

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINNACLE REHABILITATION &amp; HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3034 SOUTH DUPONT BLVD</b> <b>SMYRNA, DE 19977</b>	
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E 000	Initial Comments  An unannounced annual and complaint survey was conducted at this facility from January 12, 2020 through January 17, 2020. The facility census the first day of the survey was 146. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73.  There were no deficiencies identified related to the Emergency Preparedness Survey.	E 000		
F 000	INITIAL COMMENTS  An unannounced annual and complaint survey was conducted at this facility from January 12, 2020 through January 17, 2020. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 146. The survey sample totaled 48.  Abbreviations/Definitions used in this report are as follows:  NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; FSD - Food Service Director; FMD - Facility Maintenance Director; MD - Medical Doctor; NP - Nurse Practitioner;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/07/2020

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 OT- Occupational therapy/therapist; PA - Physician Assistant; QA - