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

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

**STATE SURVEY REPORT**



**NAME OF FACILITY: Delaware Veterans Home** **DATE SURVEY COMPLETED: April 25, 2023**

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|---|---|---|
| 3201<br><br>3201.1.0<br><br>3201.1.2 | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An unannounced Annual and Complaint Survey was conducted at this facility from April 19, 2023, through April 25, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 59. The investigative sample totaled 32 residents.<br><br>**Regulations for Skilled and Intermediate Care Facilities**<br><br>**Scope**<br><br>**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.**<br><br>This requirement is not met as evidenced by:<br><br>Cross Refer to the CMS 2567-L survey completed April 25, 2023: F558, F637, F641, | A. Employee E11 received 1st step and 2nd step PPD as of 5/9/2023. E12 has not completed TB testing as of this date. Employee E12 will not work in facility until acceptable TB testing has been completed and verified. Please see attachment #1 PPD document for E11.<br><br>B. Perspective employees including agency will produce to staff educator/designee appropriate TB testing documentation prior to start date.<br><br>C. IP ADON/designee will verify TB testing prior to start of new employee orientation. Staff educator/designee will maintain documented proof of successful PPD testing prior to new employee orientation. Potential employees that do not have completed PPD series will not proceed with new hire orientation. Don/designee will educate IP ADON, Staffing Coord, and | 06/13/23 |

Provider's Signature _____ Title _____ Date _____

Signature on subsequent pages

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| | F756, F943, F947. | Staff educator on new process 5/25/23. . Please see attachment #2 – education sheet. | |
| 3201.6.0 | **Services to Residents** | | |
| 3201.6.9 | **Communicable Diseases** | | |
| 3201.6.9.2 | **Specific Requirements for Tuberculosis** | The root cause analysis revealed that the facility failed to have a consistent process to track agency PPD status. | |
| 3201.6.9.2.4 | **Minimum requirements for pre-employment tuberculosis (TB) testing require all employ-ees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent test-ing according to risk category shall be in ac-cordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** | D.Staff educator/designee will audit 100% of new employee documents weekly x4 then monthly x2 prior to new employee orientation to ensure TB testing is completed accurately. Staff educator/designee will report finding to QAPI until 100% compliance is achieved. Please see attachment #3 – audit sheet. | |
| 3201.6.9.2.4.3 | **Persons with a prior BCG vaccination are re-quired to be tested as set forth in 6.9.2.4.** | | |
| | This requirement was not met as evidenced by: | | |
| | Based on review of facility personnel records and interview, the facility failed to ensure that two (E11, and E12) out of 10 sampled new employees had the required pre-employment TB testing. Findings include: | | |
| | 1. E11 (Agency CNA) – the first day in the facili-ty was 4/12/23. E11's first step base line | | |

Provider's Signature Carol Ehart, MHA Title Administrator Date 05/26/23

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| | two step tuberculin skin test (TST) results were documented as completed on 4/19/23. Review of the Personnel Audit Sheet provided by the facility lacked evidence of a completed second step TST result.<br><br>2. E12 (Agency LPN) – the first day in the facility was 2/21/23. E12's first step base line two step tuberculin skin test (TST) results were documented as completed on 2/4/23. Review of the Personnel Audit Sheet provided by the facility lacked evidence of a completed second step TST result.<br><br>4/24/23 12:25 PM - During an interview with E1 (NHA) the above findings were confirmed.<br><br>4/25/23 1:15 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (Interim DON). | | |

Provider's Signature Carol A Hart, LNHA Title Administrator Date 05/26/23

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| | 085051 | A. BUILDING _____ B. WING _____ | C 04/25/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| E 000 | Initial Comments<br><br>An unannounced annual and complaint survey was conducted at this facility from April 19, 2023 through April 25, 2023. The facility census was 59 on the first day of the survey.<br><br>In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were cited. | E 000 | | |
| E 037 SS=D | EP Training Program<br>CFR(s): 483.73(d)(1)<br><br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years. | E 037 | | 6/13/23 |

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

Electronically Signed | 05/16/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| E 037 | Continued From page 2<br>arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under | E 037 | | |

