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

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Pike Creek **DATE SURVEY COMPLETED: February 23, 20223**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from February 13, 2023 through February 23, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 125. The survey sample size was 67 residents.		3/24/23
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 the following: Cross Refer to the CMS 2567-L survey completed February 23, 2023: F558, F582, F641, F656, F657, F690, F710, F761, F812, and F880.	1. No resident was affected by this deficient practice. 2. All residents have the potential to be affected by the deficient practice. Future residents will be protected by the action plan outlined below. 3. Daily staffing will be reviewed by the NHA/designee both projected for current day and actual PPD for previous day to ensure adequate staffing and compliance with the Delaware Nursing Home Staffing laws. On Friday, projected staffing and PPD will be reviewed for the weekend and on Mondays the actual PPD for Friday, Saturday and Sunday will be reviewed. Additionally, we will continue to acquire new agency contracts, offer incentives to all staff, including PRN staff to pick up shifts and ensure competitive rates to help recruitment for vacant positions. 4. Daily staffing will be reviewed by NHA/ designee daily to ensure 100% compliance at all times. Cross Refer to the CMS 2567-L survey completed February 23, 2023: F558, F582, F641, F656, F657, F690, F710, F761, F812, and F880.	

Provider's Signature _____ Title NHA Date 3/15/23

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16 Del. Code, 1162 Nursing Staffing:	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** RN/LPN — CNA* Day — 1 nurse per 15 res. — 1 aide per 8 res. Evening — 1:23 — 1:10 Night — 1:40 — 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. Based on review of facility documentation, it was determined that the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD) for three days. Findings include: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following: 7/31/22 PPD =3.15 2/4/23 PPD =3.21 2/5/23 PPD =3.19		

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	2/23/23 2:15 PM - Findings were reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON). The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

Provider's Signature _____ Title NHA Date 3/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(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 Emergency Preparedness Survey was conducted at this facility beginning February 13, 2023 through February 23, 2023 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 125. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from February 13, 2023 through February 23, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records, facility documentation and other resources as indicated. The facility census on the first day of the survey was 125. The survey sample size was 67 residents. Abbreviations/definitions used in this report are as follows: Anticoagulant - medicines that increase the time it takes for blood to clot. They are commonly called blood thinners; Antiplatelet- medicines that reduce the ability of platelets to stick together (called platelet aggregation) and inhibit the formation of blood clots; Antipsychotic - class of medication used to manage psychosis, an abnormal condition of the	F 000		

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

Electronically Signed | 03/15/2023

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

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F 000	Continued From page 1 mind involving a loss of contact with reality and other mental and emotional conditions; Asthma - lung disorder characterized by narrowing of the airways, the tubes which carry air into the lungs, that are inflamed and constricted, causing shortness of breath, wheezing and cough; Autoimmune - condition arising from an abnormal immune response to a functioning body part; Body fluids - blood, urine, semen, vaginal secretions for example; Brief Interview for Mental Status (BIMS) - assessment of the resident's mental status. The total possible BIMS score ranges from 0 to 15 with 15 being the best. CAA (Care Area Assessment) - part of the MDS assessment which assists in identifying and planning for potential problem care areas; Cardiovascular - heart and blood vessels; CNA - Certified Nurse Aide; CNO - Chief Nursing Officer; Contact precautions - intended to prevent transmission of infectious agents that are spread by direct or indirect contact with the resident or the resident's environment; require the use of gown and gloves on every entry into a resident's room to minimize the transmission of infectious organisms by direct or indirect contact; Continuous Positive Airway Pressure (CPAP) - machine for breathing assistance during sleep; Contracture- a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult; DON - Director of Nursing; Dysphasia - a language disorder that affects the ability to produce and understand spoken language; eMAR (Electronic Medication Administration Record) - electronic documentation of	F 000		

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F 000	Continued From page 2 medications administered to a patient; EMR (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format; Enhanced barrier precautions - infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use only during high contact resident care activities, such as wound care, dressing, bathing, transferring, changing linens, and assisting with toileting; Epidemiological - branch of medicine which deals with the incidence, distribution, and control of diseases; Excretions - stool, urine, perspiration, and saliva; Gastroenteritis - inflammation of the gastrointestinal tract, symptoms may include diarrhea, nausea, vomiting and abdominal pain; Gastrostomy - opening into the stomach from the abdominal wall; GI - Gastrointestinal tract that includes the esophagus, stomach, small and large bowels, and rectum and anus; Hemorrhage- an escape of blood from a ruptured blood vessel; Immunosuppressive - usually from a medication(s) or treatment that suppresses or weakens the immune response of an individual; Interdisciplinary Team - professional from different fields and departments who work together with the resident to develop and implement an individualized plan of care; Jejunal - part of the small intestine; Jejunostomy Tube - soft plastic tube placed through the skin of the abdomen into the midsection of the small intestine; LPN - Licensed Practical Nurse; MD - Medical Director;	F 000		

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F 000	Continued From page 3	F 000		

