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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Renaissance

DATE SURVEY COMPLETED: 10/22/21

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and cites the findings specified in the Federal Report. An unannounced annual complaint and emergency preparedness survey was conducted at this facility from October 14, 2021 to October 22, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 98. The survey sample totaled 51 residents.		
3201.0	**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:** Cross Refer to the CMS 2567-L survey completed October 22, 2021: F550, F565, F571, F583, F584, F623, F641, F656, F657, F677,		

Provider's Signature A Rhoads, NHA Title Administrator Date 11-8-21

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	F684, F686, F689, F759, F760, F761, F791, F812, F842, F880.		
16 Del. C., Chapter 11, Sub-chapter VII § 1162	**Health and Safety – Regulatory Provisions Concerning Public Health Long-Term Care Facilities and Services. Minimum Staffing Levels for Residential Health Facilities.** **Nursing staffing** **(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness, or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.** **This requirement was not met as evidenced by:** Based on observation and interview, it was determined that the facility failed to conspicuously display the names and titles of the nursing staff direct caregivers assigned to each unit and the nursing supervisor on duty for each shift in common areas of three (Fenwick, Rehoboth, and Bethany) out of the three nursing units. Findings include:	1. We have not identified any resident impacted by this deficient practice. This practice was corrected upon being made aware on 10/21/2021 of the surveyors findings. 2. All residents have the potential to be affected by deficient	12-24-21

Provider's Signature [signature], NHA Title Administrator Date 11-8-21

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	The following observations were made of the large white boards on the nursing units where daily staffing is written: 10/14/21 10:40 AM - The Fenwick Unit's white board did not include the titles of the CNA's, the shift, the complete date, or the names of the Nurses and Supervisor on duty. 10/14/21 11:19 AM – The Bethany Unit's white board did not include the titles of the CNA's, the shift, or the name of the Supervisor on duty. 10/15/21 11:06 AM - The Fenwick Unit's white board did not include the titles of the CNA's, the shift, or the names of the Nurses and Supervisor on duty. 10/18/21 9:14 AM – The Bethany Unit's white board did not include the titles of the CNA's, the shift, or the name of the Supervisor on duty. 10/18/21 11:00 AM - The Fenwick Unit's white board did not include the titles of the CNA's, the shift, or the names of the Nurses and Supervisor on duty. 10/19/21 9:00 AM - The Fenwick Unit's white board did not include the titles of the CNA's, the shift, or the names of the Nurses and Supervisor on duty. 10/19/21 9:42 AM – The Bethany Unit's white board did not include the titles of the CNA's, the shift, or the name of the Supervisor on duty.	practice. Future residents will be protected by action plan outlined below. 3. Daily staffing will be posted on the white board of each unit. The staffing information posted will include the nursing staff direct caregivers assigned to that unit and the nursing supervisor on duty. This will be done on each shift on all three units. The Unit Manager or Supervisor of each shift, on each unit, will review the white board at the beginning of each shift to ensure this information is posted and accurate. 4. DON or Designee will audit each unit's whiteboard every day on each shift for three consecutive weeks or until 100% compliance is achieved. Then three times per week for three weeks or until 100% compliance. Then weekly for three weeks or until 100% compliance. Finally in one month an audit will be conducted, if at that time compliance is 100% then deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility Quality Assurance Meeting that will be held in January 2022.	

Provider's Signature [signature] Title Administrator Date 11.8.21

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	10/19/21 10:30 AM – The Rehoboth Unit's white board still had the night shift staffing posted. 10/19/21 4:00 PM – During an interview with E6 (RN, Unit Manager Fenwick Unit), the above findings were reviewed and confirmed. 10/19/21 4:10 PM – During an interview with E33 (RN, Unit Manager Rehoboth Unit), the above findings were reviewed and confirmed. 10/19/21 4:24 PM – The above findings were reviewed with E1 (NHA). 10/21/21 5:05 PM – The above findings were reviewed with E30 (Chief Nursing Officer) and E2 (DON). Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM. Nursing Staffing (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*	1. We have not identified any resident impacted by this deficient practice. We were unable to correct the deficiency real time as it occurred on 9/28/2021 and 10/9/2021. 2. All residents have the potential to be affected by deficient practice. Future residents will be protected by action plan outlined below. 3. Daily staffing will be reviewed by NHA/designee, both projected for current day and actual ppd for previous day, to	12.24.21

Provider's Signature J Rochesky, Nha Title Administrator Date 11.8.21

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	Day - 1 nurse per 15 res. 1 aide per 8 res. Evening 1:23 1:10 Night 1:40 1:20 * or RN, LPN, or NAIT (Nursing Assistant in Training) serving as a CNA. (g) The time 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 out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that, for two (9/28/21 and 10/9/21) out of 21 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 facility staffing worksheets, completed, and signed by the Nursing Home Administrator revealed the following: - 9/28/21 PPD = 3.22 - 10/9/21 PPD = 3.25 The facility failed to maintain the minimum PPD staffing requirement of 3.28 on these two dates.	assure adequate staffing and compliance with Delaware Nursing Home Staffing Laws. On Fridays, projected staffing and ppd will be reviewed for the upcoming weekend by the NHA/Designee and on Mondays the actual ppd for Friday, Saturday and Sunday will be reviewed by NHA/Designee. 4. Daily staffing will be reviewed by NHA/designee for three consecutive weeks or until 100% compliance is achieved. Then three times per week for three weeks or until 100% compliance. Then weekly for three weeks or until 100% compliance. Finally in one month an audit will be conducted, if at that time compliance is 100% then deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility Quality Assurance Meeting that will be held in January 2022.	

Provider's Signature [signature], MHA Title Administrator Date 11.8.21

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	10/18/21 2:19 PM – In an email, E1 (NHA) acknowledged the staffing levels and added, "There are no revisions at this time." Findings were reviewed with E1 and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.		

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	085052	A. BUILDING _____ B. WING _____	C 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION RENAISSANCE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

(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 October 14, 2021 through October 22, 2021. The facility census was 98 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint, and emergency preparedness survey was conducted at this facility from October 14, 2021 through October 22, 2021. 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 98. The survey sample totaled fifty-one (51) plus ten (10) additional residents were subsampled for activities. Abbreviations/Definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; FSD - Food Service Director; LPN - Licensed Practical Nurse; MD - Medical Doctor; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator;	F 000		

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

Electronically Signed | 11/12/2021

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

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F 000	Continued From page 1 NP - Nurse Practitioner; RD - Registered Dietician; RN - Registered Nurse; SW - Social Worker; UM - Unit Manager; Bruit - a rumbling or swooshing sound over the dialysis fistula; ESRD (End Stage Renal Disease) - kidneys are no longer functional; Extensive Assistance - resident is involved in the activity, staff provide weight-bearing support; Fistula - allows blood to flow from the body to the dialysis machine and back into the body after the blood is filtered; FSBS (Finger Stick Blood Sugar) - test which checks the level of sugar (glucose) using a blood glucose meter (glucometer); Hemodialysis (HD) - procedure to remove waste and fluid from the blood when kidneys can no longer do so; Incontinence - inability to control bowel and/or bladder; mL (milliliter) - unit liquid measurement, 5 mL equals a teaspoon; Pressure Injury - sore area of skin that develops when blood supply to it is cut off from staying in the same position for long periods of time; sic - used in quoted statements after grammar or spelling mistakes to show that the word is quoted exactly as it was originally written; Stage 4 Pressure Ulcer/Injury - open sore so deep that there is damage to the muscle and bone and sometimes to tendons and joints; Thrill - a vibration felt overlying the skin of a dialysis fistula; Total Assistance - resident does not participate in the activity, staff do all of the work.	F 000		

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F 550	Continued From page 2	F 550		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F 550		12/24/21

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F 550	Continued From page 3 reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that, for six (R16, R32, R33, R53, R54 and R55) randomly observed residents, the facility failed to provide services in a dignified manner. In addition, meals were served on trays in one (Bethany Unit) of three nursing units on numerous occasions. Findings include: 1. 10/14/21 around 11:58 AM - During an interview, E10 (RN, UM) stated the food carts were new and put into service the day before. The meal trays were in a different order in the carts compared to the old upright food cart which contained all of the meals in one cart. 10/14/21 - The following were observed during a random lunch observation on the Bethany Unit: - 12:02 PM: R54 watched R16 self feed his lunch for 15 minutes and watched staff deliver meals to several other residents at different tables before staff was available to feed R54. - 12:15 PM: R16 was in the middle of self-feeding his lunch when staff moved him to another side of the table to make room for the aide to feed R54 and another unidentified resident. - 12:20 PM: Two CNAs (E27 and E28) were talking more with each other then engaging the four residents (R32, R33, R53 and R55) they were feeding.	F 550	1. a.R54 will receive his meals at the same time as other residents seated at his table. R16 will not be moved to another location at the table while in the middle of a meal. Staff will minimize interaction with each other and focus on engaging R32, R33, R53 and R55 during mealtime. b.All residents who are provided assistance with meals have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c.The facility failed to provide meal services in a dignified manner for 5 residents. Staff Development will in service all staff that provide assistance to residents with eating, on the importance of serving all residents seated together at a table are served their meals simultaneously, that residents are not moved after their meal has begun and that staff engage with residents and not each other while providing feeding assistance. d.The Director of Nursing or designee will randomly audit during mealtimes and observe staff delivering meals and	

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F 550	Continued From page 4 2. Observations during breakfast and lunch on the Bethany Unit revealed that meals were served on trays in the dining room: 10/15/21 (lunch); 10/16/21 (breakfast and lunch); and 10/18/21 (breakfast and lunch). 10/22/21 1:30 PM - During an interview, E10 (UM) confirmed that staff have been serving meals on trays in the dining room. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 550	assisting with feeding to ensure that services are provided in a dignified manner including timely serving of food, residents are not disrupted while eating and staff are engaging residents and limiting conversation with one another. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. Staff on the Bethany Unit no longer serve meals on trays in the dining room. b. All residents who are served meals in the Bethany Unit dining room have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Meals should not be served on trays in the dining room. Nurses and CNAs will be in-serviced by Staff Development on the importance of meal service being provided in a homelike setting by ensuring that meals are not served on trays in the dining room.	