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

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| E 037 | Continued From page 4<br>personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of documents, it was determined that for four (E9, E13, E14, and E15) out of ten randomly sampled staff members, the facility failed to ensure that staff received initial Emergency Preparedness training upon hire or annual Emergency Preparedness training in the previous twelve months. Findings include:<br><br>- On 11/04/21 - E14 (RN) received the most recently documented Emergency Preparedness | E 037 | A. In leu of not being able to identify employees E9, E13, E14 all employees will be trained/educated by staff educator/designee regarding emergency preparedness no later than June 13, 2023.<br><br>B. Each department, with their active employees, will be educated by staff educator/designee to ensure their | |

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| E 037 | Continued From page 5<br>training.<br><br>- On 1/23/21 - E9 (CNA) received the most recently documented Emergency Preparedness training.<br><br>- On 4/24/23, the facility provided documents that verified that E13 (CNA) and E15 (RN) had failed to complete the initial Emergency Preparedness required for all new staff.<br><br>4/24/23 - Findings were reviewed with E1 (NHA) and E2 (Interim DON) during the exit conference, beginning at 1:15 PM. | E 037 | required training has been completed no later than June 13, 2023.<br><br>C. Staff will be educated on Emergency Preparedness Training, that will now be fully implemented using the Relias platform, to ensure compliance and tracking with the deficient practice by the QA Administrator/designee no later than June 13, 2023. Staff will be notified about their mandatory manual education through Relias. Department Heads/designee will review Relias Compliance reports monthly to ensure the deficient practice does not reoccur.<br><br>The root cause analysis confirmed that 4 staff members did not complete the required training according to facility policy. The facility utilized a hybrid manual and electronic system for staff education which failed to maintain the integrity of the facility's training program.<br><br>D. QA Administrator/designee will review new employee Relias training for compliance of Emergency Preparedness training, weekly x 4, monthly x2 and then report out monthly through the QAPI process until 100% compliance is achieved. | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Annual and Complaint Survey was conducted at this facility from April 19, 2023 through April 25, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' | F 000 | | |

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| F 000 | Continued From page 6<br>clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 59. The investigative sample totaled 31 residents.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>CNA - Certified Nurse's Aide:<br>DON - Director of Nursing;<br>NHA - Nursing Home Administrator;<br>NP - Nurse Practitioner;<br>RNAC - Registered Nurse Assessment Coordinator;<br><br>Activities of daily living (ADLs) - tasks needed for daily living, such as dressing, hygiene, eating, toileting, bathing;<br>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.<br>0-7: Severe impairment (never/rarely made decisions)<br>8-12: Moderately impaired (decisions poor; cues/ supervision required)<br>13-15: Cognitively intact (decisions consistent/reasonable;<br>Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a person's daily functioning;<br>mg - milligram;<br>Significant change - a decline or improvement in a resident's status. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences<br>CFR(s): 483.10(e)(3) | F 558 | | 6/13/23 |

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| F 558 | Continued From page 7<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and record review it was determined that for two residents (R19 and R49) out of two residents reviewed for accommodation of needs, the facility failed to ensure that the residents' call device were within reach. Findings include:<br><br>1. Review of R39's clinical record revealed:<br><br>3/21/23 - An annual MDS reflected R39 was totally dependent on staff for performance of ADL's, except for bed mobility that required extensive assistance.<br><br>4/21/23 8:54 AM - An observation of R39 in their room after returning from breakfast. R39 was seated in the wheelchair and the call device was on the nightstand and not within reach.<br><br>2. Review of R19's clinical record revealed:<br><br>3/21/23 - R19's Quarterly MDS Assessment documented R19 required extensive assist of two for bed mobility and had an impairment to one side of the upper and lower body.<br><br>4/19/23 12:54 PM - During an initial observation and interview, R19 was observed lying in bed and the call device was on the far-right side of the nightstand next to the bed. R19 revealed he had | F 558 | A. No untoward effect occurred to R19 and R39 by the practice. The call bells were immediately placed within reach of the residents. Please see attachment #6 – documentation of call light.<br><br>B. All residents have the potential of the deficient practice, and a 100% review of residents will be completed to ensure compliance with plans of care no longer than June 13, 2023.<br><br>C. Facility will educate staff by June 13, 2023, on ensuring that residents have call bells in reach when they are in their room as per the resident plan of care. Unit Manager/designee to include off shift Supervisors will conduct room rounds daily to ensure call bells are within reach on an ongoing basis. Any call bells found not in place will be corrected immediately. Please see attachment #9 – education call light.<br><br>The root cause analysis is that staff failed to follow the plan of care for the residents.<br><br>D. Unit manager/designee will audit 100% of residents call bells every shift x 7, daily x 7, weekly x 2, monthly x2 for compliance | |