Microorganisms - Bacteria, viruses and fungus that can cause disease;
Milliliter (ml) - unit of volume;
Minimum Data Set (MDS) - standardized assessment forms used in nursing homes;
Neurogenic bladder - a person lacks bladder control due to a brain, spinal cord, or nerve condition;
NHA - Nursing Home Administrator;
Norovirus - a highly contagious infection that can cause a sudden onset of severe vomiting and diarrhea;
Notice of Medicare Non-Coverage - NOMNC;
NP - Nurse Practitioner;
PPE - Personal Protective Equipment (gowns, gloves, mask and eye protection);
Renal - kidney;
Residual - amount of fluid/contents that are in the stomach;
Respiratory Failure - lungs cannot release enough oxygen into the blood;
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
Sacrum - large triangular bone at base of spine;
Stage 4 Pressure Ulcer - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints;
Standard Precautions- basic level of infection control to be used in the care of all patients;
SW - Social Worker;
Tracheostomy- small surgical opening that is made through the front of the neck into the windpipe or trachea;
Transmission - passage or transfer of infectious agents;
Traumatic Brain Injury- a head injury causing damage to the brain by external force or mechanism. It causes long term complications or

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F 000	Continued From page 4 death; Ventilator - machine that acts as a bellows to move air in and out of your lungs; Viral shedding - when a person is infected with a virus, the virus multiplies in the body and the infectious viral particles can be released into the environment through vomiting and diarrhea. VPO - Vice President of Operations.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure a call bell was in reach for one (R105) out of five residents reviewed. Findings include: Review of R105's clinical record revealed: 11/18/22 - R105 was admitted to the facility with a past medical history including paralysis and weakness of his right side following a stroke, a tracheostomy (small surgical opening that is made through the front of the neck into the windpipe), and dependence on a ventilator (machine that moves air in and out of your lungs). 2/14/23 11:28 AM - During an interview with R105, the Surveyor observed his call bell not within reach as it was hanging off the right side of R105's bed. The Surveyor asked the resident if	F 558	F558 Reasonable Accommodations Needs/Preferences A. R105□s call bell was immediately placed within reach upon discovery. 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. A Root cause analysis was conducted, and it was determined that the facility staff were not checking call bell placement prior to leaving a resident□s room. A facility wide sweep was conducted, and it was determined that no other resident was affected by this deficient practice. The Staff Educator will Inservice all nursing staff on the importance of placing a call bell within	3/24/23

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F 558	Continued From page 5 this happens often and he stated, "Sometimes. They just changed my linen." The Surveyor picked the call bell up to test the device and left it within reach of resident. 2/14/23 3:47 PM - During an observation, R105 was observed lying in bed with eyes closed. R105's call bell was lying off of the right side of his bed about 2 inches from the floor. 2/21/23 10:00 AM - The Surveyor observed R105's call bell hanging from the right side of his bed underneath the bedrail hanging a few inches from the floor. R105 was awake and watching television. E19 (LPN) confirmed that R105's call bell was out of reach and stated, "Oh, sorry sometimes it just takes me long to get down here." 2/23/23 11:19AM - Findings were reviewed with E1 (CNO) and E2 (NHA).	F 558	reach of a resident. Education will include placement per residents preference and communicating to the resident where the call bell is located. D. The Director of Nursing/ designee will randomly audit the placement of 10 residents call bells to evaluate if call bells were accessible to residents. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582		3/24/23

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F 582	Continued From page 6 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582		

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F 582	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, interview and other facility information as indicated, it was determined that for one (R223) out of three residents reviewed for the beneficiary protection notification, the facility failed to obtain R223's signature or to document R223's refusal to sign the Notice of Medicare Non-Coverage (NOMNC) when the resident was discharged from Medicare Part A Services and transferred to an assisted living facility. Findings include: Review of R223's clinical record revealed: 12/8/22 - R223 was admitted to the facility. 12/15/22 - R223's MDS assessment documented that R223 was independent and able to make decisions that are consistent and reasonable. 1/25/23 - R223 was discharged from Medicare Part A services and transferred to an assisted living facility. 2/20/23 - Review of R223's NOMNC notice which was provided with the completed SNF (skilled nursing facility) beneficiary protection notice worksheet revealed that R223 did not sign the statement acknowledging that she received and understood the NOMNC. 2/21/23 at 9:53 AM - During an interview with E22 (SW) and E23 (SW) regarding the NOMNC process, E23 confirmed that R223's family member (F1) was called and notified the end date of Medicare Part A services. E23 confirmed that R223 was not asked to sign the NOMNC notice.	F 582	F582 A. R223 no longer resides in the facility. B. All residents have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by taking the corrective actions in section C. C. A root cause analysis was conducted, and it was determined that the social workers failed to identify that R223 was their own responsible party. Social workers did not offer to R223 to sign their Notice of Medicare Non-Coverage (NOMNC) when the resident was discharged from Medicare A services. The Nursing Home Administrator/designee will in-service social services on when a NOMNC should be issued to a resident to sign or their family to sign based on the resident's cognition. D. The Corporate RNAC/ designee will audit Notice of Medicare Non-coverage (NOMNC) for compliance. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as	

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F 582	Continued From page 8 2/23/23 11:19AM - Findings were reviewed with E1 (CNO) and E2 (NHA).	F 582	successful. All results will be brought through the QAPI meetings.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		3/24/23

