspended pending a facility investigation. Additionally, E3 (MD) had been notified of the allegation." 11/30/22 - A facility investigation report documented a head-to-toe assessment had been completed for R41 and all other residents on the Arcadia unit and had not revealed any new findings by E34. In addition, education had been provided to the 3-11 and the 11-7 scheduled staff on Patient Protection guidelines. 12/1/22 - Education had been provided to the day shift on the Patient Protection guidelines for abuse and neglect by E42 (RN). 12/1/22 10:00 AM - E34 educated all Department Managers on Patient Protection guidelines. 12/1/22 11:00 AM - R41's family had been notified of the allegation. 12/1/22 12:55 PM - The Delaware State Police had been notified and a report had been filed. 12/1/22 1:00 PM - E34 documented 1. Residents were reviewed with unsafe wandering behaviors to validate care plans had been updated for current interventions for unsafe wandering. 12/1/22 - Further review of the facility investigation documented all current staff had been educated on Patient Protection guidelines	F 603		

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F 603	Continued From page 42 and abuse and neglect. 12/7/22 - A five day follow up submitted to the State Agency included: Root cause, staff member secured the door of a resident with a history of unsafe wandering, the door was secured to prevent the unsafe wandering and allow the resident to wander freely within the boundaries of her room. 12/9/22 - E32 had been terminated from employment and reported to the State of Delaware's Division of Professional Regulation. 7/13/23 12:30 PM - A brief interview with E28 (LPN) revealed, "if I suspected any type of abuse, I would report my findings to E1 and to my Supervisor or my Unit Manager." 7/18/23 9:22 AM - A brief interview with E30 (LPN) revealed "that she would report to E1 if abuse or neglect had been suspected, or a RN Supervisor or Unit Manager, in addition E30 also revealed she had training for abuse and neglect in new employee orientation on 6/18/23." The facility failed to ensure R41 a resident with dementia was free from being confined in her room, in addition reviewed documentation had not provided any evidence of unsafe wandering in R41's progress notes or interventions used during the 11-7 shift related to unsafe wandering. The physician had not been notified of any concerns on the 11/29/22 or 11/30/22 for behaviors R41 may have had on the 11-7 shift. 7/31/23 at 2:00 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 603		

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation as indicated, it was determined that for one (R179) out of 14 residents reviewed for abuse, the facility failed to have evidence of thorough investigation. Findings include: 1. Review of R179's clinical record revealed: 2/18/21- R179 was admitted to the facility 7/24/23 11:28 AM - Interview with FM1 (daughter) revealed an allegation of abuse from R179 during his stay at the facility. R179 alleged he was "beaten all the time by staff during care." 7/24/23 12:00 PM - An allegation of abuse was	F 610	F610 Investigate/Correct Alleged Violations A. R179 no longer resides within the facility. B. DON/ designee completed 100% audit on all residents that have the potential to be impacted by this deficient practice. All allegations/ reports of abuse will be investigated by the DON and Administrator and reported to the State Agency. C. To prevent recurrence of this deficient practice the RDCS/ designee will educate DON and Administrator on Focus on F-Tag 610 and interviewing direct staff when conducting investigations. It was	9/25/23

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F 610	Continued From page 44 reported to E1(NHA) and E4 (Corporate Consultant) by the surveyor as revealed by FM1. 7/24/23 1:38 PM - An allegation of abuse was submitted to State Agency. 7/26/23 - Investigation of the allegation of abuse was received by the State agency. The investigation included the incident report and interviews from the following staff: social worker, unit manager and the DON. The investigation lacked interviews with direct care staff. The facility lacked evidence of a thorough investigation related to abuse. 7/27/23 2:45 PM - Findings reviewed with E1 and E4. 8/2/23 9:09 AM - The facility submitted interviews from a nursing supervisor and a staff CNA after the 5 day investigation period ended. Findings were reviewed during the Exit Conference with E1, E2, and E4 on 7/31/23, at approximately 2:00 PM.	F 610	determined the root cause of the deficient practice was the lack of knowledge of the regulation of F610 and failure to provide thorough interviews of direct staff when conducting investigation of abuse. D. The DON/ designee will monitor all residents for allegations of abuse daily x 3 days, with the goal of meeting 100% success consecutively. All residents with allegations of abuse will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly 100% of all residents with aggressive combative behaviors until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion: 9/25/2023	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		9/25/23

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F 644	Continued From page 45 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R3 and R179) out of four residents reviewed for PASARR, the facility failed ensure that a referral for a PASARR screening was completed following a new diagnosis of psychotic disorder which was not listed on the previous PASARR. Findings include: 1. Review of R179's clinical record revealed: 2/18/21- R179 was admitted to the facility. 10/26/19 - An Admission PASARR was completed for R179. 1/19/23 - A progress note from E19 (Psychiatrist) revealed a new diagnosis of Schizophrenia. 7/24/23 10:26 AM - An interview with E9 (SW) and E20 (SW) confirmed a PASARR was not completed when the new diagnosis of Schizophrenia was identified. 7/24/23 10:30 AM - An interview with E21 (RN-MDS coordinator) confirmed the new diagnosis of Schizophrenia was not added to the medical record at the time of diagnosis.	F 644	F644 Coordination of PASARR A. R179 no longer resides within the facility. R3 no longer resides in the facility. B. DON/ designee completed 100% audit on all residents newly diagnosed with psychotic and delusion disorder to ensure a new PASARR was completed. C. To prevent recurrence of this deficient practice the Administrator/ designee will educate SW on Focus on F- Tag 644 and initiating a new PASARR for residents newly diagnosed with psychotic and delusion disorder. It was determined the root cause of the deficient practice was the lack of knowledge of the regulation of F644 and failure to provide a new PASARR for residents newly diagnosed with psychotic and delusion disorder. D. The SW/ designee will monitor all residents newly diagnosed with psychotic and delusion disorder daily x 3 days, with the goal of meeting 100% success consecutively. All residents with a new diagnosis of psychotic and delusion disorder will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored	

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F 644	Continued From page 46 The facility failed to ensure that a referral for a PASARR screening was completed following a new diagnosis of a psychotic disorder. 7/27/23 2:45 PM - Findings reviewed with E1 (NHA) and E4 (Corporate consultant). 2. Review of R3's clinical record revealed: 5/15/21 - R3 was admitted to the facility. An admission Level One PASRR dated 5/6/21 was completed for R3. 9/1/22 - A progress note from E19 (Psychiatrist) revealed that R3 was seen for increased agitation and refusing care. R3 was also started on Depakote 125 mg (milligrams) three times a day for mood. R3 had a new diagnosis of delusion disorder. 7/19/23 4:44 PM - In an email correspondence, S1 (PASRR State Authority) revealed that R3 "had a PASRR completed on 5/6/21 and no other PASRR filed for this individual." 7/20/23 2:43 PM - In an interview, E9 (SW) confirmed that R3 only has the 5/6/21 PASRR assessment on file. E9 also stated, "Medical Records did a deep dive of records retrieving and could not find any other PASRR evaluation records for (R3)." 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). Findings were reviewed during the Exit Conference with E1, E2, and E4 on 7/31/23, at	F 644	monthly 100% of all residents with a new diagnosis of psychotic and delusion disorder until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion : 9/25/2023	

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F 644	Continued From page 47 approximately 2:00 PM.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		9/25/23

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F 656	Continued From page 48 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R87, R129, R281 and R101) out of twenty-seven residents in the investigative sample, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan. Findings include: The facility's policy on "Care Planning" dated 11/01/2019 documented, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the mental, and psychosocial well-being of the patient." 1. Review of R129's clinical record revealed: 8/18/21 - R129 was admitted to the facility. 8/19/21 - A care plan for pain related to arthritis. 8/24/21 - A review of an Admission MDS revealed R129 was receiving a routine pain medication. 5/10/22 - A review of facility incident report revealed R129 had an injury of unknown origin	F 656	F656 Develop/Implement Comprehensive CP A. R87 still resides within the facility, and the care plan now includes a comprehensive care plan for hospice services. R129 no longer resides in the facility. R281 no longer resides in the facility. R101 still resides in the facility and a comprehensive care plan for hearing impairment was developed. B. DON/ designee completed 100% audit on all residents with new increase onset of pain, hospice care, pressure reducing device in bed and hearing impairment. C. To prevent recurrence of this deficient practice the DON/ designee will educate license nursing staff and IDT team on updating care plans to reflect residents current physical functioning to ensure compliance with the regulation for care plans for all residents. It was determined the root cause of the deficient practice was the lack of knowledge for developing and revising and failure to create person-centered care plan. D. The DON/ designee will monitor all	

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F 656	Continued From page 49 noted. The report revealed R129 had a bruise to the right hip and was limping when ambulating. Area was slightly edematous and tender to touch. 5/10/22 - A review of R129's Physician order sheet revealed a new order for x-ray for right hip, apply ice for 20 mins to right hip every shift, and monitor bruise to right hip. 5/15/22 - R129 was sent to the hospital for right hip pain and it was determined that R129 had a displaced fracture to right hip and displaced fracture to right foot. The facility failed to awknowledge R129's increased pain and create a comprehensive person-centered care plan related to hip pain for R129. 7/27/23 2:45 PM - Findings reviewed with E1 (NHA) and E4 (Corporate consultant). 2. Review of R87's clinical record revealed: 2/15/22 - R87 was admitted to the facility. 10/7/22 - R87 started Hospice services. 5/1/23 - R87's Hospice care plan's interventions read, "Refer to hospice provider as needed ... See hospice plan of care." The facility failed to develop and implement a comprehensive Hospice care plan for R87 that included measurable objectives and timeframes to meet a R87's medical, nursing, mental and psychosocial needs and included the resident's goals, desired outcomes and preferences.	F 656	residents with new increase onset of pain, hospice care, pressure reducing device in bed and hearing impairment daily x 3 days, with the goal of meeting 100% success consecutively. All residents with newly increase onset of pain, hospice care, pressure reducing device in bed and hearing impairment. will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly 100% of all residents with new increase onset of pain, hospice care, pressure reducing device in bed and hearing impairment until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion: 9/25/2023	