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| F 558 | Continued From page 8<br>weakness from a stroke and could not reach the call bell.<br><br>The facility failed to place the call light within reach for a resident who required extensive assist for ADL's (Activities for Daily Living).<br><br>4/25/23 1:15 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (Interim DON). | F 558 | and then report out monthly through the QAPI process until 100% compliance is achieved. Please see attachment #2 - call light audit. | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg<br>CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for one (R56) out of four residents reviewed for activities of daily living (ADL's), the facility failed to complete a significant change MDS (Minimum Data Set) assessment when R56 had a significant decline in functional and mental status. Findings include:<br><br>Review of R56's clinical record revealed: | F 637 | A. Reviewed R56 IDT information and identified that the resident qualified for a significant change. The significant change MDS was completed and submitted on ARD date of May 19, 2023, to capture the decline. Please see attachment #15 – sig change doc.<br><br>B. All residents have the potential to be affected by this deficient practice. | 6/13/23 |

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| F 637 | Continued From page 9<br>10/26/22 - R56 was admitted to the facility with dementia.<br><br>11/1/22 - R56's admission MDS documented that R56 required supervision of one staff member for bed mobility, transfers, eating, ambulation (walking) and required limited assist of two staff members for toileting. R56's BIMS (Brief Interview for Mental Status) assessment documented three out of fifteen correct answers during the interview.<br><br>1/31/23 - R56's quarterly MDS documented that R56 required extensive assistance of two staff members for bed mobility, transfers and toileting, supervision of one staff member for eating, and was non-ambulatory (unable to walk). R56's was not able to complete the BIMS interview due to a decline in his cognition. R56 required a significant increase of staff assistance for his ADL's related to a decline in functional and mental status since his 11/1/22 admission assessment.<br><br>4/25/23 12:10 PM - During an interview, E7 (RNAC) confirmed that a significant change in status MDS assessment should have been completed 1/31/23 related to R56's decline in functional and mental status.<br><br>4/25/23 12:21 PM - During an interview, E1 (Interim DON) confirmed that a significant change MDS assessment should have been completed.<br><br>4/25/23 at 1:15 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (Interim DON). | F 637 | RNAC/designee will review residents MDS and documentation to identify any potential significant changes by June 13, 2023.<br><br>C. Clinical staff will share potential significant change information during daily clinical meetings. Any identified significant change will be addressed immediately by the RNAC. The IDT/UR team will review and validate the significant change has been implemented at the weekly IDT/UR risk meeting. RNAC will process information provided to the MDS and submit per RAI manual guidelines. The interdisciplinary team was educated by the DON/designee on May 18, 2023, as to what a significant change is, how it is classified, and then the process in which the facility will follow to identify and review possible significant changes. Please see attachment #10 – education sig change.<br><br>The root cause analysis was that the facility did not have a consistent process in place that would ensure potential residents who might be identified for significant changes. The facility process also lacked the tracking and follow through to ensure those that did trigger for significant changes were completed according to the RAI Manual.<br><br>D. ADON/designee will audit 100% of resident population to determine if a significant change is indicated and verify the accuracy of submissions daily x5, weekly x 3, weekly x1, monthly x1 until 100% compliance has been achieved and | |

