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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care At Silver Lake Llc

DATE SURVEY COMPLETED: February 12, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from February 5, 2024, through February 12, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census the first day of the survey was one hundred nine (109). The survey sample totaled twenty-four (24) residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 12, 2024: cross refer: F644,	Cross refer to the CMS 2567-L survey completed February 12, 2024: Cross refer: F644, F656, F657, F688, F756, F791, and F842. The plan of correction for these deficiencies was submitted through the ePOC system on 3/4/2024. F644 Coordination of PASARR and Assessments 1. R77 had a diagnosis of bipolar disorder and paranoid personality disorder documented on 10/12/23. At this time a new level 1 PASARR should have been initiated. Once this was identified during the annual survey, a new level 1 PASARR was submitted for R77 by the social services director. No negative resident outcome has been reported because of this deficient practice. 2. Current residents within the facility will be reviewed to ensure psychological diagnoses are current and the most recent PASRR assessments reflect residents' current psychological diagnoses. Any psychological diagnoses that were not captured on the most recent PASRR assessments will be identified. A new PASARR assessment will be submitted for any affected resident. 3. MDS staff will notify the social services department any time there is a new psychological diagnosis is added to a resident's diagnosis list. 4. The administrator or designee will audit all new PASARR assessments to confirm compliance weekly x 4, then monthly x 2. Results of all audits will be presented monthly for three months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F656 Develop/Implement Comprehensive Care Plan 1. R66 no longer resides in facility as of 2/9/2024. The respiratory care plan for oxygen therapy related to ineffective gas exchange was added on 2/9/2024. R269 currently resides in the facility. R269 was educated on 2/2/2024 regarding the new behavior when it was initially identified.	3/4/24 3/4/24

Provider's Signature _____ Title NHA Date 3/4/24

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	F656, F657, F688, F756, F791 and F842.	The behavior care plan was implemented on 2/8/2024. No negative resident outcomes have been reported because of this deficient practice. 2. Current residents with a Pulmonary diagnosis will be reviewed to ensure an appropriate care plan is in place. The pulmonary care plans will be reviewed to determine that appropriate interventions are in place. Pulmonary care plans will be revised as necessary to reflect appropriate interventions to improve resident status and progress per their care plan goal. Progress notes will be reviewed for all current residents from the past 14 days to identify new behaviors. New behaviors identified will be care planned accordingly. 3. Nurse Practice Educator/NPE and/or designee will educate licensed nursing staff on the Comprehensive Person-Centered Care Plan Policy. 4. The Director of Nursing and/or designee will randomly audit 5 scheduled care plans to determine compliance weekly x 4, then 10 care plans monthly x 2. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F657 Care Plan Timing and Revision 1. There was insufficient documentation to show that all interdisciplinary team (IDT) members provided input for the post-admission care conferences/comprehensive care conferences for the residents cited in the 2567 (R9, R14, R66, R94, R96, and R 307). There was insufficient documentation to show R66 had a recent care plan meeting. No negative resident outcome has been reported as a result of this deficient practice. 2. Current residents who resided in the facility as of 2/12/24 were reviewed as having the potential for being affected by this deficient practice. 3. Administrator or designee will educate members of the interdisciplinary team (IDT) on the Complete Care Management Policy on comprehensive, person-centered care plans. The social services director will ensure that care plan meetings are conducted for each resident. Care plans will be prepared by the interdisciplinary team and	3/4/24

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		input will be provided by the physician, registered nurse, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and to the extent practicable, the resident and the resident's representative. A care plan tracking tool was created to manage the post admission and comprehensive care plans for the facility. Interdisciplinary team members will utilize this tool to provide input into each resident's post admission and comprehensive care plans. This information will be reviewed by interdisciplinary team members in the resident's care plan meeting. The Social Services Director or designee will document each interdisciplinary team member's input in designated care plan documentation. 4. The administrator or designee will audit all post admission and comprehensive care plan meetings weekly x 4 for one month, then every 2 weeks for one month, and then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for three months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F688 - Increase/Prevent Decrease in ROM/Mobility 1. R39 and R62 currently reside in the facility. R39's bilateral palm protectors were in the laundry department and were applied to R39 on 2/7/2024. R62 had her knee splints applied on 2/7/2024. E10 was educated by E11 regarding splint application and process of training staff when new splint recommendations are made by therapy. No negative resident outcome has been reported because of this deficient practice. 2. Director of Nursing and designee will audit current resident's orders for splint, brace, and palm protector orders to identify current residents who have the potential to be affected by the same deficient practice. All new splint, brace, and palm protector orders identified will be added to the respective resident's electronic medical record. 3. Nurse Practice Educator/NPE and/or designee will educate all licensed and non-licensed nursing staff on the Use of Assistive Devices policy and the Prevention of Decline in Range of Motion policy. 4. The Director of Nursing and/or designee	3/4/24