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F 550	Continued From page 5	F 550	d. The Director of Nursing or designee will randomly audit during mealtimes and observe staff delivering meals to ensure that meals are not served on trays in the dining rooms. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		12/24/21

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F 565	Continued From page 6 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of Resident Council meeting minutes, it was determined that the facility failed to have evidence of promptly acting upon grievances and recommendations from the group and reporting their responses and rationale to the group's grievances and recommendations. Findings include: April through September 2021 - Resident Council minutes were reviewed and revealed that each month documented that the Resident Council members were sharing concerns about dining services and call bell response times. There was no evidence that the concerns were addressed and that the residents were provided any information on the status of their concerns. April 2021 - Review of the monthly Resident Council minutes revealed that residents felt it took longer for call bells to be answered in the evenings and nighttime. The residents also wanted to see more soups offered and less	F 565	1. a.No resident was negatively impacted by this deficient practice. b.All residents who express grievances or make recommendations during Resident Council Meetings have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c.NHA will educate Activity Director of their responsibility to attend,record feedback provided during Resident Council Meeting and forward feedback to department heads for follow up. NHA will educate Department Heads on their responsibility to promptly respond to any grievances or recommendations made by residents during Resident Council Meeting relative to their department. Resident	

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F 565	Continued From page 7 chicken and fish options. May 2021 - Review of the monthly Resident Council minutes revealed that residents shared concerns about call lights being answered promptly and dining services related to soggy vegetables and wanting less gravy. The staff response to the call light concern was that Nursing Management would conduct call bell audits, educate staff and initiate performance improvement plans accordingly. June 2021 - Resident Council minutes lacked evidence that the call bell audits and interventions identified the month before were completed or that the facility provided a response and rationale. Concerns of long call bell response times were reported again in June. Food concerns included faster meal delivery and less salty options. July, August and September 2021 - The Resident Council minutes had concerns related to call bell response times and dining services. There was no evidence that the facility addressed them and responded to the Resident Council. On 10/22/21 11:05 AM - The Surveyor requested evidence on how the facility responded to the Resident Council concerns; no additional information was provided. 10/21/21 12:34 PM - During an interview, E38 (Activities Director) confirmed that the Resident Council minutes lacked evidence that concerns were promptly addressed by the facility and that the Council members were informed of the outcome with rationale. Findings were reviewed with E1 (NHA) and E2	F 565	Council meeting will now include an agenda that includes both reviewing Old Business and allowing for residents to express concerns and compliments. Activity Director will be responsible for attending the meeting, guiding the council to follow agenda, and taking minutes as well as providing minutes to department heads for follow up. The following month□s resident council meeting will include Old Business, where the prior month□s minutes will be reviewed as well as a thorough review of how the recommendations were addressed and the rationale behind the decisions that were made. Activity Director will ensure that all grievances and recommendations are addressed timely and responses are reflected in minutes. d.Each month□s resident council meeting minutes will be reviewed by the NHA to ensure that appropriate follow up and reporting is done related to recommendations and grievances. This will be done monthly with no end date. Monthly resident council meeting minutes will be reviewed at the quarterly Quality Assurance Committee Meetings.	

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F 565	Continued From page 8 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 565		
F 571 SS=D	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services: (A) Nursing services as required at §483.35. (B) Food and Nutrition services as required at §483.60. (C) An activities program as required at §483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,	F 571		12/24/21

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F 571	Continued From page 9 razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at §483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).	F 571		

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F 571	Continued From page 10 (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60. (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60. (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population. (iii) Requests for items and services. (A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident. (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that, for one (R22) out of three residents investigated for personal funds, the facility failed to ensure the	F 571	a.R22 was not negatively impacted by this deficient practice. b.All residents have the potential to be	

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F 571	Continued From page 11 patient pay account was not billed for non-covered services. Findings include: 10/15/21 at 10:09 AM - During an interview with F1 (R22's family and financial POA), F1 expressed concern that a personal check that was sent for deposit into R22's personal fund account was not deposited timely and that F1 had to contact the financial office for the last quarterly statement. F1 explained that there were no issues with R22's account until "the new management company took over." F1 added that R22's hair salon fee was "coming out of patient pay instead of petty cash." F1 added that non-covered charges, like haircuts, should not be taken out of the patient pay account. 10/19/21 at 3:17 PM - In an email, E1 (NHA) provided a copy of R22's financial history, dating back to 3/15/19. E1 wrote that the quarterly resident bank statements get mailed to the Corporate Office from [name of banking system company] and then mailed to the address on the account. Since statements are sent by regular mail, the facility could not provide evidence as to when they were mailed. Review of R22's financial statement back to 2019 found two recent entries that were different than all the other credits; the Surveyor informed E1. 10/21/21 at 9:41 AM - During a telephone interview, E31 (Finance Director) verified the 9/7/21 deposit was from two personal checks dated 8/10/21. E31 explained that once a week the facility would forward any checks to be deposited to the financial department (located in another State). E31 added that the length of time to delivery to her office was dependent on the	F 571	affected by this deficient practice. c.Biller will be in-serviced by Director of Billing on the importance of ensuring patient pay accounts are not billed for non-covered services. d.The Director of Billing Office or designee will randomly audit 10 residents□ financial records to ensure that patient pay accounts are not billed for non-covered services. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 571	Continued From page 12 postal service. 10/22/21 at 12:41 PM - During a telephone interview, F1 expressed concern and frustration that he received another statement (future dated 10/31/21) with another note asking which account should the hair cut should come from. F1 thought this issue was previously resolved and that the finance department should know that all haircuts should come out of petty cash since it is a non-covered service. Findings were reviewed with E1 and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 571		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		12/24/21

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F 583	Continued From page 13 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to protect the personal privacy for three (R8, R42 and R82) out of 26 sampled current residents. Findings include: Cross-refer F686, Example #1. 1. 10/19/21 beginning at approximately 10:15 AM - In preparation for R8's wound care of the right foot pressure ulcer, E7 (LPN) and E6 (RN) entered into R8's room and failed to provide privacy by closing the door to the room. 10/19/21 1:30 PM - An interview with E2 (DON) confirmed that when performing wound care, privacy must be provided by closing the door to the room. 2. 10/18/21 at 9:30 AM - During a random observation in the hallway on the Bethany Unit, R42 was seated in a shower chair with a sheet covering the bottom half of his body. R42 told E23 (CNA) "I did not want to go out." When the	F 583	1. a.R8 was not harmed due to this deficient practice b.All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c.An in-service will be conducted by Staff Development for staff that provide direct care on the importance of pulling privacy curtains closed and closing the room door when providing wound care. d.The Director of Nursing or designee will randomly audit during care to ensure that residents right to privacy is being honored by closing the room door when providing wound care. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100%	

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F 583	Continued From page 14 CNA stated, "We are going to shower", R42 responded with "I don't want one." When R42 was pulled backwards into the shower room, R42's hip was visible from the side as well as his buttocks which were seen below the shower chair seat that resembled a toilet seat. 3. 10/18/21 at 11:10 AM - During a random observation, R82 was seated in the dining/activity room along with two other residents while the two side rooms were not in use. R82 was talking to her sister on the computer while staff were having conversations among themselves around R82. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/22/21 during the Exit Conference, beginning at 3:10 PM.	F 583	compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a.R42 was not harmed due to this deficient practice b.All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c.An in-service will be conducted by Staff Development for staff that provide direct care on the importance of ensuring residents are fully covered when being transported in the hallways and that residents voiced preferences are honored. d.The Director of Nursing or designee will randomly audit during care to ensure that residents right to privacy is being honored by ensuring residents are fully covered when being transported and that if preferences are being vocalized, they are being honored. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100%	

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F 583	Continued From page 15	F 583	compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 3. a.R82 was not harmed due to this deficient practice b.All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c.An in-service will be conducted by Staff Development for staff that provide direct care on the importance of honoring residents right to privacy while having telephonic or virtual visit with family by allowing distance between other residents and staff while the virtual visit takes place. d.The Director of Nursing or designee will randomly observe 3 scheduled virtual visits to ensure that residents right to privacy is being honored by ensuring staff and other residents are maintaining a respectable distance from virtual visit. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered	

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F 583	Continued From page 16	F 583	resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 584 SS=B	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. (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	F 584		12/24/21

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F 584	Continued From page 17 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 observation and interview it was determined that, for one (Bethany unit) of three nursing units, the facility failed to maintain a safe homelike environment for the residents. Findings include: 10/14/21 - Observation between 10:09 AM - 10:43 AM on the Bethany Unit revealed the following: - Toilet paper holder loose or in disrepair: room 304, 311 and 313. - Wall-mounted sink loose: room 303. - Wall damage: room 302. - Dusty wires hanging from where a television was previously mounted: room 311. 10/14/21 12:45 PM - An interview with E10 (UM) confirmed the environmental observations during the initial tour. E10 also stated that maintenance had been working in room 313 to fix the wall. 10/18/19 8:52 AM - An interview with E29 (Maintenance Director) revealed that maintenance orders were hand-written by staff on the nursing units and he picked up new work orders from the nursing units daily.	F 584	a. Toilet paper holders were repaired in Rm 304, 311 and 313. Sink in Rm 303 was reinforced. Wall damage in Rm 302 was repaired. Dusty wires in Rm 311 were cleaned. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All staff will be in-serviced by Staff Development on the importance of timely reporting of any environmental issues that prevent a safe, homelike environment for residents via maintenance orders or notifying a supervisor as soon as identified. Maintenance Director and Housekeeping Director will conduct weekly environmental rounds of center. d. The NHA or designee will randomly audit 10 residents rooms to ensure that there are no items in disrepair. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100%	

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F 584	Continued From page 18 Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 584	compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		12/24/21

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F 623	Continued From page 19 this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and	F 623		

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F 623	Continued From page 20 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Ombudsman was notified of a hospital transfer or facility discharge for one (R8) out of two residents sampled for hospitalization. Findings include: Review of R8's clinical record review revealed a lack of evidence that the facility notified the Office of the State Long-Term Care Ombudsman when R8 was transferred to the hospital on the following dates: - 4/1/21.	F 623	a. Ombudsman was properly notified of R8 emergent transfers to hospital on 4/1/2021, 4/23/2021 and 7/13/2021. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All discharges and transfers for the month of October will be reviewed by Social Services Director to ensure Ombudsman was properly notified. AS of	

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F 623	Continued From page 21 - 4/23/21. - 7/13/21. 10/21/21 11:15 AM - An interview with E2 (DON) confirmed that the facility failed to notify the Ombudsman when R8 was emergently transferred to the hospital on 4/1/21, 4/23/21 and 7/13/21. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/22/21 during the Exit Conference, beginning at 3:10 PM.	F 623	11/1/2021 education was completed for Social Services Department to ensure understanding of requirement to notify Ombudsman of all hospital transfers and facility discharges. A log sheet has been created to document and track discharges and transfer notification. d. The NHA or designee will randomly audit 3 discharge/transfers to ensure that there is proper notification to Ombudsman. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and clinical record review it was determined that, for one (R342) out of four residents reviewed for dental services, the facility failed to complete an accurate MDS assessment. Findings include: 3/25/16 - R342 was admitted to the facility.	F 641	a. R342 MDS was corrected and dental assessment is now accurate. b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective	12/24/21

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F 641	Continued From page 22 3/28/20 and 3/29/21 - Annual MDS's documented that R342 had no broken or missing teeth and no dental issues were noted. 10/22/21 9:18 AM - Observation of the resident's mouth revealed that R342 had no upper teeth. R342 had six bottom teeth and four of them were broken off below the gums and black. R342 stated she has upper dentures and they were not in place because "They hurt." 10/22/21 10:20 AM - An interview with E10 (UM) confirmed that she had known the resident for several years and described R342's teeth as bad with only three to four teeth on the bottom and none on the top. E10 stated, "Her teeth have always been like that." 10/22/21 11:45 AM - An interview with E21 (MDS Coordinator) and E22 (Informatics Nurse) confirmed the failure to identify R342's dental status of no teeth, caries or broken teeth. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 641	actions outlined below in Section C. c. Corporate RNAC will conduct a focused review of 5 MDS assessments completed since survey exit ensure accurate completion of dental assessments. Education will be provided to facility RNAC by Corporate RNAC on importance of completing accurate dental assessments in MDS. d. Corporate RNAC or designee will conduct random selection audits of 3 MDS assessments to ensure they contain accurate dental assessments. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		12/24/21

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F 656	Continued From page 23 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for two (R24 and R342) out of 26 current residents sampled for a care area, the facility failed to initiate a comprehensive care plan for the residents' active conditions. Findings	F 656	1. a. R24 Care Plan was updated to include checking dialysis site for bruit and thrill and to notify attending physician or Nurse	

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F 656	Continued From page 24 include: 1. Review of R24's clinical records revealed the following: 8/5/21 - R24 was admitted to the facility and was on hemodialysis (HD). 8/6/21 - A Physician's Order was written to check the dialysis site (fistula) for bruit and thrill and to notify the Attending Physician or the Nurse Practitioner of diminished or absent bruit and thrill of the left arm every shift. 8/6/21 - The care plan for HD included interventions of no blood draws or taking blood pressures in the arm with the fistula, and to monitor/report/document as needed for any signs or symptoms of infection of the HD access site. There was lack of evidence of an intervention to check the left arm fistula site every shift for bruit and thrill and to notify the Attending Physician or the Nurse Practitioner if these were diminished or absent. 10/19/21 10:07 AM - An interview with E2 (DON) confirmed that the facility failed to develop a comprehensive care plan for hemodialysis to include checking for the presence of bruit and thrill of the left arm HD access site every shift. 2. The following was reviewed in R342's clinical record: 10/9/21- R342 was readmitted from the hospital with a diagnosis of depression. 10/10/21 9:00 AM - A physician's order included	F 656	Practitioner of diminished or absent bruit and thrill of left arm every shift. b. All residents who have orders to check dialysis site for bruit and thrill have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All residents who have an av fistula were reviewed to ensure that their care plan reflected checking bruit and thrill. MDS coordinator was educated by Corporate RNAC on the importance of ensuring comprehensive care plan is in place for all active conditions. d. The Director of Nursing or designee will randomly audit 3 care plans for residents on dialysis to ensure that if there is an av fistula and orders to check bruit and thrill that care plan reflects same . The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. R342 Care Plan was updated to reflect	

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F 656	Continued From page 25 to administer R342 an antidepressant medication once a day. Review of R342's care plan did not include depression. 10/21/21 9:48 AM - During an interview, E4 (SD) confirmed that R342's care plan for depression was discontinued upon discharge from the facility to the hospital and that it was not restarted upon return to the facility on 10/9/21. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 656	diagnosis of depression. b. All residents who have a diagnosis of depression have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All residents who have a diagnosis of depression were reviewed to ensure it is reflected in their care plan. MDS coordinator was educated by Corporate RNAC on the importance of ensuring comprehensive care plan is in place for all active conditions. d. The Director of Nursing or designee will randomly audit 3 care plans for residents with a diagnosis of depression to ensure that it is care planned with appropriate interventions . The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
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	F 657		12/24/21

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F 657	Continued From page 26 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 five (R1, R22, R25, R54 and R82) out of 26 current residents investigated for a care area, the facility failed to ensure the required interdisciplinary team members (Attending Physician or designee, the RN and CNA with responsibility for the resident and a member of Food and Nutrition Services staff) provided input for the comprehensive care plan. Findings include: 1. Review of R1's clinical record revealed:	F 657	1. a. All required staff members provided input for R1 Care Plan. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All care plan meeting notes as of 10/22	

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F 657	Continued From page 27 7/20/20 - R1 was admitted to the facility. Review of Care Conference Notes revealed no evidence that the required interdisciplinary team members attended or provided input for R1's comprehensive care plan: 1/27/21: "IDT team met with Resident with daughter over the phone." 4/28/21: "IDT team met with Resident, and attempted to call daughter, however she did not answer." 10/13/21: "IDT Team met to review the care plan this date. Resident's daughter participated by phone. Resident has a better appetite and participates in feeding herself more frequently. Discussed when it would be best to schedule [online] visits so that resident would not be asleep during the visit." 2. Review of R22's clinical record revealed: 2/26/19 - R22 was admitted to the facility. Review of Care Conference Notes revealed no evidence that the required interdisciplinary team members attended or provided input for R22's comprehensive care plan: 2/24/21: "IDT team met with son (F1) and case manager over the phone to review current plan of care." 5/26/21: "IDT team met with Son (F1) and case manager over phone to review current plan of care."	F 657	reflect all members of the Interdisciplinary Team that either provided input or attending care plan meeting. NHA educated Social Services Department on the importance of indicating the name and position of team members that participate in the development of the care plan including the attending physician or designee and the Certified Nursing Aide responsible for the residents. d. The NHA or designee will randomly audit 3 care plans to ensure that the list of participants does not say Interdisciplinary Team rather the names of each individual and their title. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. All required staff members provided input for R22 Care Plan. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All care plan meeting notes as of 10/22	

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F 657	Continued From page 28 8/18/21: "IDT Team me (sic) this date to review resident's care plan. Resident's son (F1) and the [insurance company] Case Manager participated by phone. Discussed palliative care (care that helps or comforts a person who is dying, including pain relief) with son. He agreed to resident receiving palliative care. Discussed whether COVID boosters would be given. Son gave his permission during the meeting for resident to receive booster." 10/15/21 at 10:34 AM - During a telephone interview, F1 (R22's family and POA) stated that he participated in the care conferences and indicated that the Unit Manager, Dietician and sometimes, Rehab were on the call. When asked if the Doctor or Nurse's Aide were ever present, R1 responded "No to the Aide, but maybe a [Nurse] Practitioner might have been at one." 3. Review of R25's clinical record revealed: 2/2/21 - R25 was readmitted to the facility (original admission 1/30/08). Review of Care Conference Notes revealed no evidence that the required interdisciplinary team members attended or provided input for R25's comprehensive care plan: 8/25/21: "IDT team met this date to review the resident's care plan. Resident's mother participate by phone. The [insurance company] Case Manager was unavailable. Resident has adjusted well to being on the Bethany Unit (locked dementia unit). Discussed COVID guidelines that are currently being observed	F 657	reflect all members of the Inter Interdisciplinary Team that either provided input or attending care plan meeting. NHA educated Social Services Department on the importance of indicating the name and position of team members that participate in the development of the care plan including the attending physician or designee and the Certified Nursing Aide responsible for the residents. d. The NHA or designee will randomly audit 3 care plans to ensure that the list of participants does not say Interdisciplinary Team rather the names of each individual and their title. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 3. a. All required staff members provided input for R25 Care Plan. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.	

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F 657	Continued From page 29 within the center." 6/9/21: "IDT team met this date to review the care plan. Resident's mother and [insurance company] case manager were called but unavailable. Resident has had no changes in medication or diet. Resident enjoys moving throughout the unit and interacting with staff and other residents." 3/17/21: "IDT team met with mother and case manager over phone to review current plan of care." 4. Review of R54's clinical record revealed: 4/3/18 - R54 was admitted to the facility. Review of Care Conference Notes revealed no evidence that the required interdisciplinary team members attended or provided input for R54's comprehensive care plan: 4/7/21: "IDT team met with husband over the phone to review current plan of care." 6/30/21: "IDT team met this date to review the resident's care plan. Husband was called but was unavailable. [Insurance company] Case Manager participated by phone. Resident is happy and pleasant. She goes to the dining room for her meals." 9/15/21: "IDT team met with Husband and case manager over phone. Reviewed current plan of care." 5. Review of R82's clinical record revealed:	F 657	c. All care plan meeting notes as of 10/22 reflect all members of the Interdisciplinary Team that either provided input or attending care plan meeting. NHA educated Social Services Department on the importance of indicating the name and position of team members that participate in the development of the care plan including the attending physician or designee and the Certified Nursing Aide responsible for the residents. d. The NHA or designee will randomly audit 3 care plans to ensure that the list of participants does not say Interdisciplinary Team rather the names of each individual and their title. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 4. a. All required staff members provided input for R54 Care Plan. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.	

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F 657	Continued From page 30 4/23/20 - R82 was admitted to the facility. Review of Care Conference Notes revealed no evidence that the required interdisciplinary team members attended or provided input for R82's comprehensive care plan: 2/3/21: "IDT team met to review current plan of care. Guardian and [insurance company Case Manager] were attempted to be contacted for the meeting, neither were available." 4/21/21: "IDT team met with Guardian over phone to review current plan of care." 7/14/21: "IDT Team met this date to review the care plan. Resident's POA and [insurance company] Case Manager participated by phone. Resident's confusion increasing slightly." 10/6/21: "IDT Team met this date to review the care plan. The resident's [insurance company] Case Manager and appointed guardian were both called but were unavailable to participate. Resident continues on a no salt added diet." 10/21/21 at approximately 2:10 PM - During an interview, E20 (RN, UM) explained that she would talk with Nurse's Aides for comments about residents due for a care conference to determine if there were any concerns and would review the history and physical and progress notes (for Physician/PA input). 10/22/21 at approximately 9:25 AM - During an interview with E20 (SW), the Surveyor asked who attended care conference meetings when IDT was recorded in the Care Conference Note. E20 stated the "Unit Manager, Social Worker, Rehab	F 657	c. All care plan meeting notes as of 10/22 reflect all members of the Interdisciplinary Team that either provided input or attending care plan meeting. NHA educated Social Services Department on the importance of indicating the name and position of team members that participate in the development of the care plan including the attending physician or designee and the Certified Nursing Aide responsible for the residents. d. The NHA or designee will randomly audit 3 care plans to ensure that the list of participants does not say Interdisciplinary Team rather the names of each individual and their title. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 5. a. All required staff members provided input for R82 Care Plan. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.	

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F 657	Continued From page 31 if needed, the Dietician at times and Activities for long term care." There was no evidence as to which IDT members, including the Attending Physician or designee or the Nurse's Aide with responsibility for the resident, attended or provided input for the aforementioned care conferences. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 657	c. All care plan meeting notes as of 10/22 reflect all members of the Interdisciplinary Team that either provided input or attending care plan meeting. NHA educated Social Services Department on the importance of indicating the name and position of team members that participate in the development of the care plan including the attending physician or designee and the Certified Nursing Aide responsible for the residents. d. The NHA or designee will randomly audit 3 care plans to ensure that the list of participants does not say Interdisciplinary Team rather the names of each individual and their title. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and	F 677	1.	12/24/21

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F 677	Continued From page 32 interview, it was determined that, for three (R1, R22 and R54) out of three (3) residents sampled for bladder and bowel incontinence (inability to control bowel and/or bladder), the facility failed to perform incontinence care according to the comprehensive care plan. Additionally, for R1, the facility failed to identify a decline in transfer function. Findings include: 1. Cross Refer F689 10/19/21 at 2:20 PM - During a random observation, E23 (CNA) and E24 (CNA) transferred R1 back to bed from her geri-chair. Each CNA placed one arm under each of R1's armpits and grabbed R1's pant waist band in the back and lifted R1 into bed, while pushing the chair out of the way. R1's feet did not touch the floor. 10/21/21 at 2:12 PM - During an interview, E10 (RN UM) and the Surveyor reviewed the transfer sheet in R1's closet, which identified R1 as needing 2 persons for transfer. The transfer sheet did not indicate how R1 should be transferred. When the Surveyor described how R1 was lifted back into bed, E10 stated, "It should not be done that way." E10 added that Therapy would be contacted to do a transfer evaluation. When informed that the CNA documentation for 10/19/21 recorded that R1 needed extensive assistance, E10 stated that it should have been documented as total since R1's feet never touched the floor. 2. Review of R1's clinical record revealed: 7/14/21 - The quarterly MDS assessment documented that R1 was always incontinent of	F 677	a. R1 was evaluated by therapy and transfer status has been changed to require staff to use a mechanical lift. Transfer sheets and orders now reflect appropriate transfer status. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff will be in-serviced by the Director of Rehabilitation on the difference between extensive assistance and total assistance to ensure appropriate transfer status is adhered to when performing transfers of patients as well as ensuring accuracy when documenting transfers. In-service will also include education to ensure that staff are aware of when to notify therapy that a residents transfer needs have changed as it pertains to safe transfers. d. The Director of Nursing or designee will select 3 residents to ensure that the orders and transfer sheet accurately reflect the residents transfer status, transfer will be observed to ensure it is being done accurately and documentation will be reviewed for that resident to ensure it also aligns with orders, transfer sheet and how the staff physically conducted transfer. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive	

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F 677	Continued From page 33 bowel and bladder and needed extensive assistance for toileting. 7/19/21 - A care plan for urinary and bowel incontinence included the intervention to check and change every two hours and PRN (as needed). During several continuous observations during the survey, R1 was not provided incontinence care during the following time frames: 10/14/21 (10:30 AM - 1:45 PM); 10/18/21 (8:02 AM - 11:20 AM) and 10/19/21 (9:50 AM - 2:15 PM). 3. Review of R22's clinical record revealed: 3/15/21 - A care plan for urinary and bowel incontinence included the intervention to check and change every two hours and PRN (as needed). 8/11/21 - The quarterly MDS assessment documented that R22 was always incontinent of bowel and bladder and needed extensive assistance with two staff for toileting. During several continuous observations during the survey, R22 was not provided incontinence care during the following time frames: 10/14/21 (9:30 AM - 1:50 PM); 10/18/21 (8:02 AM - 11:20 AM) and 10/19/21 (10:15 AM - 2:15 PM). 4. Review of R54's clinical record revealed: 1/7/21 - A care plan for urinary and bowel incontinence included the intervention to check and change every 2 hours and PRN (as needed). 9/8/21 - A quarterly MDS assessment	F 677	weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. Care staff for R1 were immediately educated on importance of check and change intervention every two hours and as needed. b. All residents who have orders for two hour check and change have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff will be in-serviced by Staff Development on the importance of and expectation that all residents who are care planned for the two hour check and change receive incontinence care according to the comprehensive care plan. d. The Director of Nursing or designee will select 3 residents who are care planned for the two hour check and change incontinence program and observe to ensure they receive this care consistently and timely. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3	

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F 677	Continued From page 34 documented that R54 was always incontinent of bowel and bladder and needed extensive assistance with one staff person for toileting. 10/14/21 - During a continuous observation on the first day of survey, R54 was not provided incontinence care between the hours of 9:40 AM - 1:45 PM. 10/18/21 4:54 PM - During an interview, the aforementioned observations were reviewed with E2 (DON) without comment. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 677	consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 3. a. Care staff for R22 were immediately educated on importance of check and change intervention every two hours as well as PRN (as needed.) b. All residents who have orders for two hour check and change have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff will be in-serviced by Staff Development on the importance of and expectation that all residents who are care planned for the two hour check and change receive incontinence care according to the comprehensive care plan. d. The Director of Nursing or designee will select 3 residents who are care planned for the two hour check and change incontinence program and observe to ensure they receive this care consistently and timely. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly	

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F 677	Continued From page 35	F 677	or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 4. a. Care staff for R54 were immediately educated on importance of check and change intervention every two hours and as needed. All residents who have orders for two hour check and change have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff will be in-serviced by Staff Development on the importance of and expectation that all residents who are care planned for the two hour check and change receive incontinence care according to the comprehensive care plan. d. The Director of Nursing or designee will select 3 residents who are care planned for the two hour check and change incontinence program and observe to ensure they receive this care consistently and timely. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly	

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F 677	Continued From page 36	F 677	or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 684 SS=D	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 record review, interview and review of other facility documentation it was determined that the facility failed to monitor fluid intake for a resident on a fluid restriction for one (R24) out of five sampled residents. Findings include: The facility policy titled Fluid Restriction, with a revision date of 1/11/21, stated that the Dietary and Nursing department would work together to ensure compliance with the Practitioner's order for fluid restrictions. Review of R24's clinical record revealed the following: 8/9/21 - R24 was admitted to the facility and was	F 684	a. Diet slip was confirmed to be correct for R24. All care staff responsible for R24 were immediately educated on importance of adhering to fluid restriction as ordered. b. All residents who have orders for fluid restriction have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Immediately upon being notified of deficient practice a whole house sweep of all residents who have orders for a fluid	12/24/21

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F 684	Continued From page 37 on hemodialysis due to kidney disease. 8/9/21 - A Physician's Order was written for a 1000 mL fluid restriction with 480 mL from dietary and 520 mL from nursing (200 mL on day shift, 200 mL on evening shift, and 120 mL on night shift). 8/9/21 - The care plan for nutritional risk related to therapeutic diet and fluid restriction for management of kidney disease included interventions of the fluid restriction as ordered: 1000 mL daily - continue order in place despite being under hydration estimations. Dialysis monitors and made this recommendation. 9/21/21 - Review of the 24 hour fluid total documentation revealed 11 days in which R24 exceeded the 1,000 mL restriction. The amounts exceeding the restriction were as follows in mL; 1,080, 1,020, 1,180, 1,920, 1,080, 1,080, 1,200, 1,480, 1,200, 1,540, and 1,200. There was lack of evidence that the facility was monitoring R24's fluid restriction. 10/1/21 through 10/17/21 - Review of the 24 hour fluid total documentation revealed four (4) days in which R24 exceeded the 1,000 mL restriction. The amounts exceeding the restrictions were as follows in mL; 1,200, 1,700, 1,080 and 1,140. There was lack of evidence that the facility was monitoring R24's fluid restriction. 10/18/21 12:05 PM - Random observation of R24's lunch meal tray revealed that R24 was offered 240 mL of iced tea.	F 684	restriction was done and the staff responsible for their care was educated on the importance of adhering to fluid restriction as ordered. Process change was initiated to require documentation of fluid intake for residents with orders for a fluid restriction to be completed by the nurse rather than by the Certified Nursing Aide. In-service will be done for dietary staff and direct care staff who serve meal trays to ensure diet slips are adhered to and appropriate fluid restrictions are adhered to on meal trays when being served. d. The Director of Nursing or designee will select 3 residents who are care planned for fluid restrictions and make sure their meal tray is accurate and that the daily fluid intake documented aligns with practitioner□s order for fluid restriction. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 684	Continued From page 38 10/18/21 12:10 PM - An interview with E5 (RD) confirmed that R24 was ordered to have 120 mL of fluid on his lunch tray and that he was incorrectly given 240 mL instead. 10/22/21 10:17 AM - An interview with E9 (LPN UM) revealed that she was uncertain who was responsible to monitor R24's fluid restriction on an ongoing basis. Findings were reviewed with E1 (NHA) and E2 (DON) on 10/22/21 during the Exit Conference, beginning at 3:10 PM.	F 684		
F 686 SS=D	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, and record review, it was determined that for two (R1 and R8) out of seven (7) residents sampled for pressure ulcer (PU) review, the facility failed to ensure that residents with pressure ulcers received the necessary treatment and services.	F 686	1. a. R8□s wound was immediately cleaned and plain wound care gel was applied as ordered.	12/24/21

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F 686	Continued From page 39 The facility failed to follow the physician's order for R8's right foot PU wound care. For R1 the facility failed to turn and reposition as prescribed by the plan of care. Findings include: The facility's policy titled Infection Control Hand Hygiene, with a revision date of 6/2/21, stated, "...When washing hands:...Wash hands thoroughly, using rigorous scrubbing action for at least 20 seconds...Dry hands with clean paper towel...Turn off faucets with clean paper towel and discard...Using an alcohol -based hand rub:...Apply alcohol-based hand rub to palm of one hand...Rub hands together, covering all areas of the hands and fingers with alcohol gel until hands are dry...". Cross reference F583, example #1 1. Review of R8's clinical record and a random observation of PU wound care revealed the following: 10/19/21 - A Physician's Order was written to clean the right lateral (outer side) foot with normal saline solution (sterile salt water solution), apply plain wound gel and cover with a dry dressing daily and as needed. 10/21/21 beginning at approximately 10:15 AM - During a PU wound care observation, E7 (LPN) removed the old dressing from R8's right foot. E7 cleaned R8's right foot PU with normal saline. E7 applied a small amount of MediHoney gel (special wound gel to remove dead tissue), in the middle of the dressing then placed the prepared dressing onto the PU wound bed to complete the treatment. E7 used the wrong kind of wound gel. 10/21/21 1:50 PM - An interview with E6 (RN)	F 686	b. All residents who receive wound care have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. In servicing of all nurses that perform wound care treatments will be done by Staff Development with a focus on the importance of using specific wound gel as ordered. d. The Director of Nursing or designee will select 3 residents who are receiving wound care treatments and observe to ensure all treatment orders are being followed accurately while wound care is being provided. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. Care staff for R1 were immediately educated on importance of turning and repositioning as well as skin check intervention every two hours and as needed.	

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F 686	Continued From page 40 confirmed that the Physician's order for the right foot PU treatment did not include using MediHoney gel. 10/21/21 2:15 PM - An interview with E2 (DON) was conducted and the Surveyor reviewed the above wound care observations. E2 confirmed that R8's PU wound care order did not include the use of MediHoney gel. The facility failed to perform the prescribed wound care to R8's right lateral PU. Cross Refer F689 2. Review of R1's clinical record revealed: 7/19/21 - A care plan was initiated for a stage 4 pressure ulcer on the sacrum (large triangular bone at the base of the spine, central area above the buttocks). Interventions included to turn and reposition every 2 hours and PRN (as needed) and perform skin checks every 2 hours. During continuous observations throughout the survey, R1 did not receive pressure relief, repositioning or skin checks while seated in the dining/activity room: - 10/14/21: 10:30 AM - 1:45 PM. - 10/18/21: 8:02 AM -11:20 AM. - 10/19/21: 9:50 AM - 2:15 PM. 10/19/21 at 10:58 AM - During an interview, E10 (UM) confirmed that repositioning and skin checks should be done every 2 hours and PRN. 10/19/21 at 2:25 PM - During an observation, E23 (CNA) and E24 (CNA) returned R1 to bed to perform incontinence care. The Surveyor visualized a circular reddened area over the bone	F 686	b. All residents who have orders for two hour turning, repositioning and skin checks have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff will be in-serviced by Staff Development on the importance of and expectation that all residents who have orders for the two hour turning, repositioning and skin checks are receiving this intervention as ordered. d. The Director of Nursing or designee will select 3 residents who are care planned for the two hour turning, repositioning and skin check program and observe to ensure they receive this care consistently and timely. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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CADIA REHABILITATION RENAISSANCE	26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966

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F 686	Continued From page 41 located on the bottom of each buttock, which was immediately confirmed by the CNAs. 10/21/21 4:54 PM - During an interview, the aforementioned observations were reviewed with E2 (DON) who had no comment. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 10/22/21, starting at 3:10 PM.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation, it was determined that, for one (R1) out of three residents sampled for bowel and bladder incontinence, the facility failed to identify a decline in transfer status, placing the resident at risk for injury. Findings include: Cross Refer F677, Example 2 7/14/21 - The quarterly MDS assessment included that R1 needed extensive assistance with two staff for transfers. 10/14/21 - A care plan for palliative care (approach addressing the person as a whole, not	F 689	a. R1 was evaluated by therapy and transfer status has been changed to require staff to use a mechanical lift. Transfer sheets and orders now reflect appropriate transfer status. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff will be in-serviced by the Director of Rehab on the difference between extensive assistance and total	12/24/21