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F 656	Continued From page 50 7/27/23 1:19 PM - E40 (RN/Staff Development) confirmed findings. 3. Review of R281's clinical record revealed: 12/1/22 - R281 was admitted to the facility with several diagnoses including Multiple Sclerosis and a deep wound of the lower back. 12/2/22 - R281's care plan did not include that there was a pressure reducing device to the bed. Progress notes written by E24 (Previous ADON) on 12/2/22, 12/7/22 and 12/14/22 stated that R281 had an air mattress in place. 12/7/22 - R281's admission comprehensive assessment, the Minimum Data Set (MDS) included that a pressure relieving device to the bed was present. Findings were reviewed with E1 (NHA), E2 (DON), E4 (RCD) and E18,(VPO) at the Exit Conference on 7/31/23 at 2:00 PM. 4. Cross refer F685 Review of R101's clinical record revealed: 8/3/22 - R101 was admitted to the facility. 8/3/22 10:27 PM - A nurse admission progress note documented that, "Resident (R101)...mild difficulty in hearing...reported that she had hearing aids before but she lost them...". 8/9/22 - R101's Admission MDS revealed that R101 had minimal hearing difficulty or had difficulty in some environments like when person	F 656		

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F 656	Continued From page 51 speaks softly or setting is noisy. 8/10/22 8:00 AM - An activity evaluation note was completed and revealed that, "Resident (R101) reports having hearing aids but they are lost at this time...". 8/10/22 7:26 PM - A physician progress note on exam details documented, "hearing impaired". 11/9/22 - Review of R101's Quarterly MDS assessment revealed that R101 had minimal difficulty with hearing. 11/9/22 9:29 AM - A quarterly recreation progress note documented that, "...Resident (101) has tendency to participate in limited to no group activities due to poor... hearing...". 2/9/23 - Review of R101's Quarterly MDS assessment revealed that R101 had minimal difficulty with hearing. 5/12/23 - Review of R101's Quarterly MDS assessment revealed that R101 had minimal difficulty with hearing. 7/27/23 - Review of R101's care plan revealed a lack of evidence that a person centered care plan with interventions was developed to identify and address R101's hearing impairment. 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). Findings were reviewed during the Exit Conference with E1, E2, and E4 on 7/31/23, at approximately 2:00 PM.	F 656		

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F 657	Continued From page 52	F 657		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (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 determined that for three (R65, R71 and R141) out of five residents reviewed for care planning, the facility failed to review and revise their care plans to reflect individual identified needs. For R65 and R71 the facility failed to facilitate an interdisciplinary care plan. For R141, the facility	F 657	F657 Care Plan Timing- Ellie A. R65 still resides within the facility, IDT care plan meeting completed with resident/RP. R71 still resides in the facility, IDT care plan meeting, physician order completed, and care plan reviewed and revised. R141 no longer resides in the	9/25/23

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F 657	Continued From page 53 failed to have the required interdisciplinary team members at the care plan conference, Findings include: The facility's policy on "Care Planning" dated 11/01/2019 documented, "... Each patient's care plan will be discussed at the care plan conference by the IDT [interdisciplinary team] under the leadership of a licensed nurse... Notes will be kept for each patient's care plan discussed at the conference. A designated staff member attending the conference will include an electronic progress note summarizing the conference and stating all who attended, including the patient and any family members who were present." 1. Review of R141's clinical record revealed: 6/21/23 - R141 was admitted to the facility. 6/29/23 - R141 attended a scheduled care plan conference. Review of the attendees at the care conference revealed that only E9 (Social Services), E45 (COTA) and E31 (LPN) attended the care plan conference. The facility lacked evidence that R141's attending Physician, a registered nurse, a nurse aide with responsibility for R141 and a member of the food and nutrition services attended the care conference. 7/24/23 12:49 PM - During an interview, E20 (Social Worker) confirmed that the required members of the IDT were not present at the care plan meeting on 6/29/23. The facility lacked evidence that the required interdisciplinary team (IDT) members participated in R141's care plan conference	F 657	facility. B. 1. SW/ designee completed 100% audit on all residents to ensure an IDT care plan meeting was conducted and or scheduled with required IDT and resident/RP. 2. DON/ designee completed 100% care plan audit on all residents that utilize a carrot device to ensure care plan reflects individual identified needs and physician orders for application. C. Root cause analysis was completed, concluded that a lack of understand that physician order is need to monitor assistive devices and care plans are revised to reflect the residents current status to ensure compliance with the regulation for care plans for all residents . DON/designed will educate license nursing to ensure physician orders are obtained for assistive devices, are in place on the TAR s for monitoring placement every shift and to revise care plans to reflect residents current interventions. Residents with a change in condition and/or new orders will be reviewed at morning clinical meeting, care plans will be updated to identify those needs and appropriate interventions are documented. Morning clinical team members will be educated on care planning identified residents needs. IDT was unaware of the required participants for care conference Administrator/designee will educate Social services on the required participants in care conferences. D. The SW/ designee will monitor all	

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 657	Continued From page 54 2. Review of R65's clinical record revealed: 11/29/20 - R65 was admitted to the facility. 7/26/22 - During record review it was observed that R65 had an assessment triggered as completed for a care plan conference. The facility was unable to provide documentation/progress notes of a care plan conference being held and its attendees. 7/13/23 - During an interview with R65 and FM2 it was voiced that they were never invited to attend care plan meetings. 1/28/23 - R65's care conference scheduled in the electronic health record was left with a status of incomplete. 7/19/23 2:04 PM - During an interview, E20 (Social Worker) stated that residents and their representatives are, "Notified [of their care conferences] by paper, and we put it in their room ...they don't need family to be called if they are their own representative ... Does it go up all the time? ...No, we are all human ... I did not get to do a care plan conference for everyone...". The facility failed to provide evidence that a care plan conference facilitated by the IDT was held for R65. Additionally, the facility failed to ensure the resident/resident representative participated in the care planning process. 3. Review of R71's clinical record revealed: 7/22/20 - R71 was admitted to the facility with a diagnosis of Brain damage and End Stage Renal Disease.	F 657	residents last IDT care plan meetings and the DON/designee will monitor all residents to ensure care plan reflects individual identified needs and physician orders daily x 3 days, with the goal of meeting 100% success consecutively, then weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly 100%. DON/designee will audit 5 residents with change in condition/new orders to ensure care planning revision weekly x 2 weeks until 100% then every 2 weeks for 2 months until 100%, then monthly for 2 months until 100%. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion : 9/25/2023	

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F 657	Continued From page 55 2/16/23 - Review of R71's care plan for "At risk for loss of range of motion related to existing contractures of the left hand" initiated on 10/24/22 documented ..."1. Will tolerate application of splint/orthotic device when worn. 2. Carrot to left hand as per order." 12/14/22 6:06 PM - A provider progress note documented by E72 (NP) included "abnormal findings related to right hand contractures of fingers and left hand flexion contractures." 12/22/22 - R71 was admitted to the hospital. 12/30/22 - R71 was readmitted to the facility with the existing left-hand contracture. The record lacked evidence of a physicians order for a carrot that had been revised in R71's care plan on 2/16/23. 7/24/23 11:18 AM - A random observation revealed that R71 did not have a carrot (soft orthotic device) in his left hand as care planned. 7/24/23 11:21 AM - Further review of R71's TAR (Treatment Administration Record) revealed that there was no order for a carrot to be placed in R71's left hand. 7/24/23 11:30 AM - During an interview and observation E25 (CNA) reviewed R71's care plan and revealed, "I'll be truthful with you, I did not know he needed to have a carrot placed in his hand. 7/26/23 8:53 AM - During an interview E26 (Rehab. Director) reviewed the order for R71's carrot to the left hand and revealed, the order fell	F 657		

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F 657	Continued From page 56 off (stopped) on 12/26/22 when R71 was in the hospital." In addition, E25 said, I don't know why the order fell off, and had not been aware R71 had not been using the carrot." 7/26/23 - An OT (Occupational Therapy) evaluation and plan of treatment documented..." Care giver goals, left hand contractures and skin integrity management. 7/26/23 11:21 AM - A physician's order written for R71 documented..."1. Apply carrot to left hand after morning care wear as tolerated, remove therapy carrot by dinner time." 7/26/23 2:40 PM - A second interview with E26 revealed "R71 had been seen for an evaluation and treatment, and had been ordered four weeks of therapy for ADL training." 7/27/23 - Further review of R71's care plan titled "At risk for loss of range of motion related to existing contractures of the left hand revised on 7/27/23 documented..."1. Carrot to the left hand as per order. The facility failed to ensure that a physician's order had been written for R71's plan of care that included applying a carrot (soft hand device) to the left hand for contractures after readmission to the facility on 12/30/23. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		9/25/23

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F 677	Continued From page 57 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that for two (R479 and R79) out of six residents reviewed for Activities of Daily Living (ADLs), the facility failed to ensure that residents, who are unable to carry out ADLs, received the necessary services to maintain good grooming and personal hygiene. Findings include: 1. On 7/24/23 at 10:10 AM, R479 was observed self ambulating in the Arcadia hallway. When she stopped walking she lifted her feet up, one at a time, showing the Surveyor the bottom of her non-skid socks. Observation revealed that the bottoms of her non-skid socks were black and filthy. R479 was wearing two different colored non-skid socks, one tan and one light blue. Observation was immediately confirmed with E12 (Agency LPN). The Surveyor asked if there were clean non-skid socks available on the Arcadia Unit. E54 (CNA) stated "no, we have to get the key to the supply closet to get a new pair." Observation of the supply closet on the Arcadia Unit revealed the absence of extra non-skid socks. The Surveyor asked if R479 had an extra pair in her room that was laundered. 7/24/23 at 10:15 AM - Observation of E12 (Agency LPN) checking R479's room confirmed that R479 did not have another pair of clean non-skid socks. 7/24/23 at 10:21 AM - During an interview, E22 (LPN/UM) was asked about the availability of	F 677	F677 ADL Care- Ellie A. R479 still resides within the facility. R3 no longer resides in the facility and is now receiving necessary services to maintain good grooming and necessary hygiene. B. 1. DON/ designee completed 100% audit on all residents that are dependent on ADL□s are receiving necessary services to maintain good grooming and necessary hygiene. 2 DON/designee completed 100% audit on all residents that have non-skid socks intervention for fall prevention. Clean non-skid socks are provided to the identified residents C. To prevent recurrence of this deficient practice the DON/ designee will educate nursing staff on maintaining grooming and hygiene care. It was determined the root cause of the deficient practice was the lack of knowledge of identifying residents□ need for assistance with personal hygiene care. DON/designee will educate nursing staff on providing ADL care to ensure residents are receiving necessary services to maintain good grooming, necessary hygiene and to locate that information on the Kardex feature in POC. Unit Managers/designee perform daily rounds to ensure residents are receiving necessary services to maintain good grooming and necessary	

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F 677	Continued From page 58 non-skid socks on the Arcadia Unit. E22 immediately left the Arcadia Unit with the Surveyor following and went to laundry to obtain a clean pair of light blue non-skid socks for R479. The Surveyor observed E22 change the non-skid socks and confirmed they were dirty. 2. Review of R79's clinical record revealed: 1/21/23 - R79 was admitted to the facility with a diagnosis of Dementia and Chronic kidney disease. 1/23/23 - Review of R79's care plan for ADL self-care deficit related to cognitive deficits and impaired mobility revised on 6/29/23 documented: 1. Will receive assistance necessary to meet ADL (Activity of Daily Living) needs. 2. Will be clean, well dressed, and well-groomed daily to promote dignity and psychosocial wellbeing. 3. Assist with daily hygiene, grooming, oral care and eating as needed. 4/29/23 - A quarterly MDS Assessment documented, that R79 was severly cognitively impaired and required extensive assist with one-person physical assist for bed mobility, transfers, eating, toileting, and personal hygiene. 6/8/23 - Review of R79's care plan for risk for falls revised 6/29/23 documented the use of non-skid socks while out of bed. 7/17/23 10:32 AM - A random observation revealed R79's nails were long and had dark thickened debris underneath all fingernails on the right and left hand. 7/17/23 12:46 PM - An interview with E28 (LPN)	F 677	hygiene, by DON/designee. D. The DON/ designee will monitor 5 resident□s ADL□s daily x 3 days, with the goal of meeting 100% success consecutively, then weekly for 4 weeks until the facility reaches 100% success. Then monitored monthly 100% until the facility reaches 100% success for two months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion: 9/25/2023	

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F 677	Continued From page 59 revealed, that R79 needed assistance with all ADL's. 7/18/23 9:26 AM - A second observation revealed R79's privacy curtain had been pulled and R79 was not visible from the hallway and had not been provided morning care or nail care. In addition, R79 was observed sitting up on the bedside with a gown pulled over the top of R79's head and both feet dangling and had no socks or shoes on. 7/18/23 9:36 AM - During an interview E50 (LPN) had been made aware that R79's privacy curtain had been pulled and that R79 needed nail care E50 said, "nail care is done whenever it can be done. In addition, E50 revealed, "we try to make it an activity, but yes, her nails do need to be cut especially her thumbs, I will try to get them cut sometime this afternoon." Additionally, E50 revealed R79's privacy curtain may have been pulled "because her caregiver had not provided care yet." 7/18/23 9:46 AM - A interview with E29 (CNA) revealed, "nail care is done when we have time or when everything is done around here, and then again some resident's nails are going to be dirty you have to clean them when you can." The facility had not provided good nail grooming for a dependent resident and did not assure that a resident at risk for falls had not been wearing any type of non-skid socks or other footwear as care planned. In addition, a resident that is at risk for falls and is severely cognitively impaired had a privacy curtain pulled while sitting up on the side of the bed. 7/31/23 at 2:00 PM - Findings was reviewed	F 677		

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F 677	Continued From page 60 during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 677		
F 684 SS=E	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 interviews and reviews of clinical records and facility documentation, it was determined that for 56 out of 113 residents sampled, the facility's failure to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan were evidenced by the following: - For 15 out of 34 residents in the Arcadia Unit during a weekend night shift, the facility failed to ensure that residents were administered medications, provided treatments, supervised/monitored and assessed for pain. - For 35 out of 37 residents in the New Castle Unit during a weekend night shift, the facility failed to ensure that residents were administered medications, provided treatments, monitored and assessed for pain. - For R135, the facility failed to provide care and treatment per her plan of care by the daily administration of a laxative medication in the setting of repeated loose stools with perianal skin	F 684	F684 Quality of Care- A. R70, R56, R57,R62, R63, R74, R80, R81, R88, R94, R96, R97, R135, R139, R140, R133, R12,R26,R33,R34,R39,R50,R58,R89,R93,R95,R99,R117,R105,106,R119,R1,RR,R4,R5,R14,R21,R23,R24,R28,R32,R35,R36,R37,R43,R46, R47, R52,R54 still reside in facility and are receiving all medications and treatments according to physician orders. B. DON/ designee completed a 100% audit of all residents Mars and Tars to ensure treatment and care is now being provided. C. To prevent recurrence of this deficient practice the DON/ designee will educate the licensed nursing staff on facility□s policy for administration of medication and treatments with documentation on the MAR□s and TAR□s. It was determined the root cause of the deficient practice	9/25/23

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F 684	Continued From page 61 alteration and the failure to notify the physician; and the facility failed to monitor R135's blood pressure and properly assess the resident by obtaining current vital signs during a change of condition. - For R139, the facility failed to administer physician-ordered medications on the evening of admission. - For R140, the facility failed to schedule two follow-up appointments with R140's surgeon: one for assessment and drain removal within a week to ten days after admission to the facility; and one at the 2-week timeframe from facility admission. - For R133 with CHF, the facility failed to obtain weights for five consecutive days, which revealed a 20 lb weight gain during the week. - For R138, the facility failed to monitor the resident's daily blood pressure and heart rate. - For R279, the facility failed to monitor the resident's heart rate. Findings include: 1a. Cross refer to F725, example 2 From 11:00 PM on 7/1/23 (Saturday) through 7:00 AM on 7/2/23 (Sunday), the locked dementia Arcadia Unit did not have an assigned nurse on duty for the entire shift. As a result, the following 15 out of 34 residents were not administered medications and/or provided treatments and/or monitored/supervised according to each residents' plan of care. - R12: Omeprazole (for GERD), Oxycodone, Tylenol, applications of an Icy Hot Patch and Bengay Patch to right knee (for pain); and assessment of pain level. - R19: Synthyroid (for Hypothyroidism) and medicated mouthwash.	F 684	was the lack of knowledge of the regulation of F684 and failure to provide stand of care, medications and treatment administration. D. The DON/ designee will monitor documentation, medication and treatment administration to ensure that residents are receiving medication and treatments per physician orders x 3 days, with the goal of meeting 100%,m weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly x 2 months reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion: 9/25/2023	

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F 684	Continued From page 62 - R26: Synthyroid (for Hypothyroidism), Omeprazole (for GERD), Lactulose (for constipation), Metoclopramide (for Gastroparesis), Sucralfate (for GERD), and application of Icy Hot Patch (for pain). Required 1:1 supervision. - R33: Combigan eye drops (for Glaucoma), Pilocarpine eye drops (for Glaucoma), Bengay cream (for pain) and Icy Hot Patch (for pain). - R34: Protonix (for GERD). - R39: Omeprazole (for GERD) and application of edema glove to right hand. - R50: Tylenol (for Arthritis) and Bengay cream (for Arthritis). - R58: Famotidine (for GERD). - R70: Synthyroid (for Hypothyroidism) and Omeprazole (for GERD). - R84: Lorazepam (for Anxiety). - R89: Finasteride (for BPH) and Bengay Patch to right rib cage (for pain). - R93: Omeprazole (for GERD) and Wixela puff (for COPD). - R95: Synthyroid (for Hypothyroidism), Tylenol (for pain) and Lansoprazole (for GERD). - R99: Synthyroid (for Hypothyroidism) and Tylenol (for pain) and assessment of pain level. - R117: Omeprazole (for GERD). 7/28/23 at approximately 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). No further information was provided to the Surveyor. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO). 1b. Cross refer to F725, example 3	F 684		

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F 684	Continued From page 63 From 11:00 PM on 7/15/23 (Saturday) through 7:00 AM on 7/16/23 (Sunday), the New Castle Unit did not have an assigned nurse on duty for the entire shift. As a result, the following 35 out of 37 residents were not administered medications and/or provided treatments and/or monitored during the entire shift according to each residents' plan of care: - R1: Omeprazole (for GERD), blood glucose check, and monitored for psychotropic meds side effects. - R3: Tylenol (for pain), removal and application of Rivastigmine 24 hours Patch (for Dementia), provided with the allocated 120 mls of fluid on night shift as R3 was on a fluid restriction, check placement of wanderguard bracelet every shift, and monitored for left AV fistula for bruit and thrill and psychotropic meds side effects. - R4: Omeprazole (for GERD) and application of Zinc Oxide paste to the sacrum/buttocks for protection. - R5: monitored for psychotropic meds side effects. - R6: Tylenol (for pain) and application of ace wraps to bilateral lower extremities (for edema). - R14: Omeprazole (for GERD/GI bleed), incentive spirometry 10 breaths every 2 hours to prevent complications and exercise lungs, and offload heels when in bed. - R21: Xanax (for Anxiety) and Synthyroid (for hypothyroidism), monitored for psychotropic meds side effects, and application of ted stockings to bilateral lower extremities (for edema). - R23: Omeprazole (for GI bleed) and two scheduled doses of Tylenol (for headache), encourage fluids every shift, incentive spirometry 10 breaths, and application of Eucerin lotion to	F 684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 64 bilateral lower extremities (for dry skin). - R24: elevate left lower extremity on 2 pillows. - R28: Omeprazole (for GERD) and Tylenol (for pain), encourage oral fluids for hydration, sling to right upper arm at all times (for Olecranon fracture), check skin under right upper arm sling every shift, and monitor antidepressants side effects. - R32: monitored for psychotropic meds side effects. - R35: Omeprazole (for GERD), offloading boots while in bed, and application of Z-guard skin protectant paste to scrotum/sacrum (for MASD). - R36: Pantoprazole (for GERD), CPAP settings (for Obstructive Sleep Apnea), apply bilateral heel boots when in bed, and maintain suprapubic indwelling catheter and provide catheter site care. - R37: Tylenol (for pain) and Synthyroid (for Hypothyroidism), monitored for continuous oxygen at 4 Liters by nasal cannula (for shortness of breath/chronic respiratory failure), and application of Remedy Z Guard to bilateral buttocks (for MASD). - R43: two scheduled doses of Tylenol (for pain) and Synthyroid (for Hyperthyroidism), and application of Z-guard to bilateral groin and sacrum, elevate heels on a pillow, application of skin prep to both heels for skin protectant, and monitored for psychotropic meds side effects. - R46: Lokelma oral packet (for Hyperkalemia) and blood glucose check/notify the physician (for Diabetes). - R47: Omeprazole (for GERD) and provided with 240 mls of fluid to increase oral fluid intake every shift for elevated sodium. - R52: Omeprazole (for GERD), elevate bilateral lower extremities, maintain Prevalon boots to bilateral heels while in bed, and monitor psychotrophic meds side effects.	F 684		

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 684	Continued From page 65 - R54: encourage increased oral fluids, application of Prevalon boots on while in bed, and monitoring of psychotropic meds side effects. - R56: Synthyroid (for Hypothyroidism), monitored for maintaining pulse oxygenation >92% as R56 was on continuous oxygen 2 L by nasal cannula and psychotropic medications side effects, and application of gerry sleaves to bilateral upper extremities for skin protection. - R57: monitored for antipsychotic and antidepressant medications side effects. - R62: application of ace wraps (for edema). - R63: Synthyroid (for Hypothyroidism) and Gabapentin (for Neuropathy), monitored for psychotropic medications side effects, and application of ted stockings to bilateral lower extremities (for edema). - R65: Synthyroid (for hypothyroidism), monitored for antidepressant medications side effects, and application of Z-Guard skin protectant to sacrum/bilateral buttocks for prevention. - R74: Ferrous sulfate (for anemia). - R80: two doses of eye drops (for dry eyes), monitored for psychotropic medications side effects, and elevate heels while in bed to prevent skin breakdown. - R81: provided with allocated 120 mls of fluids for night shift as R81 was on a fluid restriction, and applications of ace wraps to bilateral lower extremities and zinc oxide paste for skin protection. - R88: Synthyroid (for Hypothyroidism), monitoring for psychotropic meds side effects, and checking placement of the wanderguard bracelet every shift. - R94: Omeprazole (for GERD) and two scheduled doses of Tylenol (for pain). - R96: Synthyroid (for Hypothyroidism), Gabapentin (for Neuropathy), blood glucose	F 684		

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F 684	Continued From page 66 check, and monitoring of psychotropic meds side effects. - R97: Omeprazole (for GERD) and monitored for antidepressant side effects. - R101: Vitamin A&D ointment to bilateral legs and feet and monitoring of psychotropic meds side effects. - R105: Omeprazole (for GERD), application of an ankle stirrup brace and monitoring of psychotropic meds side effects. - R106: Incentive spirometry 10 breaths. - R119: monitored antipsychotic and antidepressant medications side effects. 7/28/23 at approximately 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). No further information was provided to the Surveyor. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO). 2a. Review of R135's clinical record revealed: 11/16/22 - R135 was readmitted to the facility with diagnoses that included Dementia, known liver mass and recent COVID-19 infection. 11/16/22 at 3:30 PM - A nursing admission note documented that R135's skin was intact. 11/16/22 - R135 was care planned for at risk for alteration in skin integrity related to incontinence with interventions that included, but was not limited to: - barrier cream to peri area/buttocks as needed; - observe skin condition with ADL care daily,	F 684		

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F 684	Continued From page 67 report abnormalities; and - provide preventative skin care routinely and as needed. 11/16/22 - A physician's order stated to give two tablets of Senna-S (bowel laxative/stimulant) medication at bedtime for constipation. 11/16/22 - R135 was care planned for bowel elimination alteration, constipation with interventions that included, but was not limited to: - administer medications per physician order and observe effectiveness; - notify physician of any changes in bowel function; - record BM (bowel movement) and report abnormalities; and - report signs and symptoms... diarrhea.... Review of the November 2022 CNA Documentation Survey Report revealed R135 had the following bowel incontinent episodes: - Saturday, 11/19/22: two large loose (L); - Sunday, 11/20/22: two small and one large semi-formed (SF); - Monday, 11/21/22: two medium SF; - Tuesday, 11/22/22: one medium SF; one large L; - Wednesday, 11/23/22: one medium SF; one medium L; - Thursday, 11/24/22: none; - Friday, 11/25/22: one small and two medium SF; one large L; - Saturday, 11/26/22: two medium L; one large L; - Sunday, 11/27/22: one medium SF; one medium L; - Monday, 11/28/22: two small L; - Tuesday, 11/29/22: one small SF; two small L; one large L.	F 684		

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F 684	Continued From page 68	F 684		

Review of the Nursing Notes documented from 11/19/22 through 11/29/22 revealed the absence of R135's repeated episodes of loose stool and perianal skin alteration. In addition, there was no evidence in the clinical record that E3 (Physician) was notified of R135's loose stools per the plan of care.

Despite repeated episodes of loose stools, R135 continued to be administered Senna-S medication daily according the November 2023 eMAR.

11/21/22 - A speech therapy note documented, "... Pt was A&Ox3 (alert and oriented times 3-person, place and time). She was weepy to sitting in BM (bowel movement) and not having insight to push callbell. She stated, "I thought I pushed it...maybe I didn't...".

11/25/22 - An occupation therapy note documented that R135 was "anxious and soiled" (incontinent) upon therapist arrival for session. "... Pt was dependent to wash while supine (flat)... Pt was pulled up in bed...".

11/29/22 - A physical therapy note documented that R135 was "found in bed incontinent of urine and feces, liquid stools with moderately found odor. Performed rolling max assist for hygiene and to change disposable brief, as well as clean (R135)... noted to have been incontinent of urine and liquid stool in pants and brief. Nursing notified, and vaginal and anal region assessed...".

11/29/22 - An occupational therapy note documented that "Nursing was notified of extensive redness in the perineal area, noted

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F 684	Continued From page 69 while washing and changing the pt (patient). The nurse and unit manager examined the pt and will follow up with the pt. The bedsheets were changed with the pt still in the bed. The CNA was notified of the Pt's BM and skin redness after the pt was washed and changed and examined by the nurse... following very loose stool... Toileting hygiene = Dependent...". Despite two therapists notifying nursing staff of R135's incontinent episodes and perianal skin alteration, there was no nurse's documentation in R135's clinical record of either observation. 11/29/22 at 6:35 PM - R135 was sent to the hospital for altered mental status and shortness of breath. 7/28/23 at 5:00 PM - During a combined interview with E1 (NHA), E2 (DON) and E4 (RCD), the Surveyor discussed concerns of R135's continued administration of a laxative medication despite have repeated loose stools and her perianal skin alteration. The Surveyor asked if there was additional documentation that the facility would like to provide for review. No further documentation was provided to the Surveyor upon exit. The facility failed to ensure that R135 failed to receive care and treatment per her plan of care as evidenced by daily administration of a laxative medication in the setting of repeated loose stools with perianal skin alteration and the failure to notify the physician. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 684		