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		will audit all current residents with splint, brace, or palm protector orders weekly x 4 for one month, then every 2 weeks x 2 for one month, then monthly x 1 for one month until 100% compliance has been achieved. Results of all audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F756 - Drug Regimen Review, Report Irregular, Act On 1. There were no residents impacted by this deficient practice. The facility updated the policy on 2/15/2024 to be in compliance with federal regulation. 2. All MRR's (Medication Regimen Review) received will be responded to in accordance with the Medication Regimen Review policy and procedure. 3. The Nurse Practice Educator and/or designee will educate the nursing management team on the Medication Regimen Review Policy with emphasis on the time frames for the different steps in the MRR process. 4. The Director of Nursing and/or designee will manage the MRR process to ensure that time frames for the different steps of each process are being adhered to. The Director of Nursing will audit for compliance weekly x 4 weeks, then monthly x 2. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F791 Routine/Emergency Dental Srvcs In NFs 1. R77 is currently in the facility and there have been no negative outcomes because of this deficient practice. An Oral Health Assessment was completed on 2/27/2024 which noted well fitted full upper denture and natural bottom teeth without decay or broken teeth. The contracted Dentist was contacted via email to schedule a date to provide a routine cleaning for the bottom teeth of R77. 2. An Oral Health Assessment will be completed on all current long-term care residents to identify any who require routine dental services.	3/4/24 3/4/24

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		The Oral Health Assessment will identify and document those residents who refuse dental treatment. 3. The Nurse Practice Educator and/or designee will educate Licensed nurses, Unit Clerk, members of the Social Services Department on the Dental Services policy. 4. The Social Services Director and/or designee will offer dental services in accordance with scheduled annual assessments. The Social Services Director and/or designee will document the resident's response to offered dental services. The Social Services Director and/or designee will report compliance to policy monthly x 3 to the Quality Assurance Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan. F842 Resident Records - Identifiable Information 1. R61 no longer resides in the facility as of 2/16/2024. The incorrect encounter note written by the provider that was documented in the electronic medical record (EMR) for R61 was stuck out. No negative outcome was reported because of this deficient practice. R306 no longer resides in the facility as of 12/23/2023. The employee who recorded the inaccurate responses to the pain assessment was educated on 2/27/2024. 2. Current residents who received services on 1/25/2024 by the provider with inaccurate encounter notes will be reviewed for accuracy in the EMR. Pain assessments completed within 14 days of acceptance of survey plan of correction will be reviewed for accuracy and residents with inaccurate pain assessment responses will be reassessed. 3. Nurse Practice Educator/NPE and/or designee will educate licensed nursing staff and Vista Medical Services providers on the Maintenance of Electronic Clinical Records. 4. The Director of Nursing and/or designee will audit all encounter notes written by Vista Medical Services provider and all pain assessments completed weekly x 4, then 10 encounter notes by	3/4/24

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		Vista Medical Services and 10 pain assessments x 2 months. Results of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement Commiltee for further evaluations, recommendations, and sustainability of plan.	

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	085003	A. BUILDING _____ B. WING _____	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from February 5, 2024 through February 9, 2024. The facility census was 35 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, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were identified.	E 000		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		3/29/24

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

Electronically Signed — 02/27/2024

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

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

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

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

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E 037	Continued From page 4 personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of documents, it was determined that for three (E8, E9, and E10) out of eight (8) sampled staff members, the facility failed to ensure that staff received Initial Emergency Preparedness training upon entry into the facility. Findings include: - 12/29/23 was E9's (Dietary Aide) first day in the facility. E9 had no documented Emergency Preparedness training.	E 037	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law. E037	

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E 037	Continued From page 5 - 11/21/23 was E10's (Agency CNA) first day in the facility. E10 had no documented Emergency Preparedness training. - 1/2/24 was E11's (Agency Speech Therapist) first day in the facility. E11 had no documented Emergency Preparedness training. 2/9/24 3:30 PM - Findings were reviewed at the Exit Conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director), E4 (RN Unit Manager) and E5 (ADON).	E 037	A. E9, and E11 have completed Emergency Preparedness Training. E10 is no longer employed at Willowbrooke Court at Country House B. The NHA/Designee will audit active Newly Hired employees who have been hired since July 1, 2023 and are working on Willowbrooke Court at Country House, to ensure that these employees have received training on Emergency Preparedness. If any employees are found to not be in compliance with this training requirement, they will compete the training and brought into compliance. C. A Root Cause analysis was completed on the identified area of concern and it was determined that Willowbrooke Court at Country House failed to assign Emergency Preparedness Training for newly hired employees to be completed during their orientation period. Emergency Preparedness Training has been added to the agenda of items reviewed with Newly Hired employees. The NHA/Designee will in-service the Human Resources Coordinator, Director of Culinary Services, Director of Nursing, Assistant Director of Nursing, Housekeeping Manager, Plant Operations Manager, and Director of Rehabilitation that Newly Hired Employees will complete Emergency Preparedness Training during New Hire Orientation. D. The NHA/Designee will conduct	