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F 689	Continued From page 42 just their disease) was initiated and included the intervention to adjust the provision of ADLs (activities of daily living such as eating, dressing and toileting) to compensate for R1's changing abilities. 10/18/21 - The current CNA assignment sheet included that R1 needed extensive assistance with two staff for transfers. 10/19/21 at 2:20 PM - During a random observation, E23 (CNA) and E24 (CNA) transferred R1 back to bed from her geri-chair. Each CNA placed one arm under each of R1's armpits and grabbed R1's pant waist band in the back and lifted R1 into bed, while pushing the chair out of the way. R1's feet did not touch the floor. 10/21/21 at 2:12 PM - During an interview, when the Surveyor described how R1 was transferred back into bed, E10 (RN, UM) stated, "It should not be done that way." E10 added that Therapy would be contacted to do a transfer evaluation. 10/22/21 at 10:27 AM - E25 (PT) conducted a transfer assessment with E26 (CNA), resulting in R1 now needing a mechanical lift for transferring in and out of bed. E25 added, "It's best for her, to not injure her shoulders. When they [residents] get to where they do not put weight on their legs, they should let me know to change their transfer method." Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 689	assistance to promote adequate performance of transfers of patients as well as ensuring accuracy when documenting transfers. In-servicing will also include education to ensure that staff are aware of when to notify therapy that a resident needs have changed as it pertains to safe transfers. d. The Director of Nursing or designee will select 3 residents to ensure that the orders and transfer sheet accurately reflect the residents transfer status, transfer will be observed to ensure it is being done accurately and documentation will be reviewed for that resident to ensure it also aligns with orders, transfer sheet and how the staff physically conducted transfer. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		12/24/21

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F 759	Continued From page 43 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to ensure that residents were free of a medication error rate of 5% or greater. Medication passes identified two errors out of 25 opportunities equaling an 8% error rate. Findings include: Cross-refer to F760 1. Review of R43's clinical record and medication pass observation revealed the following: 10/19/21 11:33 AM - During a random medication observation, E8 (RN) administered 6 units of Novolog (fast acting insulin) to R43. 10/19/21 12:21 PM - R43 was served her lunch meal and began eating the meal at 12:21 PM, approximately 48 minutes after receiving the Novolog, increasing the risk for low blood sugar (hypoglycemia). 10/19/21 1:30 PM - An interview with E2 (DON) confirmed that Novolog should not be administered more than 15 minutes prior to a meal. 2. Review of R34's record and observation of R34's medication pass revealed the following:	F 759	1. a. R43 was not harmed by this deficient practice. R43s nurse was immediately educated that Novolog should not be administered more than 15 minutes prior to a meal. b. All residents who receive fast acting insulin have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. An In-service will be conducted by Staff Development for all nurses educating them on the importance of administering Novolog within 15 minutes before a meal. d. The Director of Nursing or designee will select 3 residents who have orders for fast acting insulin and observe administration to ensure the time is not more than 15 minutes before residents meal. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive	

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F 759	Continued From page 44 10/19/21 11:43 AM - During a random medication observation, E8 (RN) administered 4 units of Humalog (fast acting insulin) to R34. 10/19/21 12:29 PM - R34 was served her lunch meal and began to eat a small container of watermelon approximately 46 minutes after the administration of the Humalog. R34 stated she was not hungry and did not consume any other items from the lunch tray and R34 began to consume a nutritional supplement that was at the bedside. 10/19/21 1:30 PM - An interview with E2 (DON) confirmed that Humalog should not be administered more than 15 minutes prior to a meal. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 10/24/21, starting at 3:10 PM.	F 759	weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. R34 was not harmed by this deficient practice. R34s nurse was immediately educated that Humalog should not be administered more than 15 minutes prior to a meal. b. All residents who receive fast acting insulin have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. An Inservice will be conducted by Staff Development for all nurses educating them on the importance of administering Humalog within 15 minutes before a meal and in the event meal delivery is delayed or resident refuses food after fast acting insulin is administered, residents condition must be reassessed by nurse. d. The Director of Nursing or designee will select 3 residents who have orders for fast acting insulin and observe administration to ensure the time is not more than 15 minutes before residents meal. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will	

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F 759	Continued From page 45	F 759	continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of product information, it was determined that the facility failed to ensure that residents were free from significant medication errors for two (R34 and R43) out of 11 residents randomly sampled during medication pass observations. The facility failed to adhere to the manufacturer's information for the administration of fast-acting insulins, Novolog and Humalog for R34 and R43, thus, increasing the risk for low blood sugar. Findings include: Novolog Manufacturer Information indicated to administer the insulin within 15 minutes before a meal or right after eating a meal. (https://www.novocare.com) Humalog Manufacturer Information indicated to administer the insulin within 15 minutes before a meal. (https://www.humalog.com)	F 760	1. a. R43 was not harmed by this deficient practice. R43s nurse was immediately educated that Novolog should not be administered more than 15 minutes prior to a meal. b. All residents who receive fast acting insulin have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. An Inservice will be conducted by Staff Development for all nurses educating them on the importance of administering Novolog within 15 minutes before a meal. d. The Director of Nursing or designee will select 3 residents who have orders for	12/24/21

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F 760	Continued From page 46 1. Review of R43's clinical record and medication pass observation revealed the following: 10/2021 - The Monthly Physician's Order Sheet documented that R43's FSBS (Finger Stick Blood Sugar) was to be completed before meals (breakfast, lunch, and dinner) and at bed time and to administer a fast acting insulin, Novolog, based on the result of the FSBS. 10/19/21 - The lunch cart arrival times to the unit were 11:40 AM and 11:50 AM. 10/19/21 11:33 AM - During a random medication observation, E8 (RN) administered 6 units of Novolog (fast acting insulin) to R43. 10/19/21 11:50 AM - An interview with E8 (RN) revealed that the lunch cart usually arrived in the unit around 12 noon. E8 stated it was their understanding that Novolog insulin could be administered up to 30 minutes before the meal. 10/19/21 12:00 PM - An interview with R43 revealed that sometimes she can tell her blood glucose was low as she would feel "Weird." 10/19/21 12:21 PM - R43 was served her lunch meal and began consuming the meal at 12:21 PM, approximately 48 minutes after receiving the Novolog insulin, increasing the risk for low blood sugar (hypoglycemia). 10/19/21 1:30 PM - An interview with E2 (DON) confirmed that Novolog insulin should not be administered more than 15 minutes prior to a meal. The facility failed to adhere to the manufacturer	F 760	fast acting insulin and observe administration to ensure the time is not more than 15 minutes before residents meal. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. R34 was not harmed by this deficient practice. R34s nurse was immediately educated that Humalog should not be administered more than 15 minutes prior to a meal. b. All residents who receive fast acting insulin have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. An Inservice will be conducted by Staff Development for all nurses educating them on the importance of administering Humalog within 15 minutes before a meal and in the event meal delivery is delayed or resident refuses food after fast acting insulin is administered, residents condition must be reassessed by nurse.	

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F 760	Continued From page 47 information for Novolog insulin, thus, increasing the possibility of R43 experiencing signs or symptoms of low blood sugar. Additionally, after R43 was administered the insulin at 11:33 AM, the facility failed to reassess R43's condition when R43's lunch meal was delayed. 2. Review of R34's record and observation of R34's medication pass revealed the following: 10/2021 - The Monthly Physician's Order Sheet documented that R34's FSBS was to be completed before meals (breakfast, lunch, and dinner) and at bedtime and to administer a fast acting insulin (Humalog) based on the result of the FSBS. 10/19/21 - The lunch cart arrival times to the unit were 11:40 AM and 11:50 AM. 10/19/21 11:43 AM - During a random medication observation, E8 (RN) administered 4 units of Humalog insulin to R34. 10/19/21 11:50 AM - An interview with E8 (RN) revealed that the lunch cart usually arrived in the unit around 12 noon. E8 stated it was their understanding that Humalog can be administered up to 30 minutes before the meal. 10/19/21 12:29 PM - R34 was served her lunch meal and started to consume a small container of watermelon approximately 46 minutes after the administration of Humalog. R34 stated she was not hungry and did not eat any other items from the lunch tray, then started to consume a nutritional supplement that was at the bedside. The facility failed to adhere to the manufacturer	F 760	d. The Director of Nursing or designee will select 3 residents who have orders for fast acting insulin and observe administration to ensure the time is not more than 15 minutes before residents meal. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 760	Continued From page 48 information for Humalog insulin, thus, increasing the possibility of R34 experiencing signs or symptoms of low blood sugar. Additionally, after R34 was administered the insulin at 11:43 AM, the facility failed to reassess R34's condition when R34's lunch meal was delayed. 10/19/21 1:30 PM - An interview with E2 (DON) confirmed that Humalog insulin should not be administered more than 15 minutes prior to a meal. Findings were reviewed with E1 (NHA) and E2 on 10/22/21 during the Exit Conference, beginning at 3:10 PM.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		12/24/21