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F 684	Continued From page 70 2b. Review of R135's clinical record revealed: 11/25/23 - A progress note by E3 (Physician) documented, "... HTN (high blood pressure) Continue to monitor blood pressure...". R135's clinical record lacked evidence that her blood pressure was being monitored. The last blood pressure of 102/63 was documented on 11/19/22. 11/28/22 at 4:30 PM - A consult with P6 (Cardiologist) documented that R135 "... Now she is a bit lightheaded and the SBP (Systolic blood pressure) has declined... history of orthostatic hypotension... she is symptomatic again, regarding her hypotension (low blood pressure)... recommend reducing her Losartan (blood pressure medication)...Her BP will be evaluated daily and see how she does...". 11/29/22 at 2:21 PM - A progress note by 68 (NP) documented, "... therapy requested her to be evaluated for dysarthria (slurred speech) and R (right) side facial droop... A&O (alert and oriented) x (times) 2 (person, place)... Exam details: BP 102/63 - 11/19/2022, pulse 58 - 11/19/2022, respirations 18 - 11/19/2022, O2 saturations 96% - 11/29/2022, temperature 97.8 - 11/29/2022... Diagnosis: 1. Acute kidney injury... she does not want to go to the ER... 2. Acute lethargy...". 11/29/22 at 6:08 PM - The facility's Acute Transfer Form completed by E55 (RN Supervisor) documented R135's most recent vital signs as: - blood pressure 102/63 - date 11/19/22 at 19:57	F 684		

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F 684	Continued From page 71 (7:57 PM); - pulse 58 - date 11/19/22 at 19:57; - respirations 18 - dated 11/19/22 at 19:57; - temperature 98 - dated 11/29/22 at 19:29 (7:29 PM); - pulse ox 95% on room air - dated 11/29/22 at 19:29. 11/29/22 at 6:14 PM - The EMS Prehospital Care Report documented R135's vital signs as BP 92/46, HR 62, R 16, pulse ox 100% on supplemental oxygen 5LPm (liters per minute) at R135's bedside in the facility. 11/29/22 at 7:20 PM - E55 (RN Supervisor) documented in a Change of Condition note, "... Upon assessment this evening, patient noted with increased lethargy and hypoxia (shortness of breath) VS (vital signs) 98 (temperature) - 58 (heart rate) - 18 (respirations) 102/63 blood pressure POX (pulse oximetry) 88% on RA (room air). O2 (oxygen) applied via NC (nasal cannula) @ 3LPM. POX up to 95%...". Despite R135's change of condition on 11/29/22, the facility's staff failed to obtain current vital signs (blood pressure, heart rate and respirations) and instead used old vital signs obtained on 11/19/22, which was then communicated to the receiving acute care hospital upon her transfer. 3. 12/9/22 - R140 was admitted to the facility following abdominal surgery. Review of R140's facility clinical record and hospital record revealed: 12/9/22 - Discharge orders from the hospital	F 684		

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F 684	Continued From page 72	F 684		

included: "drain care, empty and record every shift. Follow up with P5 (General Surgeon) in 2 weeks."

12/10/22 - A Physician's order included: "Empty x 5 Abdominal JP drains Q (every shift) and record drainage amount."

12/12/22 - Three days following R140's admission to the facility, a Physician's order included: "Abdominal Binder when OOB week 2 until F/U (follow up appointment with Surgeon. May remove for care." An additional Physician's order included: "Cleanse abdominal JP (Jackson Pratt) drain sites (5) [five drain sites] with NSS (normal saline solution) and LOA (leave open to air) every shift."

12/12/23 - A Physician's order for R140 included to schedule a follow-up appointment with P5 (General Surgeon). The order did not specify a date for the follow-up, and lacked evidence of clarification.

Although the Physicians order for R140 was to have his five drains emptied every shift, review of R140's treatment administration record revealed that the facility lacked evidence that R140's abdominal JP drain sites were cleansed and emptied per order (on day shift) at 7:15 AM on 12/13/22 and 12/21/22.

12/20/22 1:39 PM - A nursing progress note included: "Surgery f/u (follow up) appt. (appointment) 12/27/(22)." 12/27/22 was 18 days after admission and the follow-up appointment had not been scheduled until eleven days after admission.

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F 684	Continued From page 73 12/23/22 4:04 PM - A nursing progress note documented: "Patient sent out to the ER at (name of) hospital due to abnormal lab (sic) and change of mental status." 12/23/22 11:24 PM - A hospital nursing transport team picked up R140 to transfer her from one hospital to another for further care. The transport documentation included: "PT (patient) has 5 Jackson prat drains with brownish drainage in drains. PT Jackson Prat drainage site with yellow foul odor drainage from all sites. 12/24/22 7:43 PM - A hospital history and physical note documented: (R140) " ...presented to the ED (Emergency Department) from (facility name) with abdominal pain and foul-smelling JP drains." 12/24/22 11:39 AM - A hospital surgical note documented: "Has not come to see me post op (after surgery) JP (drains) still in." 12/24/22 12:55 PM - A hospital consult note documented that R140 had a "surgical site infection". 2/14/23 - A hospital discharge summary note included: "The patient actually had not been followed up in either (Surgeon) office and was manifesting signs of fat necrosis (death of fat tissue due to injury and loss of blood supply) in her JP drains, which had not yet been removed." 8/4/23 8:35 AM - During an interview, P2 (Surgical Practice Manager for P3 [surgeon]) confirmed that R140 should have been scheduled a follow up appointment with P3 for assessment	F 684		

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F 684	Continued From page 74	F 684		

and drain removal within a week to ten days after admission to the facility. In addition, P2 stated R140 should have had a follow-up appointment with P5 (an additional surgeon) at the 2-week time frame from admission to the facility. The facility had not followed this process.

8/4/23 5:07 PM - E2 (DON) confirmed that the facility lacked evidence of R140 receiving her treatments at 7:15 on 12/13/22 and 12/21/22.

4. Review of R139's clinical record revealed:

5/12/23 approximately 5:30 PM - R139 was admitted to the facility with diagnoses of respiratory and heart failure.

5/12/23 8:00 PM - Review of R139's medication record revealed that R139 was due to be administered a sleep aide medication, an asthma medication, a stomach medication, eye drops and a high blood pressure medication. The facility lacked evidence that these medications were administered.

7/27/23 1:24 PM - During an interview, E4 (Regional Clinical Director) stated that there are cutoff times for the pharmacy to deliver medications. E4 added that there are a number of medications in the Pyxis (an automated medication dispensing system) at the facility. E4 stated that the facility also has a back-up pharmacy to acquire medications if you cannot obtain medications for the resident from the facility pharmacy. E4 confirmed R139 did not receive her evening meds on the day of admission.

5. Review of 133's clinical record revealed:

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F 684	Continued From page 75 4/8/21 - R133 was admitted to the facility with multiple diagnoses including heart failure. 4/15/21- A Physician's order was written for R133 to be weighed daily and to notify the physician if R133 had a weight gain of 3 pounds (lbs.) in 24 hours or 5 lbs. in 1 week. R133's weights: 4/19/21 - 199.8 lbs. 4/26/21 - 219.0 lbs. Weights were not obtained on R133 for five (5) consecutive days, from 4/20/21 thru 4/25/21. R133 experienced a twenty-pound (20) weight gain during the week of 4/19/21 - 4/26/21. 6. Review of 138's clinical record revealed: 5/31/21 - R138 was admitted to the facility with diagnoses including cardiac disease and high blood pressure. 5/31/21 - R138's care plan for heart disease had an intervention that stated to call the physician if R138's heart rate was less than 50. 6/1/21 - A Physician's order was written for Metoprolol 25 milligrams (mg) by mouth daily for high blood pressure. 6/3/21 - A Physician's order was written to take a temperature and an oxygen level on R138 every shift. Other vital signs such as blood pressure and heart rate were not ordered to be taken on R138.	F 684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 76 R138 had diagnoses including high blood pressure and was ordered a daily blood pressure medication that could have affected R138's blood pressure and heart rate. R138 did not receive a daily blood pressure or heart rate measurement from 6/3/21 thru 6/24/21. A daily blood pressure and heart rate measurement would have reflected changes in R138's blood pressure and heart rate related to the daily Metoprolol medication. 7/20/23 8:30 AM - During an interview, E31 (LPN) stated that she would get vital signs on her assigned residents based on their medical issues and the type of medications that were ordered to be given. For example, if a resident is on a blood pressure medication, E 31 would make sure that there was a recent blood pressure on the resident to check prior to giving the medication. If the resident was on a medication that could affect the heart rate, E31 would check the resident's recent heart rate prior to giving the medication. According to the 2023 Nursing Drug Handbook, a harmful reaction of Metoprolol includes a slowed heart rate. 7. Review of R279's record revealed: 5/14/21 - R279 was admitted to the facility with multiple diagnoses including heart failure and atrial fibrillation (irregular heartbeat). 5/31/21 - R279's care plan for heart disease had an intervention that stated to call the physician if R279's heart rate was less than 50. 5/15/21 - A Physicians order was written for	F 684		

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F 684	Continued From page 77 Amiodarone 200 (mg) tablet to be given by feeding tube one time daily for atrial fibrillation. 5/17/21 - A Physician's order was written to take a temperature and an oxygen level on R279 every shift. Other vital signs such as blood pressure and heart rate were not ordered to be taken on R279. R279 had diagnoses including cardiac disease with an irregular heartbeat and was ordered daily heart medications that could have caused changes in R279's heart rate. R279's heart rate was not measured daily from 6/18/21 thru 7/8/21. A daily heart rate measurement would have reflected changes in R279's heart rate related to the daily Amiodarone medication. 7/9/21 - R279 was sent to the hospital for a sudden change in condition when R279 experienced a sudden increase in heart rate. 7/20/23 8:30 AM - During an interview, E31 (LPN) stated that she would get vital signs on her assigned residents based on their medical issues and the type of medications that were ordered to be given. For example, if a resident is on a blood pressure medication, E31 would make sure that there was a recent blood pressure on the resident to check prior to giving the medication. If the resident was on a medication that could affect the heart rate, E31 would check the resident's recent heart rate prior to giving the medication. According to the 2023 Nursing Drug Handbook, a harmful reaction of Amiodarone can be a change in heart rate. 7/31/23 at 2:00 PM - Findings were reviewed	F 684		