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E 037	Continued From page 6	E 037	weekly audits of Newly Hired employees that have completed New Hire Orientation to ensure that the employee completed training in Emergency Preparedness. This audit will be conducted once weekly until we reach success for 4 consecutive weeks, then twice a month until we reach success for 2 consecutive months, then once a month until we determine 100% compliance has been achieved. Outcomes of these audits will be reported at he Quarterly QAPI Committee Meeting for review and recommendation as indicated.	
F 000	INITIAL COMMENTS An unannounced Annual survey was conducted at this facility from February 5, 2024 to February 9, 2024. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. the facility census on the first day of the survey was thirty-five. The survey sample was five. Findings include: Abbreviations/definition used in this report are as follows: ADON - Assistant Director of Nursing; DON - Director of Nursing; EMR - elcetronic medical record; NHA - Nursing Home Administrator; RN - Registered Nurse.	F 000		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits	F 712		3/29/24

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F 712	Continued From page 7 §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R8) out of five residents reviewed for physician services, the facility failed to ensure the resident was seen for the required physician visits. Findings include: R8's clinicial record revealed: 12/5/23 - R8 was admitted to the facility. Review of R8's clinical record revealed the absence of an initial comprehensive visit by the Physician. 2/8/24 at 2:03 PM - During a combined interview, finding was confirmed with E1 (NHA) and E3 (Regional Clinical Director).	F 712	F712 A. R2 was seen by the physician on 1/24/24 to bring physicians visits into compliance and satisfy the requirement of a physician visit every 60 days. R2 expired on 2/9/24. R3 was seen by the physician on 1/29/24 and is scheduled to have the next physicians visit 3/29/24 to satisfy the requirement of a physicians visit every 60 days. R7 is scheduled to have a physicians visit on 2/26/24 to establish a timeline of physicians visits every 30 days for the first 90 days, and then again on 4/26/24 to establish and satisfy the requirement of a physicians visit every 60 days.	

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F 712	Continued From page 8 2/9/24 at 3:30 PM - Finding was reviewed at the exit conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director), E4 (RN Unit Manager) and E5 (ADON).	F 712	B. Residents currently residing in the facility have the ability to be affected by this deficient practice. The DON/ designee will audit the current residents physicians visits to determine a timeline of physicians visits. Residents identified as out of compliance with physician visits will be added to the physicians calendar to establish a timeline of visits and ensure they are seen again in the next 60 days to be brought into compliance per regulation. C. A root cause analysis was completed and determined that the prior Medical Director was not following the protocols for physician visits due to a lack of proper tracking and communication with Nursing Management. A new medical director started with the facility on 12/15/2023 and nursing management is implementing an improved tracking and communication with Medical Director on physician visits. The facility will utilize Point Click Care physicians visits tab as a tracking tool for scheduling visits due. ADON/ Staff development will in-service the Nurse Supervisor on the use of Point Click Care physicians visit tab as a tracking tool for future visits. The physician will be in-serviced on the facilities process of tracking visits to ensure compliance with regulation. D. The DON/ designee will conduct audits of Point Click Care physicians visits due tab against actual physicians visits to ensure compliance of physicians visits	

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F 712	Continued From page 9	F 712	every 30 days for the first 90 days and then every 60 days thereafter. Audits will be conducted daily until we reach success for 2 consecutive weeks, then weekly until we reach success for 2 consecutive weeks, and then monthly until we reach success for 2 consecutive months until 100% compliance has been achieved. Outcomes of these audits will be submitted to the Quality Assurance Committee for review and recommendation as indicated.	
F 812 SS=F	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 and interview during the	F 812	F812	3/29/24