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F 656	Continued From page 9 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for two (R102 and R619) out of 35 residents sampled for review of care plans. Findings include: 1. Review of R619's clinical record revealed the following: 12/25/22 - R619 was admitted to the facility with multiple diagnoses, including respiratory failure and asthma. 12/28/22 - A Physician's order was written for Ipratropium-Albuterol Solution 3 ml inhale orally every 6 hours as needed for shortness of breath. 12/28/2022 - A Physician's order was written for Continuous Positive Airway Pressure (CPAP) breathing machine use at bedtime. 12/29/22 - A Physician's order was written for Montelukast Sodium 1 tablet by mouth one time a day for asthma. Review of R619's comprehensive	F 656	F656 Comprehensive Care Plan (1) R619 A. R619 no longer resides in the facility. No corrective actions could be taken prior to her discharge. B. All residents who require respiratory care for the use of Continuous Positive Airway Pressure (CPAP) 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. A root cause analysis was conducted, and it was determined that the respiratory staff failed to initiate a comprehensive care plan for R619 to include respiratory care for a CPAP and ordered respiratory treatments. A facility wide sweep was conducted, and no further issues were identified. The Corporate Registered Nurse Assessment Coordinator (RNAC) will educate the facility RNACs to care plan respiratory care and treatments. D. The Corporate RNAC will audit residents with orders for respiratory	

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F 656	Continued From page 10 person-centered care plan revealed a lack of evidence regarding the respiratory care for CPAP and treatment to be provided to R619. 2/20/23 at 12:13 PM - During an interview, E5 (Respiratory Therapist) acknowledged that R619's comprehensive person-centered care plan did not contain evidence regarding the respiratory care and treatment to be provided to R619. 2. Review of R102's clinical record revealed: 11/6/22 - R102 was admitted to the facility with a past medical history including traumatic brain injury, dysphagia following a brain hemorrhage, and contractures of the left hip and knee. 11/13/22 - R102's comprehensive MDS assessment revealed that he was a totally dependent (requiring full staff performance every time during a 7-day period) in the following activities of daily living (ADL) care areas: dressing, eating, toileting, and personal hygiene. Record review lacked evidence of an ADL care plan for R102. 2/20/23 11:09 AM - During an interview, E21 (RNAC) was asked for a copy of R102's ADL care plan. E21 looked through R102's care plan and stated, "I don't see one in here for him." The Surveyor asked who initiates the care plans? E21 replied, "The CAA (Care Area Assessment) will trigger ... the resident did not trigger for ADLs. We do what the CAA triggers, if not it's up to nursing to make that decision...". The facility's policy on "Care Planning" revised on	F 656	treatments to ensure there is a care plan addressing the respiratory treatments. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. (2) R102 A. R102 still resides in the facility and was not negatively impacted by this deficient practice. R102's ADL care plan was initiated. B. All residents who are totally dependent for Activities of Daily Living (ADLs) have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. C. A root cause analysis was conducted, and it was determined that the RNAC failed to develop and implement a comprehensive ADL care plan for R102. A facility wide audit was conducted, and it was determined that no other residents were affected by this deficient practice. The facility RNAC's will be inserviced by	

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F 656	Continued From page 11 1/12/23 documented, "A comprehensive care plan should be developed to address medical, nursing, nutritional, and psychosocial needs within 7 days of completion of the comprehensive assessment. A comprehensive care plan must be prepared by an interdisciplinary team ...Care plans should include: Services furnished to maintain highest practical well-being ...". The facility failed to develop and implement a comprehensive ADL care plan for R102. 2/23/23 11:19 AM - Findings were reviewed with E1 (CNO) and E2 (NHA).	F 656	Cadia's Corporate RNAC on care planning all residents who are totally dependent for ADL's. D. The RNAC/ designee will randomly audit the comprehensive care plans for 10 residents totally dependent for ADLs. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		3/24/23

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F 657	Continued From page 12 (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 one (R97) out of 35 sampled residents for care plan investigation, the facility failed to ensure that the required interdisciplinary team (IDT) members attended or otherwise participated in the care plan meeting. Findings include: Review of the facility's policy and procedure titled Care Planning, with a revision date of 1/12/23, stated that the comprehensive care plans should be reviewed and revised by the interdisciplinary team (IDT) after each assessment. The following was reviewed in R97's clinical record: 10/2/22 - R97 was admitted to the facility. 10/19/22 -An admission MDS (Minimum Data Set) assessment was completed. 10/19/22 - Review of the Care Conference	F 657	F657 A. R97 was not negatively impacted by this deficient practice. B. All residents have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined in section C. C. A root cause analysis determined that the Social Service Department did not have evidence that the physician and certified nursing assistant (CNA) are participating in care conferences. The interdisciplinary care team will participate in care plan meetings. The Staff Educator/Designee will in-service the interdisciplinary team on who should participate in care plan meetings. D. Nursing Home Administrator/ Designee will audit care conference participant sheet for compliance with CNA and provider input. The audit process will be conducted three times a week until	

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F 657	Continued From page 13 Participation Form lacked evidence of participation by R97's Attending Physician and the assigned CNA. 1/5/23 - A quarterly MDS assessment was completed. 1/5/23 - Review of the Care Conference Participation Form lacked evidence of participation by R97's Attending Physician and the assigned CNA. 2/17/23 12:00 PM - An interview with E22 (SW) confirmed that the facility was unable to provide evidence that R97's Attending Physician or the assigned CNA participated in the above two Care Conference Meeting's on 10/19/22 and 1/5/23. 2/23/23 2:15 PM - Finding was reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON).	F 657	compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		3/24/23