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F 684	Continued From page 78 during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, it was determined that the facility failed ensure that residents received the proper treatment and assistive device to maintain vision/hearing for two (R101 and R65) and two residents reviewed for vision/hearing. Findings include: 1. Review of R101 clinical records revealed: 8/3/22 - R101 was admitted to the facility. 8/3/22 10:27 PM - A nurse admission progress note documented that, "Resident (R101)...mild difficulty in hearing...reported that she had hearing aids before but she lost them...wears glasses but her (R101) daughter is going to bring a new set...no glasses present on admission...".	F 685	F685 Treatment/Devices Hearing-Vision A. R101 still resides in the facility and does have glasses in the facility, has been assessed by SightRite Eye Care Services and indicated the current glasses are sufficient R 101 was seen by Audiologist 9/18/23 recommendations are being followed. R65 still resides in the facility. ENT treatment instructions completed. B. DON/ designee completed a 100% audit of all residents with vision and/or hearing consults to ensure recommendations have been addressed in a timely manner. C. Root cause analysis determined vision and hearing consult recommendations were not addressed in a timely manner. DON/designee will	9/25/23

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F 685	Continued From page 79 8/9/22 - R101's Admission MDS revealed that R101 had minimal hearing difficulty or had difficulty in some environments like when person speaks softly or setting is noisy. R101's MDS assessment also documented that R26's vision was impaired, she can see large print but not regular print in newspapers/books. R26 did not have corrective lenses. 8/10/22 8:00 AM - An activity evaluation note was completed and revealed that, "Resident (R101) reports having hearing aids but they are lost at this time...". 8/10/22 7:26 PM - A physician progress note on exam details documented, "hearing impaired". 8/10/22 - An activity care plan for R101 revealed that R101 enjoys activities such as keeping up with current events, watches TV (television) listening to any kind of music , watching movies on TV...going shopping and on outings... and socializing...Resident (R101) has a past interest in knitting, reading, word games, playing cards...cannot always engage in activities of interest due to poor vision...enjoys both independent and group activity. R101's interventions included but not limited to arranging for seating close to leader of activity programs as patient is hard of hearing and offer/supply large print materials. 8/17/22 - R101 had a care plan developed for impaired vision as evidenced by patient report due to no eye glasses in the facility. R101's interventions were to attempt to keep frequently used items within easy reach, provide ADL (Activities of Daily Living) assistance as needed	F 685	monitor resident with vision and/or hearing consults ensure that recommendations are addressed in a timely manner. DON/designee will educated licensed nursing staff of ensuring vision and/or hearing recommendations are followed through in a time fashion D. The DON/ designee will monitor all residents with vision and hearing impairments to ensure residents receive the proper TX and assistive device in a timely manner daily x 3 days, with the goal of meeting 100% success consecutively. Residents with vision and hearing impairments will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly 100% Residents with vision and hearing impairments until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. E. Date of completion: 9/25/2023	

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F 685	Continued From page 80 and to use large print materials. 11/9/22 - Review of R101's Quarterly MDS assessment revealed that R101 had minimal difficulty with hearing, impaired vision and did not have corrective lenses. 11/9/22 9:29 AM - A quarterly recreation progress note documented that, "...Resident (101) has tendency to participate in limited to no group activities due to poor vision and hearing...". 2/9/23 - Review of R101's Quarterly MDS assessment revealed that R101 had minimal difficulty with hearing, impaired vision and did not have corrective lenses. 5/12/23 - Review of R101's Quarterly MDS assessment revealed that R101 had minimal difficulty with hearing, impaired vision and did not have corrective lenses. 5/22/23 - An "Ear, Nose & Throat Consultation Report revealed suspected bilateral hearing loss and for audiology evaluation. 7/28/23 8:40 AM - In an interview, E12 (LPN) stated that, "Resident (R101) is able to make her needs known but you just have to make your voice louder as she has hearing issues. I don't know if she had a hearing aid before nor if she wore glasses. I am not familiar if resident was already seen by and eye and ear doctor, 7/28/23 9:53 AM - In an interview, E14 (CNA) stated that, "when I talk to the resident (R101), I had to make voice louder because she can not hear very well - specially if you talk in your regular voice."	F 685		

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F 685	Continued From page 81 7/28/23 9:53 AM - Review of the (named company) Hearing Assessment Report dated 5/11/23 revealed, "...cerumen present to both ears, patient states she has difficulty hearing. Continue to evaluate hearing, difficulty in some environments - people talking softly, noisy settings; no hearing aids at time of the assessment. Recommendation: ENT (Eyes, Nose and Throat)Consult with Hearsay ENT doctor for cerumen management and decreased hearing". 7/28/23 9:58 AM - Review of Audiology Testing/Hearing Services report dated 7/25/23 revealed that resident was on the list of patients to be seen by the audiology consultant on 8/1/23. 7/28/23 9:59 AM - In an interview, E1 (NHA) confirmed that R101 was only started being seen by the ear doctor in May 2023. E1 also stated that R101 was already on the list of patients to be seen by the audiology consultant on 8/1/23. 7/28/23 10:19 AM - In an interview E2 (DON) confirmed that R101 was, "...already seen by the eye doctor for the first time yesterday (7/27/23) and R101's follow up visit will be on 1/24/23. The facility failed to ensure that R101 received the proper treatment and assistive device in a timely manner to maintain her vision/hearing. 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). 2. Review of R65's clinical record revealed: 11/29/20 - R65 was admitted to the facility.	F 685		

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F 685	Continued From page 82 3/30/23 - Due to a complaint of a decrease in hearing, R65 completed a hearing assessment that recommended a follow-up with an ENT (Ears, Nose, and Throat Doctor). 5/22/23 - During R65's ENT follow-up, R65 was found to have cerumen (earwax) accumulation in the left ear with instructions for treatment stating, "debridement and treatment of ear drops Acetasol HC both ears 3 drops BID (twice a day) x 14 days." 6/9/23 - R65's quarterly MDS (Minimum Data Set) assessment evaluated the resident to have adequate hearing. 7/13/23 11:05 AM - An interview with R65 and FM2 revealed that the M.D. (Medical Director) recommended a hearing evaluation for R65 who is hard of hearing. FM2 said "I have to speak loudly and clearly to [my] mom because she can hardly hear... she turns the TV volume up because she can hardly hear ... They were supposed to have a hearing evaluation done because she may need hearing aids ...". 7/17/23 - During record review, it was determined the facility lacked evidence of following up with R65's ENT treatment instructions. 7/18/23 1:06 PM - During an interview with E22 (LPN/Unit Manager), the Surveyor asked if there are any treatments or recommendations on R65's ENT consult? E22 replied, "Yes, ear drops." The Surveyor asked if the medication was ordered for R65. E22 stated, "No, I don't see it." 7/18/23 1:20 PM - E51 (Director of Clinical Informatics) confirmed that R65's ear drops were	F 685		

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F 685	Continued From page 83 not ordered. The facility failed to ensure that R65 received the proper treatment to maintain hearing abilities. The facility failed to follow-up on R65's ENT consult on 5/22/23, which founded a diagnosis cerumen accumulation (earwax blockage) in the left ear and recommended treatment with Acetasol HC in both ears 3 drops BID (twice a day) x 14 days which was never ordered for the resident. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (Corporate Nurse), and E18 (Vice President of Operations) on 7/31/23, at approximately 2:00 PM.	F 685		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other documentation, it was determined that for three (R140, R38 and R36)	F 686	F686 Treatment (Pressure Ulcers)- F686 1.	9/25/23

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F 686	Continued From page 84 out of four residents reviewed for pressure ulcers, the facility failed to ensure that residents at risk for pressure ulcers, or those with pressure ulcers received the care and services to promote healing and to prevent new pressure ulcers from occurring. For R140, the facility lacked evidence of a turning and repositioning intervention causing harm to the resident related to avoidable new unstageable and suspected deep tissue pressure ulcer development. In addition, for R140, the facility failed to identify and treat R140's pressure ulcers. For R38 the facility lacked evidence of physician ordered wound treatments and interventions being implemented causing harm to the resident related to new avoidable pressure ulcer development. This lack of treatment also failed to promote healing of an existing pressure ulcer.For R36, the facility failed to ensure that R36 received the necessary daily treatment frequency of pressure ulcer dressing changes to promote the healing. Findings include: A facility policy entitled "Pressure Ulcer Monitoring & Documentation" (initiated 11/1/2019) included: -A licensed nurse will assess patients for the presence of pressure ulcers/injuries. A facility policy entitled "Skin Assessments" (initiated 11/1/2019) included: -A licensed nurse will ensure that the skin risk assessment is done upon admission and quarterly thereafter. -The weekly skin assessment will be completed thereafter. 1. Review of R140's clinical record revealed: 12/9/22 - R140 was admitted to the facility	F 686	A. R140 no longer resides at the facility. R38 continues to reside at the facility. R38□s care plan, Kardex and POC task have been updated with turning/repositioning, heel offloading intervention by DON/designee. B. All residents who are at risk for developing and have existing pressure ulcers are at risk from this practice. DON/designee will review residents□ Braden Scales to identify those who are at risk for developing and those identified that have existing pressures to ensure that turning/repositioning, and heel offloading if assessed as needed, are added to their care plans, tasks and Kardex in POC documentation. C. Root cause analysis determined that it was a knowledge deficit regarding implementation of turning/repositioning and heel offloading for residents at risk for and have existing pressure ulcers. No policy revisions required. Residents at risk of developing and having existing pressures will be reviewed on admission and weekly at IDT meeting to ensure that turning/repositioning, heel offloading if assessed to need are added to their care plans Kardex and POC tasks. DON/designee will in-service nursing management team on reviewing residents at risk and with existing pressure ulcers to ensure that turning/repositioning and heel offloading documentation is in place. DON/designee will educate the nursing staff on turning/repositioning and heel offloading, residents who are identified at risk for developing and existing pressure ulcers	