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F 761	Continued From page 49 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, it was determined that for one (Fenwick Unit) out of two medication rooms inspected, the facility failed to ensure that refrigerated drugs and biologicals were stored under proper temperature controls. Findings include: 7/15/13 - The facility form entitled "Medication Refrigerator and Freezer Temperature Record" stated that "It is the responsibility of the 11-7 nurse to check and record fridge and freezer temperatures daily. Normal range is 36 to 46 degrees F [Fahrenheit] for fridges...Out of range findings are to be reported to the maintenance department immediately." 4/29/21 (date of last revision) -The facility policy for Refrigerator/Freezer Temperatures included for medication refrigerators "...Refrigerator and freezer temperatures shall be logged and maintained daily by the Supervisor/designee. Refrigerator temperatures shall be maintained between 36 and 46 degrees Fahrenheit...All deviations from the temperatures shall be immediately reported to the Maintenance Department." September 2021 - Review of the facility temperature record for Fenwick, provided by E9 (LPN, UM), revealed that 18 of the 29 days (62%) completed recorded temperatures were above 46	F 761	a. No resident was harmed by this deficient practice. All medication was immediately removed from the refrigerator that was reading a temperature higher than is proper for medication storage. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. A new thermometer was procured and temperature was adjusted, refrigerator is functioning properly and able to maintain appropriate temperature. New temperature log forms were created and are now being used for all medication refrigerators which have an area that requires staff to indicate what action was taken if temperature check results in temperature being out of range. All staff responsible for medication administration and/or storage will be in serviced by Staff Development on how to use new form and to immediately notify maintenance if temperature is not within the required range of 36-46 degrees. d. The Director of Nursing or designee will check all medication refrigerators to ensure that the temperature is within	

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F 761	Continued From page 50 degrees F. October 2021 - Review of the facility temperature record for Fenwick, found on the outside of the Fenwick Unit's medication refrigerator, revealed that 16 of the 18 days (89%) completed recorded temperatures above 46 degrees F. 10/19/21 3:10 PM - An inspection of the Fenwick Unit's Medication Refrigerator with E8 (RN) revealed that there were two thermometers, one that read 52 degrees F and one that read 70 degrees F. This finding was immediately reported to E6 (RN UM). 10/19/21 3:15 PM - During an interview and observation, E29 (Maintenance Director) confirmed that there were two thermometers in the Fenwick Unit's medication refrigerator that read warmer than acceptable. E29 stated that no one reported high refrigerator temperatures to him over the past several months. E29 confirmed that the temperature was too high using another thermometer. E29 then increased the temperature setting to maximum cold and closed the refrigerator door. E29 stated he would follow up and recheck the temperature to ensure proper functioning of the refrigerator. 10/19/21 4:15 PM - The above findings were reviewed with E1 (NHA) and E2 (DON). E1 stated they would transfer the intravenous and other medications in the Fenwick refrigerator to the Rehoboth refrigerator. 10/21/21 5:05 PM - The above findings were reviewed with E30 (Chief Nursing Officer) and E2. E2 confirmed that the intravenous medications that were removed from the Fenwick refrigerator	F 761	appropriate range and that there are no instances on temperature log of staff logging a temperature out of range without indicating what steps were taken to resolve. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 761	Continued From page 51 on 10/19/21 were examined and had no signs of improper storage like cloudiness or separation. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		12/24/21

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F 791	Continued From page 52 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined that, for two (R8 and R342) out of four residents reviewed for dental services, the facility failed to assist in obtaining routine dental services. Findings include: Cross Refer F641 1. Review of R342's clinical record revealed: 3/25/16 - R342 was admitted to the facility. 3/28/20 and 3/29/21 - Annual MDS assessments documented that R342 had no broken, missing teeth, or dental issues noted. 10/14/21 2:30 PM - Observation of resident's mouth revealed that R342 had no upper teeth. R342 had six bottom teeth and four of them were broken off below the gums and were black. R342 stated that she had upper dentures and they were not in place because "They hurt." 10/22/21 8:05 AM - Review of clinical records lacked evidence that R342 was offered dental services.	F 791	1. a. R342s dental assessment was corrected. R342 was offered dental services. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Social Services Director will review all active Long-Term Care residents to ensure that they have been offered routine dental service. If a resident indicates that they wish to receive routine dental care, it will be arranged. A log will be created and maintained by Social Services Director to ensure that all Long-Term Care Residents are offered assistance with arranging routine dental services annually. d. The Director of Nursing or designee	

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F 791	Continued From page 53 10/22/21 9:06 AM - Interview with E20 (SSD) confirmed that there was no evidence of a dental consult. E20 revealed that dental services would be offered to R342 today. 2. Review of R8's clinical records revealed the following: 10/21/19 - R8 was admitted to the facility. 7/28/21 - The Significant Change MDS Assessment indicated that R8 had no problems with oral health including his teeth and gums. 10/14/21 10:15 AM - R8 was observed with natural teeth, both upper and lower. R8 denied pain or discomfort and stated he had not had any routine dental services since admission (10/21/19). R8 stated he was unable to brush his teeth and that staff brushed his teeth daily. 10/21/19 through 10/17/21 - Record review lacked evidence that R8 was provided routine dental services. 10/18/21 12:41 PM - An interview with E2 (DON) revealed that routine dental services did not require a physician's order. 10/18/21 1 PM - An interview with E3 (ADON) revealed the facility was unable to provide any evidence that R8 was offered routine dental services since his admission on 10/19/19, approximately two (2) years ago. 10/19/21 10 AM - A follow-up interview with E3 revealed it was her understanding that R8's Mother was attempting to locate dental services	F 791	will audit 5 Long Term Care residents records to ensure they have been offered assistance with arranging routine dental services. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. R8 was offered routine dental services. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Social Services Director will review all Long-Term Care residents in house to ensure that they have been offered routine dental service. If a resident indicates that they wish to receive routine dental care, it will be arranged. A log will be created and maintained by Social Services Director to ensure that all Long-Term Care Residents are offered assistance with arranging routine dental services annually. d. The Director of Nursing or designee will audit 5 Long Term Care residents	

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F 791	Continued From page 54 in the community and that E3 spoke with his Mother earlier today during the survey and requested that the facility coordinate routine dental services for R8. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 791	records to ensure they have been offered assistance with arranging routine dental services. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation of the facility kitchen and	F 812	a. No resident was harmed by this	12/24/21

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F 812	Continued From page 55 interview of staff, it was determined that the facility failed to maintain consistent food temperature (temp) logs, maintain safe refrigerator temperatures, and dispose of outdated food. Findings include: During the initial and follow-up tours of the facility kitchen unit refrigerators on 10/14/21, the surveyor observed the following: -11:20 AM- Review of facility food temp logs revealed a total of one thousand forty seven (1047) meals served between January 1, 2021 and October 14, 2021. Five-hundred four (504) meals had no food temperatures recorded and twenty (20) meals had incomplete food temperature information. - 12:00 PM - Refrigerator located on Fenwick Unit had a temperature of 50 degrees Fahrenheit (F). According to Delaware Food Code 3-501.16, Food shall be maintained: At 41 degrees (F) for cold holding. - 12:32 PM - Refrigerator located on Bethany Unit contained a salad dated 10/10/21 and a peanut butter and jelly sandwich dated 10/10/21. Findings were reviewed with E18 (Food Service Director) during on 10/14/21, starting at 12:52 PM. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 812	deficient practice. All outdated food was immediately removed from the refrigerator on the Bethany Unit. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All dietary staff will be in serviced by the Food Service Director on the importance of recording food temperatures for meals, ensuring all refrigerator doors are closed properly and ensuring there is no outdated food in refrigerators on units. It was found that the reason the refrigerator on Fenwick was above the appropriate temperature for cold holding was because the door was not properly shut. Temperature log was reviewed, and refrigerator has been checked frequently and there have been no other instances of the temperature being above 41 degrees. d. Food Services director will audit 10 meals daily to ensure the food temperature is logged, check the temperature log on the Fenwick refrigerator and check the Bethany refrigerator to ensure there is no outdated food. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1	

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F 812	Continued From page 56	F 812	month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		12/24/21

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F 842	Continued From page 57 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, it was determined that, for three (R1, R22 and R54) out of 26 current sampled residents, the facility failed to ensure that records were accurate. Findings include:	F 842	1. a. No resident was harmed by this deficient practice. Hospice documents belonging to R62 were removed from R1s	

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F 842	Continued From page 58 Cross Refer F677, Example 2 1. Review of R1's clinical record revealed: a. During several continuous observations during the survey, R1 did not receive incontinence care every 2 hours during three time frames: 10/14/21 (10:30 AM - 1:45 PM); 10/18/21 (8:02 AM - 11:20 AM); and 10/19/21 (9:50 AM - 2:15 PM). Review of CNA documentation found that incontinence care every 2 hours was recorded as being done on the aforementioned dates. Cross Refer F689 b. 10/19/21 at 2:20 PM - During a random observation, E23 (CNA) and E24 (CNA) transferred R1 back to bed from her geri-chair. Each CNA placed one arm under each of R1's armpits and grabbed R1's pant waist band in the back and lifted R1 into bed, while pushing the chair out of the way. R1's feet did not touch the floor. 10/21/21 at 2:12 PM - During an interview with E10 (RN UM), the Surveyor described how R1 was transferred back to bed and that CNA documentation recorded R1's transfer as "extensive" assistance with two staff. E10 explained that the transfer should have been recorded as "total" assistance since R1 did not provide any weight bearing when her feet did not touch the floor. c. Hospice documents belonging to R62 were found scanned into R1's chart. 10/19/21 at 10:58 AM - During an interview, E10 (RN, UM) confirmed R62's hospice information	F 842	chart and placed in R62s chart. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff and medical records staff will be in serviced by staff development on the importance of accurate documentation and record keeping. d. The Director of Nursing or designee will review 3 resident electronic medical records to ensure that records are accurate by making sure all documentation belongs to specific resident and accurately reflects care provided. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. No resident was harmed by this deficient practice. Fall assessment found in R22 chart was removed and placed in R79s chart where it was intended.	