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F 690	Continued From page 14 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the clinical record, it was determined that for one (R108) out of four residents reviewed for urinary catheters/urinary tract infection (UTI), the facility failed to ensure that R108 received appropriate treatment and services to prevent the risk of infection UTI when R108's urinary catheter bag was observed lying on a visibly soiled floor. Findings include: The following was reviewed in R108's clinical record: 12/17/22 - R108 was admitted to the facility with a neurogenic bladder and required a foley catheter (a tube in the bladder to drain urine).	F 690	F690 A. R108 catheter bag was removed from the floor and the floor was cleaned immediately. B. All residents who have an order for a catheter have the potential to be affected by this deficient practice. Further residents will be protected from this deficient practice by taking corrective action outline in section C. C. A root-cause analysis determined that the nursing staff was not checking the resident's catheter bags for placement prior to exiting the resident's room. A facility wide sweep was conducted, and no other issues were identified. The staff educator/designee will in-service the	

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F 690	Continued From page 15 12/21/22 - A Physician's order included indwelling catheter care every shift. 2/14/23 10:14 AM - During a random observation, R108's foley catheter drainage bag was noted to be hooked to the left side of R108's bed, approximately one half full of urine and lying on the floor. Beneath R108's catheter drainage bag the floor was observed to be visibly soiled with dried spill-like soiled areas beneath it. 2/14/23 10:36 AM - During an interview, E30 (CNA) confirmed that R108's catheter drainage bag was on a visibly soiled floor. The facility failed to prevent the risk for R108 to acquire a bladder infection related to placement of the catheter drainage bag on a visibly soiled floor. 2/23/23 at 2:15 PM - The finding was reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON) during the exit conference.	F 690	nursing staff on checking all residents with an ordered urinary catheter bag for placement (hanging on bed) and to assure the catheter bag is off of the floor prior to exiting the resident room. D. Staff Educator/ designee will audit all residents with foley catheters to ensure the catheter bag is in an appropriate position and not on the floor. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that-	F 710		3/24/23

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F 710	Continued From page 16 §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interviews and review of clinical records, the facility's policy and procedure and other source as indicated, it was determined that for two (R54 and R80) out of two residents reviewed for Gastrojejunostomy (GJ) Tubes, the facility failed to ensure that the active Physician orders that were provided for the residents' immediate care and needs clearly specified which port of the GJ tube to use when administering medications, tube feedings, checking residual and tube placement. Findings include: Gastrojejunostomy Tube (GJ Tube) - a soft, narrow tube that enters the stomach in the upper part of the abdomen and then into the small intestine. On the outside of the tube there are three ports labeled: gastric, jejunal and balloon and each serve a different purpose. The gastric port of the tube enters in the stomach and used to give medications. The end of the jejunal port sits in the small intestines and is used for feeding. The tube is held in place by a small balloon on the inside to prevent it from coming out. (https://patient.uwhealth.org/healthfacts/7986) The facility's policy and procedure entitled Enteral Tube Management and Feeding Guidelines: Gastric and Jejunostomy, last revised on 1/12/23, stated, " ... Verification of Placement of Gastrostomy Tube ...	F 710	F 710 Resident care supervised by a physician A. R54 and R80 orders for the Gastrojejunostomy (GJ) tubes were immediately clarified as to which ports of the GJ tube were to be used when administering medications, tube feedings, and checking the residual and tube placement. The residents were not harmed by this deficient practice. B. All residents with GJ tubes have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by taking corrective action outline in section C. C. A root-cause analysis was conducted, and it was determined that the nursing staff and the attending provider were not aware to specify which port of the GJ tube is to be used when administering medications, tube feeding and checking the residual and tube placement. The staff educator/designee will in-service the nursing staff and the provider when orders are given/received for GJ tubes to specify which port of the GJ tube to use when administering medications, tube feeding and checking the residual and tube	

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F 710	Continued From page 17 Gastric Residual Volume Check of Gastrostomy Tube ... -Residual volume checks are performed per physician order ... Jejunostomy Tubes: -Residual Volume Checks for Jejunostomy Tubes require a physician order. Medication Administration: -Verify MD (Medical Doctor) orders... -Verify tube placement prior to medication administration...". 1. Review of R54's clinical record revealed the following active Physician orders (as of 2/22/23 at 11:52 AM) and the initial Physician's order date: 12/21/21 - Admitted to the facility with GJ tube malfunction. 12/21/21 - Medication orders included: Keppra for seizures, Furosemide for edema, Gabapentin for pain/spacticity, Propranolol for high blood pressure, Senna / Docusate / Lactulose / Miralax / Milk of Magnesia for constipation, Metoclopramide for gastric reflux, Multivitamin for supplement, Acetaminophen for fever/pain, were ordered "enterally." 12/21/21 - Check residual prior to each feed, flush, or medication. If residual greater than 100 ml (milliliters), hold feeding for 1 hour and recheck. If residual is still greater than 100 ml, notify Physician. Every shift. 12/21/21 - Check tube placement before initiation of formula, medication administration, and flushing tube or at least every shift. 1/19/22 - Bromocriptine Mesylate for neuroleptic syndrome (life-threatening reaction that can occur in response to antipsychotic medication). 6/24/22 - Feeding tube type: GJ. 8/4/22 - Enteral Feed Order - Vital 1.5 (tube feeding name) at 45 ml/hr (milliliter per hour) for	F 710	placement. D. The Director of Nursing/nursing designee will audit GJ tube orders to determine the orders specify which port the GJ tube to use when administering medications, tube feeding and checking the residual and tube placement. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. The information requested was sent via email.	