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F 686	Continued From page 85 following an abdominal surgery. 12/9/22 - R140's Braden Scale Assessment on admission revealed mild risk for pressure ulcer development. 12/9/22 5:30 PM - R140's nursing evaluation on admission documented no pressure ulcers at the time of entry to the facility. 12/9/22 - A physician's order included body audits on every evening shift every Tuesday and Friday for skin observation. 12/12/22 - A physician's order included that R140 was required to wear an "abdominal binder when out of bed OOB week 2 until f/u (follow up) appointment with surgeon. May remove for care/hygiene." 12/12/22 - R140's care plan for being at risk for alteration in skin integrity had not intervention the resident required assistance for turning and repositioning in bed. The facility lacked evidence of turning and repositioning in the CNA tasks. 12/15/22 - R140's Admission MDS assessment documented that R140 required extensive assistance of two staff members to be repositioned in bed, was at risk for pressure ulcers and R140 did not have any pressure ulcers. There was no update to the care plan for the resident's repositioning needs. 12/23/22 - R140's discharge (to the hospital)	F 686	D. DON/designee will audit 10 residents who have been identified as at risk for and have existing pressure ulcers for documentation of turning/repositioning and offloading heels in care plans, Kardex and tasks, weekly times 4 weeks until 100%, then every 2 weeks times one month 100%, then monthly times one month until 100%. Results will be brought to QAPI for review and further recommendations. 2. A. R38 continues to reside at the facility. DON/designee reviewed wound orders with practitioners to ensure that the orders were correctly entered into PCC, and the resident is receiving the ordered care. B. All residents who have pressure ulcers are at risk from this practice. DON/designee will review residents with pressure ulcers with practitioners to confirm wound orders were correctly entered into PCC and audit that the identified residents are receiving the ordered care. C. Root cause analysis determined that the license nursing staff failed enter wound care orders correctly and to document wound orders were carried out. DON/Designee will provide in-service licensed nursing staff on entering wound care orders correctly, performing treatments and documenting that the treatment was completed. No policy revision required. D. DON/designee audit 10 residents with	

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F 686	Continued From page 86 MDS assessment documented that R140 did not have any pressure ulcers. 12/23/22 4:04 PM - A nursing progress note documented: "Patient sent out to the ER at (name of) hospital due to abnormal lab (sic) and change of mental status." 12/23/22 11:24 PM - A nursing transport team picked up R140 to transfer her from one hospital to another for further care. The transport documentation included: - "Abdominal Comments: distended and tender to touch. PT (patient) has 5 Jackson Prat (sic) drains with brownish drainage in drains. PT Jackson Prat drainage site with yellow foul odor drainage from all sites. PT had additional wounds around where abdominal binder was in place." - "Back Findings: meplex (a type of wound dressing) in place in sacral area. PT has multiple pressure wounds to right and left buttocks with eschar noted." - "Skin Findings: ... multiple open wounds noted on PT skin." 12/23/22 - A physician hospital history and physical progress note documented that R140 had "multiple ulcerations of patient's backside." 12/24/22 (untimed) - Hospital nursing admission assessment documented: - Abdomen noted with multiple suspected deep tissue injuries surrounding edges of binder. Previously noted suspected pressure injuries to left thigh and right thigh are the posterior	F 686	wound orders will be conducted to ensure that treatment orders have been entered correctly, have been completed and documented weekly times 4 weeks until 100%, every 2 weeks for 2 months until 100%, monthly times 2 months until 100%, results will be brought to QAPI for review and further recommendations. 3. A. R36 continues to reside at the facility, the wound treatment recommendations were reviewed with the practitioners and order was entered correctly into electronic medical record by DON/designee. B. All residents who have treatment orders, have the potential to be affected by this practice. DON/designee will review residents with treatment orders with the practitioner to ensure that the orders have been entered correctly. C. Root cause analysis determined that the treatment order had not been entered correctly into the electronic medical record, due to a knowledge deficit. DON/designee will in-service licensed nurses on entering treatment orders according to practitioners directions. No policy revisions required. D. DON/designee audit wound NP weekly recommendations and orders in place to ensure accuracy weekly times 4 weeks until 100%, then every 2 weeks for 2 months until 100%, monthly for 2 months until 100%, results will be brought to QAPI for review and further recommendations. E. Date of completion: 9/25/2023	

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F 686	Continued From page 87 aspect/ischial regions. - Suspected pressure injuries: Right buttock, left thigh and right thigh all present on admission to the hospital. 7/24/23 1:46 PM - E2 (DON) confirmed the physician ordered body audits were just initialed on the MAR and the facility lacked evidence of the skin assessments completed by facility staff. R140 sustained harm when she developed avoidable pressure ulcers due to the lack of assessment, binder use, and lack of turning and repositioning. 7/27/23 10:17 AM - During an interview, E1 (NHA) confirmed that the facility lacked evidence of a thorough skin assessment and turning and repositioning schedule for R140. The facility lacked evidence of a turning and repositioning intervention causing harm to the resident related to avoidable new unstageable and suspected deep tissue pressure ulcer development. In addition, the facility failed to identify and treat R140's pressure ulcers. The resulted in harm to the resident. 2. Review of R38's clinical records revealed: 12/10/22 8:35 PM - R38 readmitted to the facility with a surgical incision on her right hip and orders to clean the incision with normal saline and cover with dry dressing daily. 12/22/22 - A significant change MDS (Minimum Data Set) documented that R38 required extensive assistance and one person for bed mobility, was at risk for pressure ulcers, had a	F 686		

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F 686	Continued From page 88 pressure ulcer reducing device for the bed and chair and was not on a turning and repositioning program. The facility lacked evidence of a current care plan for the prevention of pressure ulcers including the failure to identify the need for a turning and repositioning program and the need to offload / remove pressure of the heels by floating off of the bed. 1/26/23 - A significant change MDS documented that R38 was at risk for pressure ulcers, utilized pressure ulcer reducing devices for the bed and chair and was not on a turning and repositioning program. 1/31/23 - The Wound Care Practitioner Evaluation documented, "Sacral (area at the base of the spine) was wound (sic) identified with multiple open areas - combined measurement with epithelial (new skin cells that are a different color - usually white or pink from surrounding area) ridging measured 11.5 cm x 14.0 cm x unable to determine with 30% slough - yellow, tan, gray, green or brown dead tissue: 30% granulation- new tissue with blood vessels formed during wound healing; and 40% necrosis (dead tissue). Moderate serous (watery red) drainage. Treatment: Clean with normal saline, apply wet to dry dressing every day and evening shift." R38 developed an avoidable pressure ulcer. R38 lacked a care plan for pressure ulcer prevention and was not on a turning and repositioning program to reduce pressure. 1/31/23 - A new care plan was created - Unstageable ulcer to sacro-coccyx area (sacrum	F 686		

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F 686	Continued From page 89 - large triangular bone at base of spine, coccyx - tailbone), with interventions to "Elevate heels as able, Repositioning during ADLS (activities of daily living). Encourage to reposition as needed; use assistive devices as needed." 1/31/23 - A physicians order for daily skin checks was written. 2/1/23 - A Wound Care Practitioner Order stated, "Clean sacro-coccyx ulcer with normal saline, apply Medi honey (gel treatment to remove dead tissue to area of slough and necrosis, cover site with dressing daily." February 2023 - The TAR lacked evidence that R38's daily skin checks were performed on 2/15, 2/16 and 2/17/23. February 2023 - March 2023: The TAR lacked evidence of treatment to R38's sacro-coccyx ulcer on 2/9, 2/15, 2/16, 2/17, 2/28, 3/8, 3/9, 3/24 and 3/28/23. Additionally, there was no evidence that R38 refused care. 4/14/23 - A physician order for "Skin Prep (liquid dressing for intact skin to form protective film) to bilateral heels every shift." Review of the record lacked evidence of an approach to reduce pressure to heels by floating / offloading pressure when in bed. 4/23/23 - The TAR lacked evidence of skin prep treatment to R38's heels. April 2023 - The TAR lacked evidence that R38's sacro-coccyx ulcer treatment was completed on 4/14, 4/15, 4/21 and 4/24/23.	F 686		

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F 686	Continued From page 90 4/28/23 - A quarterly MDS documented that R38 had a pressure ulcer, was at risk for developing pressure ulcers and was not on a turning and repositioning program, 5/1/23 - The TAR lacked evidence of R38's sacro-coccyx treatment. May 2023 - The TAR lacked evidence of R38's skin prep treatment to bilateral heels on 5/6, 5/7, 5/14/23. 5/9/23 11:05 PM - Review of a progress note documented, "During care, resident noted with unstageable pressure ulcer to right medial heel, measuring 3/(by)3 cm. Sight is warm, with dry scab, painful to touch, no drainage noticed. Skin prep applied as ordered, off-loading boots applied to B/L (bilateral) feet." R38 developed an avoidable pressure ulcer to the right heel. There was no evidence of heel off-loading prior to the identification of the unstageable pressure ulcer. 5/9/23 - A physicians order for Prevalon (Pressure Redistribution Device) boots to bilateral heels while in bed. 5/12/23 - A wound note documented, "...right heel Measurements Length: 2.5 cm Width: 2 cm L x W: 5 cm Depth: 0.00 cm Observations Location: right heel Etiology: Pressure Stage/Severity: Unstageable, 100% eschar..." 5/18/23 - A Wound Care Practitioner documented, "New wound on right heel - 3 cm x 3 cm x unable to determine, clean area with	F 686		

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F 686	Continued From page 91	F 686		

normal saline, apply Medi-honey, calcium alginate foam dressing daily."