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F 842	Continued From page 59 was in the wrong chart. Cross Refer F677, Example 3 2. Review of R22's clinical record revealed: a. During several continuous observations during the survey, R22 did not receive incontinence care every 2 hours during three time frames: 10/14/21 (9:30 AM - 1:50 PM); 10/18/21 (8:02 AM - 11:20 AM); and 10/19/21 (10:15 AM - 2:15 PM). Review of CNA documentation found that it was documented that incontinence care was completed every 2 hours on the aforementioned dates. b. An incomplete post-fall assessment, dated 10/13/21, was found in R22's record. 10/15/21 at approximately 10:20 AM - During an interview, F1 (R22's family and financial POA) stated that R22 had not fallen recently. 10/19/21 at 10:48 AM - During an interview, E10 (RN, UM) stated that R22 did not fall on 10/13/21 and, after investigation, confirmed the assessment belonged to R79 and not R22. Cross Refer F677, Example 4 3. Review of R54's clinical record revealed: 10/14/21 9:40 AM - 1:45 PM - During a continuous observation, R54 remained in the dining/activity room the entire time and did not receive incontinence care every two hours. Review of CNA documentation found that it was documented that incontinence care was completed every 2 hours.	F 842	b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. All direct care staff and medical records staff will be in serviced by staff development on the importance of accurate documentation and record keeping. d. The Director of Nursing or designee will review 3 resident electronic medical records to ensure that records are accurate by making sure all documentation belongs to specific resident and accurately reflects care provided. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 3. a. No resident was harmed by this deficient practice. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient	

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F 842	Continued From page 60 Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 842	practice by taking the corrective actions outlined below in Section C. c. All direct care staff and medical records staff will be in serviced by staff development on the importance of accurate documentation and record keeping. d. The Director of Nursing or designee will review 3 resident electronic medical records to ensure that records are accurate by making sure all documentation belongs to specific resident and accurately reflects care provided. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		12/24/21

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F 880	Continued From page 61 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 62 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of facility policies and procedures, and reviews of the Center for Disease Control and Prevention (CDC) and National Institute of Health information, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. The facility failed to ensure that the written standards for insulin injection were followed and failed to ensure that the hand hygiene policy and procedure (P & P) incorporated potential exposure to blood during a procedure. Additionally, the facility failed to actively screen staff for COVID-19 prior to the start of their shift. Findings included: Review of the CDC's Injection Safety stated, "...Recommended Practices for Preventing Bloodborne Pathogen Transmission during Blood	F 880	1. a. No resident was harmed by this deficient practice. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. DON immediately met with E8 and made him aware of the need to remove contaminated gloves and perform proper hand hygiene after completing the FSBS and before preparation of the insulin injection. All nurses will be in-serviced by Staff Development on the importance of performing hand hygiene after checking FSBS and before preparing insulin injection.	

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F 880	Continued From page 63 Glucose Monitoring and Insulin Administration in Healthcare Settings... Hand Hygiene (Hand washing with soap and water or use of an alcohol-based hand rub)...Wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids. Change gloves between patient contacts. Change gloves that have touched potentially blood-contaminated objects or fingerstick wounds before touching clean surfaces. Discard gloves in appropriate receptacles...". (https://cdc.gov/injectionsafety/blood-glucose-monitoring.html). The facility's policy and procedure (P & P) titled Blood Glucose Monitoring, with a revision date of 2/17/21, was reviewed. This P & P did not include the removal of gloves after completing the procedure and performing hand hygiene. The facility's P & P titled Infection Control Hand Hygiene, with a revision date of 6/2/21, stated, "...Alcohol based hand rub...is an acceptable form of hand hygiene in the following situations..After coming in contact with bodily fluids...when hands are not visibly soiled...After removing gloves post resident care...". 1. 10/19/21 beginning at approximately 11:30 AM - During a random medication observation, E8 (RN) performed hand hygiene and donned (put on) a new pair of gloves to perform a FSBS by pricking a finger on R43's left hand. E8 squeezed R43's finger to obtain a blood sample for testing. Upon getting the result of the FSBS, E8 immediately obtained the multidose Novolog insulin bottle and proceeded to fill the syringe with the ordered amount of insulin. E8 failed to	F 880	d. The Director of Nursing or designee will complete 3 medication observations to ensure that proper hand hygiene is done after performing FSBS and before preparation of insulin injection. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. a. No resident was harmed by this deficient practice. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. DON immediately met with E8 and made him aware of the need to remove contaminated gloves and perform proper hand hygiene after completing the FSBS and before preparing of the insulin injection. All nurses will be in serviced by Staff Development on the importance of performing hand hygiene after checking FSBS and before preparing the insulin injection.	

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	085052	A. BUILDING _____ B. WING _____	C 10/22/2021

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F 880	Continued From page 64 remove the contaminated gloves and perform hand hygiene after completing the FSBS. 10/19/21 1:30 PM - An interview with E2 (DON) was conducted to review the above observation. E2 confirmed that after the FSBS, the expectation would be for the gloves to be removed and hand hygiene to be performed prior to beginning the preparation of the insulin injection. 2. 10/19/21 beginning at approximately 11:40 AM - During a random medication observation, E8 (RN) performed hand hygiene and donned a new pair of gloves to perform a FSBS by pricking a finger on R34's left hand. E8 squeezed R34's finger to obtain a blood sample for testing. Upon getting the result of the FSBS, E8 immediately obtained the multidose Humalog insulin bottle and proceeded to fill the syringe with the ordered amount of insulin. E8 failed to remove the contaminated gloves and perform hand hygiene after completing the FSBS. 10/19/21 1:30 PM - An interview with E2 (DON) was conducted to review the above observation. E2 confirmed that after the FSBS, the expectation would be for the gloves to be removed and hand hygiene to be performed prior to beginning the preparation of the insulin injection. 3. 10/8/21 - 10/14/21 - Review of schedules and screening forms revealed the following staff were not actively screened for COVID-19 symptoms: - E1 (NHA): October 8, 11, 12, 13 and 14. - E11 (Cook): October 8 and 14. - E12 (Cook): October 8. - E13 (Dietary Aide): October 10 and 12. - E14 (Cook): October 12. - E15 (Dietary Aide): October 12.	F 880	d. The Director of Nursing or designee will complete 3 medication observations to ensure that proper hand hygiene is done after performing FSBS and before preparation of insulin injection. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 3. a. No resident was harmed by this deficient practice. b. All residents have the potential to be affected by this practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. c. Root cause analysis found that all staff who were not properly screened prior to their shift had a start time outside of the hours that the screening check point is manned by staff screener. In the event that staff members start time is outside of regular shift change hours where the screening check point is manned, staff are to call using the house phone and	

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F 880	Continued From page 65 - E16 (Dietary Aide): October 13. - E17 (Dietary Aide): October 13. 10/14/21 at 9:30 AM - During an interview about the process for staff screening, E1 (NHA) stated that during regular shift change times, someone would man the screening station at the employee entrance [to actively screen for COVID-19 symptoms]. Outside of those times, the front desk (or supervisor) would let the staff enter the building from the front door then conduct the screening. 10/21/21 at 7:59 AM - During an interview a list of staff identified as being on the kitchen schedule and not on the screening logs was given to E18 (Food Service Director) to verify dates actually worked. 10/21/21 at 9:25 AM - E18 returned the list to the Surveyor with the staff marked with 'yes' or 'no' to indicate whether they worked or not. Nine employees were marked with 'yes' as having worked the identified dates. 10/21/21 at 1:36 PM - During an interview, E19 (Front Office) stated that E1 (NHA) might be doing her own monitoring. 10/22/21 8:00 AM - E19 provided a copy of E1's screening log to the surveyor. Review of the log showed "no fever" written in the temperature column for each of the twenty (20) entries on the screening log dating back to 9/24/21. 10/22/21 12:55 PM - During an interview, E1 stated that she had a thermometer in her desk and took her temperature prior to the start of each shift and wrote that she did not have a fever	F 880	page the house supervisor to come to the service hallway and screen them prior to their entering the building, All staff will be in serviced on the requirement to be actively screened for COVID-19 symptoms prior to beginning their shift and what to do in the event the screening check point is not manned. d. The HR director or Designee will review our time and attendance system daily and cross reference the screening logs to ensure that every staff member in the building conducted the daily screening requirement. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 880	Continued From page 66 on her log sheet. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/22/21, starting at 3:10 PM.	F 880		