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F 710	Continued From page 18 20 hours or until total volume of 900 ml is infused. Water flush at 30 ml/hr for 20 hours or until total volume of 600 ml infused. One time a day. 9/9/22 - Baclofen for spasticity. 9/14/22 - Omeprazole suspension for gastric reflux. 2/13/23 - Klonopin for seizure disorder. 2. Review of R80's clinical record revealed the following active Physician orders (as of 2/22/23 at 11:03 AM) and the initial Physician's Order date: 3/28/22 - Medication orders included: Levetiracetam / Valproic Acid for seizures, Docusate / Lactulose for constipation, Acetaminophen for fever/pain, were ordered "enterally." 3/28/22 - Check residual prior to each feed, flush, or med. If residual greater than 100 ml, hold feeding for 1 hour and recheck. If residual is still greater than 100 ml, notify Physician. Every shift. 3/28/22 - Check tube placement before initiation of formula, medication administration, and flushing tube or at least every shift. 6/24/22 - Feeding Tube Type: GJ. 7/6/22 - Famotidine for gastric reflux. 7/16/22 - Baclofen for spasticity. 7/21/22 - Apixaban for deep vein blood clot. 8/16/22 - Gabapentin for muscle spasm. 12/9/22 - Phenobarbital for seizures. 12/19/22 - Propranolol for a heart rhythm disorder with heartbeats faster than normal. 12/21/22 - Enteral Feed Order - Promote (tube feeding name) at 60 ml/hr (milliliters) for 20 hours or until total volume of 1200 ml is infused. Flush with 15 ml per hour for 20 hours or until total volume of 300 ml is infused. One time a day. The active Physician orders for both R54 and R80, two residents with GJ Tubes, failed to	F 710		

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F 710	Continued From page 19 specify the port to use when administering medications, tube feedings, checking residual and tube placement. 2/22/23 at 12:45 PM - During an interview with E24 (NP), the Surveyor asked about R54's Physician orders for medications. E24 stated that R54 was not her patient. E24 stated that E28 (NP) managed R54 and she was not accessible at the time. The Surveyor asked E24, as a general question, which port should the nurses administer medications (G or J ports) for residents who have a GJ tube. E24 stated that she did not know and called out to E21 (RNAC), who was sitting in the office next door. E21 stated that this was a medical question to address. During the interview, E24 attempted to reach E27 (Medical Director), but E27 did not answer her call while the Surveyor was present in the office. Upon leaving E24's office, the Surveyor observed E21 talking to E1 (CNO) in the dining room. The Surveyor met with E1 to discuss the findings where active Physician orders for the two residents who have GJ tubes (R54 and R80) stated to give medications enterally instead of specifying which port (G or J) to use for administering medications, continuous tube feedings, checking residual and tube placement. 2/23/22 at 2:15 PM - Findings were reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON).	F 710		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		3/24/23

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F 761	Continued From page 20 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 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 observations and interviews, it was determined that the facility failed to ensure that medications were stored and labeled properly in two out of five medication carts and in one out of two medication rooms reviewed. Findings include: The facility policy on storage of medications, last updated 1/31/23, indicated, "...When opening a multi-dose container, place the date on the container...". 2/16/23 - During a medication storage review of the first floor the following was observed: 2/16/23 10:30 AM- The White Clay 3 medication	F 761	F761 Label/Store Drugs and Biologicals A. No residents were negatively impacted by this deficient practice. All undated opened medications were removed from the medication rooms and medication carts. B. All residents have the potential to be impacted by inappropriate labeling and storage of medication. The facility did a whole house sweep to establish a base all med carts and storage are dated correctly. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.	

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F 761	Continued From page 21 cart had one opened vial containing Olopatedine (used for allergies) that did not have an open date. E19 (LPN) confirmed the finding. 2/16/23 11:00 AM - The White Clay 1 medication cart had one opened bottle of Keppra (used for seizures) that did not have an open date. E19 confirmed the finding. 2/16/23 11:30 AM - The White Clay medication room had a refrigerated bottle of Omeprazole (used for acid reflux) liquid that did not have an open date. E9 (RN) confirmed the finding. 2/23/23 2:15 PM - Findings were reviewed during the Exit Conference with E1 (CNO), E2 (NHA) and E3 (DON).	F 761	C. A root cause analysis determined that the nursing staff were not following the guidelines related to medication storage and dating medications upon opening. A facility-wide sweep was conducted, and no further issues were found. Nursing staff will be educated by the Staff Educator/ designee regarding dating bottles and vials of eyedrops upon opening. D. The Unit Manager/ designee will audit all medication carts and medication rooms for appropriate dating of opened bottled and vials of eyedrops. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. The information requested was sent via email.	
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 -	F 812		3/24/23