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| F 637 | Continued From page 10 | F 637 | report to QAPI committee. Please see attachment #5 – MDS sig change audit. Please see attachment #14 0 sig change audit. | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, it was determined that for one (R44) out of one resident reviewed for dental, the facility failed to have a MDS (Minimum Data Set) assessment that accurately reflected R44's missing teeth. Findings include:<br><br>Review of R44's clinical record revealed:<br><br>9/21/22 - R44 admitted to facility.<br><br>2/28/23 - A significant change MDS assessment documented that R44 had no broken or loosely fitting full or partial denture.<br><br>4/19/23 10:11 AM - During a random observation R44 had missing upper, front teeth.<br><br>4/21/23 10:03 AM - During an interview, E5 (RN, unit manager) stated they (the facility) knew about the resident's missing partial denture plate since his admission. In addition, E5 confirmed that the oral assessment section for R44's MDS was "a mistake."<br><br>4/25/23 at 1:15 PM - Findings were reviewed | F 641 | A. R44 will have a corrective MDS for oral assessment submitted on May 23, 2023. Process is in place for R44 to receive partial denture that was lost at previous facility. R44 is scheduled for dental appointment June 5, 2023. Please see attachment #3 – Conte Order. Please see attachment #4 – Conte order progress note. Please see attachment #7 – MDS oral assessment update.<br><br>B. On-site dentist will screen current residents to identify any residents with missing teeth by June 13, 2023.<br>C. Dentist/Designee will complete oral assessments upon admission and then bi-annually. The dentist will report findings to the interdisciplinary team, to include the RNAC for proper coding on MDS. Staff educator will educate the dentist, Unit Managers, RNAC on the process. RNAC/designee will maintain schedule of oral assessments by the dentist to ensure compliance. Please see attachment #11 – oral assessment in service. | 6/13/23 |

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| F 641 | Continued From page 11<br>during the Exit Conference with E1 (NHA) and E2 (DON). | F 641 | The root cause analysis is that RNAC failed to code MDS properly from resident's oral assessment as per the RAI manual.<br><br>D. Unit Manager/designee will audit 100% resident population to determine the accuracy of the MDS as it relates to the oral assessment weekly x4, monthly x 2 and then report monthly through the QAPI process until 100% completion is achieved. Please see attachment #1 – oral assessment audit. | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. | F 756 | | 6/13/23 |

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| F 756 | Continued From page 12<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review it was determined that for one (R31) out of five residents reviewed for unnecessary medications the facility failed to provide evidence that the attending physician reviewed irregularities/recommendations documented on the monthly Medication Regimen Review (MRR). Findings include:<br><br>The facility policy for MRR last updated 1/2023, indicated that, "all recommendations shall be acted upon within 30 calendar days. For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the residents medical record."<br><br>Review of R31's clinical record revealed:<br><br>6/14/22 - The MRR documented the following | F 756 | A. R31 MRR was reviewed by DON and Medical Director and confirmed the order was placed accurately at the time of the recommendation and was signed on May 19, 2023, by the medical director. Please see attachment #8 – Dr. M MMR.<br><br>B. Pharm. recommendations have been reviewed for the last 3 months to ensure no other resident has been affected by the deficient practice.<br><br>C. DON/Designee will receive pharmacy recommendations timely and present the pharmacy recommendations to medical provider for review and validate signature within 7 days. The Medical providers will be educated by staff educator or designee to be aware of the process that they need to respond and sign pharmacy recommendations no later than June 13, 2023. A new policy has been created to | |

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| F 756 | Continued From page 13<br>recommendation in a pharmacy consultant note, to the physician. This resident has been taking an antidepressant at a dosage of 150 milligrams daily. Please evaluate the current dose and consider a dose reduction. The signature line for the attending physician acknowledgement was blank, and the clinical record lacked evidence that R31's attending physician reviewed the recommendation.<br><br>4/24/23 11:15 AM - During an interview, E2 (Interim DON) confirmed the facility lacked evidence that R31's attending physician reviewed/responded to the 6/14/22 MRR. E2 did provide an order of a dose reduction for R31's antidepressant medication written by the facility's psychiatric NP dated 6/30/22.<br><br>4/25/23 1:15 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (Interim DON). | F 756 | ensure compliance with MRR process that includes medical records doing a reconciliation. Please see attachment #12 – medication regime review policy. Please see attachment #16 – MMR in-service.<br><br>The root cause analysis was that there was impaired continuity with facility practices related to the changes in nursing administration as well as facility medical directors over the last 18 months. This is a direct result of there not being a facility policy to direct the process of how pharmacy recommendations are handled.<br><br>D. DON/Designee will review all recommendations for completions to include signature of the medical provider monthly x 3 and report findings to QAPI Committee until 100% compliance. Please see attachment #13 – MMR audit initial. | |
| F 943 SS=D | Abuse, Neglect, and Exploitation Training<br>CFR(s): 483.95(c)(1)-(3)<br><br>§483.95(c) Abuse, neglect, and exploitation.<br>In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property | F 943 | | 6/13/23 |

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| F 943 | Continued From page 14<br>§483.95(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required trainings on abuse, neglect and exploitation were completed as required for one (E8) out of ten randomly sampled staff members. Findings include:<br><br>Review of the facility submitted staff training records revealed:<br><br>11/8/20 - E8 (CNA) began working at the facility. E8 had no documented date of completion of abuse training.<br><br>4/24/23 12:25 PM - During an interview, E1 (NHA) confirmed the findings.<br><br>4/25/23 1:15 PM- Findings were reviewed during the Exit Conference with E1 (NHA), and E2 (Interim DON). | F 943 | A. In leu of not being able to identify employee E8 all employees will be educated by staff educator/designee regarding Abuse, Neglect, and Exploitation no later than June 13, 2023.<br><br>B. Each department with their active employees will be educated by staff educator/designee to ensure their required training has been completed no later than June 13, 2023.<br><br>C. Staff will be educated on Abuse, Neglect, and Exploitation Training that will now be implemented using the Relias platform to ensure compliance with the citation by the staff educator/designee no later than June 13, 2023. Department Heads/designee will review Relias Compliance reports monthly to ensure the deficient practice does not reoccur.<br><br>The root cause analysis confirmed that 1 staff member did not complete the required training according to facility policy. The facility utilized a hybrid manual and electronic system for staff education which failed to maintain the integrity of the facility's training program.<br><br>D. Staff educator/designee will review new employee Relias training for compliance of Abuse, Neglect, and Exploitation training, weekly x 4, monthly x2 and then report out monthly through the QAPI | |

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| F 943 | Continued From page 15 | F 943 | process until 100% compliance is achieved. | |
| F 947 SS=D | Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)<br><br>§483.95(g) Required in-service training for nurse aides.<br>In-service training must-<br><br>§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.<br><br>§483.95(g)(2) Include dementia management training and resident abuse prevention training.<br><br>§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.<br><br>§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation as indicated, it was determined that the facility failed to provide required in-service training (12 hours per year) for three (E8, E9, and E10) out of three CNA's reviewed additionally the facility failed to ensure these three CNA's had trainng on dementia management and care of the cognitively impaired. Findings include:<br><br>4/24/23 12:18 PM - Review of the facility submitted staff training worksheet revealed a lack | F 947 | A. In leu of not being able to identify employees E8, E9, E10 all employees will be trained/educated by staff educator/designee regarding Dementia no later than June 13, 2023.<br><br>B. Each department with their active employees will be educated by staff educator/designee to ensure their required training has been completed no later than June 13, 2023. | 6/13/23 |

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| F 947 | Continued From page 16<br>of evidence of dementia training for the CNA's sampled. The space for CNA dates of training and hours had a line drawn through the space for E8, E9 and E10. Indicating that none of the 12 hours were completed.<br><br>4/24/23 12:25 PM - During an interview with E1 (NHA), it was reported that the facility was unable to provide evidence of dementia training and the hours completed because that information was unable to be located after the prior human resources staff was released from the facility's employment.<br><br>4/25/23 1:15 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (Interim DON). | F 947 | C. Staff will be educated on Dementia Training, that will now be fully implemented using the Relias platform, to ensure compliance and tracking with the deficient practice by the QA Administrator/designee no later than June 13, 2023. Staff will be notified about their mandatory manual education through Relias. Department Heads/designee will review Relias Compliance reports monthly to ensure the deficient practice does not reoccur.<br><br>The root cause analysis confirmed that 3 staff members did not complete the required mandatory training including dementia management according to facility policy. The facility utilized a hybrid manual and electronic system for staff education which failed to maintain the integrity of the facility's training program.<br><br>D. Staff educator/designee will review new employee Relias training for compliance of Dementia training, weekly x 4, monthly x2 and then report out monthly through the QAPI process until 100% compliance is achieved. | |