June 2023 - July 2023 - The TAR lacked evidence of wound treatment to R38's right heel on 6/24, 6/25, 7/12, 7/20/23.

The TAR lacked evidence of R38's sacro-coccyx treatment on 6/24 and 6/25/23.

June 2023- July 2023 - R38's MAR (Medication Administration Record) and TAR were reviewed for orders for turning, repositioning and floating heels. There was no evidence of physician's orders or approaches for providing this care.

June 2023 - July 2023 - R38's CNA's (Certified Nursing Assistant) records were reviewed for floating of heels. There was no evidence that this care was provided.

7/13/23 - A Wound Care Practitioner documented, "Clean wound on sacro-coccyx area with wound cleanser, apply medi- honey cover with gauze daily and PRN (as needed)".

The TAR lacked evidence of R38's sacral wound care on 7/15/23 - 7/20/23.

The following was observed:

7/17/23 8:00 AM - R38 was observed laying on her left side with her heels flat on the bed. No heel boots were on bilateral feet despite order for Prevalon boots bilaterally. R38 was care-planned for bilateral heel boots when in bed.

7/17/23 9:45 AM - R38 was observed laying on her left side with her heels flat on the bed. No

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F 686	Continued From page 92 heel boots were on bilateral feet. 7/17/23 10:05 AM through 10:30 AM - R38 was observed laying on her left side with her heels flat on the bed. No heel boots were on bilateral feet. Observations were confirmed with E31(LPN) who stated, " I don't work often on this floor but R38 should have been wearing her heel boots." 7/21/23 8:30 AM, 9:30, 10:30 AM and 11:30 AM - R38 was observed laying on her left side with her heels flat on the bed. No heel boots were on bilateral feet. 7/21/23 11:30 AM - E60 (CNA in the resident care are) was asked if resident should be wearing the Prevalon boots. E60 stated, "I don't have that resident." Observations confirmed with E31. 7/24/23 7:07 AM - The Electronic Health Record (EHR) noted, "R38 was noted with a new open area of 1 x 1 cm on lower bottom towards the left side." 7/24/23 8:30 AM - R38 was observed laying on her left side on the bed with her heels flat on the bed. No heel boots were on bilateral feet. This observation was confirmed with E40 (RN). July 2023 - A review of CNA documentation revealed R38 was provided bed mobility / turning and repositioning 68 out of 144 opportunities. 7/14/23 - 5 times 7/15/23 - 5 times 7/16/23 - 7 times 7/17/23 - 7 times 7/18/23 - 6 times 7/19/23 - 7 times	F 686		

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F 686	Continued From page 93 7/20/23 - 5 times 7/20/23 - 5 times 7/21/23 - 4 times 7/22/23 - 7 times 7/23/23 - 7 times 7/24/23 - 4 times Residents at risk or that have pressure ulcers should be turned and repositioned at least every two hours and as needed (National Institute of Health 2/1/20). The facility failed to implement approaches including turning and repositioning and heel off-loading to prevent pressure ulcer development resulting in R38 developing avoidable pressure ulcers. Additionally, the facility failed to carry approaches and orders that were in place to treat existing pressure ulcers and prevent new pressure ulcers from developing. 7/31/23 at 2:00 PM - Findings reviewed during the Exit Conference with E1(NHA), E2(DON), E4 (RCD) and E18 (VPO). 3. Review of R36's clinical records revealed: 12/27/22 - R36 was readmitted to the facility. 4/21/23 - R36's Significant Change MDS revealed that R36 had an unhealed Stage 4 pressure ulcer (ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints) injury with treatment for pressure ulcer or injury care. 6/16/23 - originated 5/1/23 - A care plan was developed for R36's risk for pressure ulcers and an actual Stage 4 chronic pressure ulcer to the	F 686		

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F 686	Continued From page 94 sacrum. R36's interventions included but not limited to referral to wound physician as indicated and treatment per TAR (Treatment Administration Record). 6/23/23 - R36 had an active physician's order to cleanse sacral wound with NSS (normal saline solution), pack with iodaform and to apply bordered foam dressing every day shift every other day. Review of the following skin and wound notes by E67 (NP Wound Care) revealed conflicting frequency of treatments for R36's Stage 4 sacral pressure ulcer dressing changes: 6/15/23 - change daily and PRN (when necessary) 6/23/23 - change daily and PRN, BID (two times a day) 6/29/23 - change daily and PRN, BID 7/6/23 - change daily and PRN 7/13/23 - change daily and PRN 7/20/23 - change daily and PRN 7/26/23 10:00 AM - Review of R36's June 2023 TAR revealed that the daily sacral treatment was discontinued on 6/23/23 with a new order to start R36's sacral wound dressing changes on dayshift every other day. The staff nurses were noted signing off for the every other day dressing changes on the TAR. Review of R36's July 2023 TAR revealed that staff nurses were noted signing off for the every other day dressing changes on the TAR. 7/26/23 11:15 AM - In an interview, E11 (LPN) confirmed that, "... Resident (R36) has a Stage 4 sacral wound and the treatment is done every	F 686		

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F 686	Continued From page 95 other day." 7/27/23 12:55 PM - In an interview, E2 (DON) confirmed that, "...Resident's (R36) sacral wound frequency is daily and PRN and not every other day. A new doctor's order was obtained yesterday (7/26/23) with the correct order". E2 provided this surveyor a copy of the new treatment order. 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD).	F 686		
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 record review and interview it was determined that for one (R71) out of one sampled resident for range of motion, the facility failed to ensure appropriate treatment and services to	F 688	F688 Increase/Decrease ROM/Mobility A. R71 still resides at the facility. R71 occupational therapy evaluation was completed, and a new order was written	9/25/23

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F 688	Continued From page 96 increase range of motion and or prevent further decrease in range of motion for R71's left hand contractures. Findings include: 7/22/20 - R71 was admitted to the facility with a diagnosis of brain damage and End Stage Renal Disease. 10/21/22 - A physicians order written for R71 documented..." 1. Apply therapy carrot to left hand after morning care. 2. Wear as tolerated. 3. Remove therapy carrot by dinner time. Check skin regularly. 4. One time a day for contractures and remove per schedule." 10/24/22 - A review of R71's care plan for "At risk for loss of range of motion related to existing contractures of the left hand" last revised 2/16/23 documented..." 1. Will tolerate application of splint/orthotic device when worn. 2. Carrot to left hand as per order." 12/14/22 6:06 PM - A provider progress documented by E72 (NP) included "abnormal findings related to right hand contractures of fingers and left-hand flexion contractures." 12/14/22 - Further review of OT evaluation and treatment documented..."1. Functional limitations related to contractures. 2. OT will treat to address contracture impairment." 12/22/22 - R71 was admitted to the hospital. 12/30/22 - R71 was readmitted to the facility with the existing left-hand contracture. The record lacked evidence of a physicians order for a carrot. 7/24/23 11:18 AM - During an interview E25	F 688	for carrot to left hand. R71 care plan updated to reflect intervention. B. The Director of Nursing or administrative nurse will audit residents admitted/readmitted in the last 30 days to verify occupational therapy evaluation completion. If OT eval needed, it will be completed, and any interventions (if applicable) followed up on. C. To prevent recurrence of the deficient practice, the Director of Rehab/designee will educate the occupational therapist on evaluating/treat admissions/readmissions for contractures and implement interventions if appropriate. The root cause of the deficient practice was the lack of knowledge of the occupational therapist to complete OT evaluation on admissions/readmissions. D. The Director of nursing/designee will audit all admission/readmissions to ensure OT evaluation is completed daily x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. E. Date of completion: 9/25/2023	

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F 688	Continued From page 97 (CNA) said "she had already done R71's morning care." 7/24/23 11:30 AM - E25 reviewed R71's care plan and revealed, "I'll be truthful with you, I did not know he needed to have a carrot placed in his left hand." 7/26/23 8:53 AM - During an interview with E26, (Rehab. Director) reviewed the order for R71's carrot to the left hand and revealed, "the order fell off (stopped) on 12/26/22." In, addition E26 said, "I don't know why the order fell off." 7/26/23 - An OT (Occupational Therapy) evaluation and plan of treatment documented..."Care giver goals, left hand contractures and skin integrity management." 7/26/23 11:21 AM - A physician's order written for R71 documented...1. Apply carrot to left hand after morning care wear as tolerated, remove therapy carrot by dinner time." 7/26/23 2:40 PM - A second interview with E26 revealed, "R71 had been seen for an evaluation and treatment, and had been ordered four weeks of therapy for ADL training." 7/27/23 Further review of R71's care plan titled "At risk for loss of range of motion related to existing contractures of the left hand revised on 7/27/23 documented..."1. Carrot to the left hand as per order." The facility failed to provide care and services for a resident that was at risk for further contractures. 7/31/23 2:00 PM - Findings were reviewed during	F 688		