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F 812	Continued From page 22 §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 observations and interview, it was determined that the facility failed to ensure that the kitchen's handwashing stations were properly maintained. Findings include: The following were observed on 2/13/23 from 8:45 AM to 9:30 AM during the initial kitchen tour: 1. The cleaning supplies were stored on top of the handwashing sink in the dishwashing room, blocking access to the handwashing sink. 2. No handwashing sign was present designating handwashing only at the handwashing sink outside of the Dietary Director's office. 2/13/23 at approximately 10:10 AM - Findings were reviewed and confirmed with E29 (Food Service Director).	F 812	F812 Food Procurement A. The cleaning supplies stored on top of the handwashing sink in the dish room were immediately removed. The hand washing sign is now present on the wall designating handwashing sinks. 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 in section C. C. A root cause analysis was conducted, and it was determined that the kitchen staff were not aware they could not store cleaning supplies on top of the handwashing sink and that the handwashing sign had fallen off of the wall. The Registered Dietitian/ designee will educate kitchen staff on proper storage of cleaning supplies and making	

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F 812	Continued From page 23	F 812	sure there is a handwashing sign present. D. The Registered Dietitian/ designee will audit the handwashing sinks to see that there are no cleaning supplies stored on the handwashing sinks and the hand washing sign is present. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. The information requested was sent via email.	
F 880 SS=J	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 program. The facility must establish an infection prevention	F 880		3/24/23

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F 880	Continued From page 24 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 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 25 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 and reviews of clinical records, facility documentation and other sources as indicated, it was determined that the facility failed to maintain an infection prevention and control program to protect the residents against an outbreak of norovirus (a highly contagious infection that can cause a sudden onset of severe vomiting and diarrhea) and they failed to have a system in place to control a contagious disease to residents, staff and visitors. For three (R52, R167 and R417) out of nine sampled residents, the facility failed to actively adhere to contact precautions and hand hygiene among healthcare personnel, residents, and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis, including a process to identify the residents who were symptomatic with signs and symptoms of norovirus as per CDC guidance. The facility's system failure put all residents, including R52, R167 and R417 at immediate jeopardy (IJ) of a serious adverse outcome by not having a method of identifying residents that required contact	F 880	F880 (1) Norovirus A. These residents were immediately placed in contact/enteric precautions. The staff line listing was provided to Delaware Department of Health which included all staff who were experiencing signs and symptoms of the norovirus. 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. A root cause analysis was conducted, and it was determined that the facility did not follow the process outlined in the facilities policy for "Standard and Transmission Based Precautions" to ensure that residents who experience signs and symptoms of the norovirus were properly isolated in contact/enteric precautions after the above residents	

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F 880	Continued From page 26 precautions as it relates to Norovirus, not providing staff the necessary education and PPE (Personal Protective Equipment) to use for contact precautions while delivering resident care and lack of evidence of staff surveillance as per CDC guidance. The IJ was identified on 2/16/23 at 4:11 PM and was abated on 2/20/23 at 10:19 AM. In addition, the facility failed to use infection control precautions for R29 during wound care. Findings include: The facility policy titled, "Standard and Transmission Based Precautions", effective June 2013 and revised 1/27/23 documented, "'Contact Precautions' -applies to all residents infected or colonized with a MDRO (multidrug-resistant organisms or bacteria that resist treatment with more than one antibiotic) in the following situations: presence of acute diarrhea... c. diff (or clostridium difficile, a bacterial overgrow that releases toxins that attack the lining of the intestines)... norovirus... Special Situations: Organisms likely to have spores like Clostridium difficile and some diseases with ongoing transmission like Norovirus and Influenza may require special contact precautions. In addition to contact precautions, perform hand hygiene using soap and water and use a hypochlorite solution (e.g., bleach) for environmental cleaning... Resident Care Equipment and Articles - cleaned and disinfected after use... ." The CDC's Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, last updated 2/15/17, documented, "... The Summary of Recommendations includes recommendations organized into the following categories: -Patient Cohorting and Isolation Precautions ...	F 880	experienced signs and symptoms associated with the norovirus. The facility failed to ensure that staff and visitors were aware of the precautions to follow during an outbreak of the norovirus. A sign was immediately placed at the front entrance alerting staff and visitors of precautions to follow during an outbreak of norovirus. A facility wide sweep was conducted and all residents who were experiencing signs and symptoms of the norovirus were placed in contact/enteric precautions. LW Consulting completed an initial education with all staff and an additional root cause analysis as to the steps needed to ensure that when the facility experiences a suspected norovirus outbreak, the appropriate steps are taken to isolate the affected residents and to have staff removed from the facilities schedule while experiencing symptoms associated with the norovirus. The staff educator will in-service all staff on appropriate steps to take for a suspected outbreak of the norovirus to include making staff and visitors aware of an outbreak in the facility. Teaching will include discussion and questions with associated answers. The Director of Nursing was educated on the process for submitting an employee line listing for all staff who are experiencing norovirus symptoms to the Delaware Department of Health daily. The Delaware Department of Health cleared the facility of norovirus outbreak on March 10, 2023. D. The Staff Educator/ designee will audit all residents who have signs and symptoms of the norovirus to ensure they	