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F 812	Continued From page 10 initial kitchen tour, it was determined that the facility failed to ensure food was stored in accordance with professional standards for food service safety. Findings include: 2/5/24 from 8:22 AM to 8:35 AM, observation of the kitchen with E1 (NHA) revealed the following: - observed 1/4 tray of cake (vanilla with chocolate icing) and a full tray of sloppy joe were undated in the refrigerator; - observed a full tray of frozen dough that was not covered completely and undated, a plate with two pieces of cooked chicken was uncovered and undated and a clear bag of chicken nuggets was undated in the walk-in freezer. Finding was immediately confirmed with E1 (NHA). 2/9/24 at 3:30 PM - Finding was reviewed at the exit conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director), E4 (RN Unit Manager) and E5 (ADON).	F 812	A. Tray of cake was labeled and dated. Tray of Sloppy Joe was labeled and dated. Frozen dough was properly covered and labeled and dated. The plate of two pieces of cooked chicken was disposed of. The bag of chicken nuggets was disposed of. B. The NHA/Designee will conduct a follow-up unannounced tour of kitchen and inspect the dry storage, refrigerators and freezers to identify if any other stored food items are not stored in accordance with professional standards for food service safety. Any food items identified as improperly stored will be corrected immediately. C. A Root Cause analysis was completed on the identified area of concern and it was determined that culinary service staff lacked the knowledge to ensure that all food stored in the kitchen require proper covering, label and date in accordance with professional standards for food service safety. The Director of Culinary Services/Designee will inservice the Assistant Restaurant Manager, Executive Chef, Lead Cook, Lead Diet Aide, Line Cooks, Medical Diet Aides, Nutrition Services Manager, Prep Cooks, Restaurant Manager, Shift Supervisor and Sous Chefs that food will be stored in the kitchen in accordance with professional standards for food service safety, to include proper covering, labeling and	

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F 812	Continued From page 11	F 812	dating. D. The NHA/Designee will conduct weekly unannounced audits of the kitchen and inspect dry storage, refrigerators and freezers to ensure food is stored in accordance with professional standards for food service safety, to include proper covering, labeling and dating. These audits will be conducted once weekly until we reach success for 4 consecutive weeks, then twice a month until we reach success for 2 consecutive months, then once a month until we determine 100# compliance has been achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee Meeting for review and recommendation as indicated.	
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-	F 842		3/29/24

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F 842	Continued From page 12 (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, 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;	F 842		

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F 842	Continued From page 13 (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 and interview it was determined that for one (R4) out of five residents reviewed for clinical records, the facility failed to ensure that R4's medical records were complete and readily accessible as evidenced by the failure to upload the attending physician notes in the EMR (electronic medical record). Findings include: 5/21/20 - R4 was admitted to the facility. 1/23/23 - R4 was seen by E6 (MD) for R4's required 60 day visit. 3/27/23 - R4 was seen by E6 for R4's required 60 day visit. 5/6/23 - R4 was seen by E6 for R4's required 60 day visit. 6/26/23 - R4 was seen by E6 for R4's required 60 day visit. 8/28/23 - R4 was seen by E6 for R4's required 60 day visit. 10/23/23 - R4 was seen by E6 for R4's required	F 842	F842 A. Physician Visit Records have been scanned into R4□s electronic medical record so that they are readily accessible. B. The DON/Designee will audit active resident records for the prior 90 days to ensure that physician Visit Records have been scanned into each active resident□s electronic record so that they are readily accessible. Any records identified as not having complete Physician Visit Records will be brought into compliance. C. A Root Cause analysis was completed on the identified area of concern and it was determined that a revision was necessary to the process of tracking physician visit records and ensuring those records were received timely and uploaded to the resident□s electronic medical record. A new audit has been developed to utilize the electronic medical record (Point Click Care) to track physician visits and receipt of the documented Physician Visit Record.	

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F 842	Continued From page 14 60 day visit. 2/8/24 - There was no evidence in R4's EMR of the 1/23/23, 3/27/23, 5/6/23, 6/26/23, 8/28/23 and 10/23/23 encounter or the subsequent progress note by E6. 2/9/24 3:30 PM - Findings were reviewed at the Exit conference with E1 (NHA), E2 (DON), E3 (Regional Clinical Director), E4 (RN Unit Manager) and E5 (ADON).	F 842	Further those records will be uploaded to the resident□s electronic medical record. The DON/Designee will in-service the Health Care Coordinator on the new process of comparing the list of physician visits in Point Click Care to the visit summaries that are sent to Willowbrooke Court at Country House and ensure those records are uploaded to the appropriate resident□s electronic medical record. D. The DON/Designee will audit the list of residents being seen that is generated by the physician□s visit tab in Point Click Care and ensure that physician notes have been received and uploaded to the resident□s electronic medical record. These audits will be conducted daily until we reach success for 2 consecutive weeks, then weekly until we reach success for 2 consecutive weeks, then monthly until we achieve 100% compliance. Outcomes of these audits will be submitted to the Quarterly QAPI Committee for review and recommendation as indicated.	