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F 880	Continued From page 27 Avoid exposure to vomitus or diarrhea ... During outbreaks, place patients with Norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients ... Consider longer periods of isolation or cohorting precautions for complex medical patients (e.g., those with cardiovascular, autoimmune, immunosuppressive, or renal disorders) as they can experience protracted episodes of diarrhea and prolonged viral shedding. Patients with these or other comorbidities have the potential to relapse, and facilities may choose longer periods of isolation based on clinical judgment ... Staff who have recovered from recent suspected norovirus infection associated with an outbreak may be best suited to care for symptomatic patients until the outbreak resolves ... -Hand Hygiene ... Actively promote adherence to hand hygiene among healthcare personnel, patients and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis ... During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis ... -Personal Protective Equipment ... If norovirus infection is suspected, adherence to PPE use according to Contact and Standard Precautions is recommended for individuals entering the patient care area (i.e. gowns and gloves upon entry) to reduce the likelihood of exposure to infectious vomitus or fecal material ... Use a surgical or procedure mask and eye protection or a full face shield if there is an anticipated risk of splashes to the face during the care of patients, particularly among those who are vomiting ... -Education ... Provide education to staff, patients,	F 880	are in the appropriate isolation, with the appropriate signage, and the necessary personal protective equipment (PPE). The Staff Educator/ designee will audit the staff gastrointestinal symptom line listing for submission. The audit process will be conducted five times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. (2) Wound Care A. B. All residents with wounds have the potential to be impacted by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions in section C. C. A root cause analysis was conducted and it was determined that the wound care nurse did not follow handwashing guidelines after completing a wound treatment and did not set up a clean field correctly prior to the dressing change. The staff educator/ designee will in-service nurses on proper handwashing to include using rigorous scrubbing action for at	

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F 880	Continued From page 28 and visitors, including recognition of norovirus symptoms, preventing infection, and modes of transmission upon the recognition and throughout the duration of a norovirus gastroenteritis outbreak ... -Active Case-Finding ... Begin active case-finding when a cluster of acute gastroenteritis cases is detected in the healthcare facility. Use a specified case definition, and implement line lists to track both exposed and symptomatic patients and staff. Collect relevant epidemiological, clinical, and demographic data as well as information on patient location and outcomes ... -Communication and Notification ... Provide timely communication to personnel and visitors when an outbreak of norovirus gastroenteritis is suspected and outline what policies and provisions need to be followed to prevent further transmission ...". (https://www.cdc.gov/infectioncontrol/guidelines/norovirus/) According to the facility's completed form entitled Gastroenteritis Data Collection Line Listing for Patients, from 1/31/23 to 2/15/23, 46 residents were documented with gastrointestinal (GI) symptom(s) on both floors of the facility. Observations and clinical record reviews of three current residents with recent GI symptoms identified on the GI Line Listing revealed: 1a. Review of R167's clinical record revealed the following: 2/9/23 - R167 was admitted to the facility. 2/13/23 5:47 PM - Review of the Electronic Medication Administration Record (eMAR)	F 880	least 20 seconds and how to correctly set up and maintain a clean field prior to completing a dressing change. D. The Staff Educator / designee will audit hand washing and wound care treatments. The audit process will be conducted five times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 880	Continued From page 29 revealed that R167 was administered a medication to treat diarrhea and another medication to treat nausea and vomiting. Subsequently, the eMAR documented that these medications were effective in treating the diarrhea, as well as the nausea and vomiting. 2/14/23 8:45 AM - A Physician Order was written to chart GI symptoms, which included to monitor for nausea, vomiting, and diarrhea every shift for three days. 2/15/23 3:30 PM - An interview with R167 revealed that he had nausea yesterday on 2/14/23, but denied nausea, vomiting and/or diarrhea today. An observation of the exterior door into R167's room revealed that there was no signage indicating that R167 was on contact precautions and there was no PPE hanging on his door for staff and visitors to apply prior to entering the room. 2/16/23 3:40 PM - An interview with the assigned nurse E8 (LPN) revealed that R167 was not on contact precautions. The facility failed to ensure R167 had contact precautions implemented (including PPE and signage) and the facility failed to ensure that staff were aware of the precautions to follow during an outbreak in the facility. 1b. Review of R417's clinical record revealed the following: 2/8/23 - R417 was admitted to the facility. 2/14/23 3:26 PM - A progress note by E24 (NP) stated that R417 was experiencing loose stools	F 880		

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F 880	Continued From page 30 and had orders for medications to treat diarrhea and nausea and vomiting. 2/15/23 3:45 PM - An interview was done with E6 (CNA) and E7 (CNA). E6 stated that a stomach bug is "growing and growing and it is hard to make sure that you don't catch it." E6 and E7 both stated they do not know when residents are positive for a stomach virus and that they ask the Nurses to find out information about residents because the Nurses do not automatically tell them. E6 and E7 added that it is hard to tell who has a stomach virus because some residents are on laxatives and it is hard to know the difference when the residents have loose stools. 2/16/23 9:00 AM - A review of the facility's infection control tracking document for gastroenteritis documented that R417's last episode of diarrhea was on 2/15/23 at 2:00 PM. 2/16/23 11:00 AM - An observation of R417's exterior room door lacked evidence of contact precautions signage and the presence of PPE for staff and visitors to apply prior to entering R417's room. 1c. Review of R52's clinical record revealed the following: 12/23/22 - R52 was admitted to the facility. 2/14/23 3:15 AM - A nurses note in the electronic medical record (EMR) revealed that R52 was being monitored for GI symptoms. 2/14/23 2:00 PM - A nurses note in the EMR revealed that R52 was experiencing loose stools and a new order was received for a medication to	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 treat R52's diarrhea. R52's onset of diarrhea was noted on the facility's Gastroenteritis: Data Collection Line Listing. 2/16/23 11:00 AM - While PPE was present outside of R52's door as the resident was already on enhanced barrier precautions, an observation of R52's exterior door revealed the absence of contact precautions signage to inform staff and visitors to apply the PPE prior to entering the room. According to the facility's Gastroenteritis: Data Collection Line Listing, R52's last episode of diarrhea was on 2/16/23 at 8:30 AM. 2/16/23 4:11 PM - Based on observations, interviews, review of facility documentation and other sources, an Immediate Jeopardy was called and reviewed with facility leadership including E1 (CNO), E2 (NHA), E3 (DON) and E26 (VPO). 2/16/23 7:02 PM - It was confirmed by Surveyors that the affected three resident rooms had contact precautions signage and PPE in place for staff and visitors on what was required prior to entering the rooms. The facility started staff education that was ongoing around the clock and through an electronic module available to staff. In addition, a CDC sign for norovirus was posted at the receptionist desk educating visitors on what precautions were required during the outbreak. 2/16/23 7:30 PM - E2 submitted an acceptable Abatement Plan signed, dated, and timed 2/16/23 at 7:29 PM. 2/17/23 4:00 PM - E1 was advised by the Surveyor to send via email evidence of staff education once completed.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 02/23/2023

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F 880	Continued From page 32 2/17/23 5:40 PM - In an email correspondence, E2 sent proof of staff education status as of 2/17/23 at 5:30 PM and stated, "continuing to educate staff." 2/20/23 10:19 AM - The date and time E2 stated that staff in-service was completed. 2. The facility failed to provide evidence of an infection control surveillance program that included monitoring staff for GI signs and symptoms. The CDC's Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, last updated on 2/15/17, documented " ... The Summary of Recommendations includes recommendations organized into the following categories: -Staff Leave and Policy ... Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Once personnel return to work, the importance of performing frequent hand hygiene should be reinforced, especially before and after each patient contact...". 2/14/23 12:17 PM - An interview with E9 (LPN) stated that a GI illness started on the second floor last weekend and then spread to the first floor residents. E9 stated that she believed a random test was done, but she was not sure if the residents were tested specifically for Norovirus. 2/15/23 3:00 PM - E3 (IC/DON) provided the survey team with copies of the correspondence from the State of Delaware Department of Public Health (DPH). This included the Gastroenteritis Data Collection Line List. DPH recommended 2-3 resident stool samples for testing. E3 also stated	F 880		

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F 880	Continued From page 33 that the official start of the outbreak was 2/8/23 when the facility received notification of a positive test for norovirus. 2/16/23 10:35 AM - A joint interview with E1 (CNO), E2 (NHA) and E3 revealed that DPH sent an email for the facility to call DPH to go over the results and recommendations when the positive norovirus test came back on 2/8/23. According to E1 and E3, the recommendations included "to quarantine (resident) cases in their room ...if ...any more staff please exclude them until ... (diarrhea) symptoms have resolved ...isolating precautions ...cohorting or exclusion for staff...". 2/16/23 10:45 AM - An interview with E3 confirmed that an infection control line listing was not initiated for staff. It was further revealed there were "sporadic" staff cases based on who called out sick. E3 stated that symptomatic staff could not come back to work until they were without nausea, vomiting, diarrhea and/or fever for 48 hours. E3 stated that she'll start creating the staff line list using the DPH template. 3. Review of the facility policy and procedure, revised 6/2/2021, titled Infection Control Hand Hygiene included, "...it is the policy of Cadia Healthcare to help control the spread of infection through hand hygiene, wash hands thoroughly, using rigorous scrubbing action for at least 20 seconds...". Review of "When and How to Perform Hand Hygiene" included...after touching a patient or the patient's immediate environment, after contact with blood, body fluids or a contaminated surface. https://www.cdc.gov/handhygiene/providers/index.html.	F 880		

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F 880	Continued From page 34 2/20/23 9:55 AM - During an observation, R29's breakfast tray and a urinal containing urine were on the bedside table. E14 (LPN) placed dressing supplies on the unclean bedside table and then picked up R29's breakfast tray and left the room. E14 then picked up the urinal from the bedside table and emptied it in the bathroom and washed her hands for five seconds. E14 placed a blue pad on the bedside table to create a clean field, then picked up the dressing supplies that had been placed on a dirty bedside table, and put them on the blue pad causing contamination of the clean field. E14 then put on clean gloves and opened the treatment supplies that had been contaminated causing the nurses gloves to no longer be clean. The nurse proceeded to complete the dressing change with gloved hands that were contaminated. 2/21/23 11:00 AM - The Surveyor asked E1 (CNO) for a policy and procedure for wound care, and E1 replied, "No, we don't have a policy and procedure for wound care." 2/21/23 2:11 PM - During an interview with E14 she stated, "I put the dressings on the table and put the dressings on top of the pad." 2/23/23 - Findings were reviewed with E1 (CNO), E2 (NHA) and E3 (DON) during the exit conference beginning at 2:15 PM.	F 880		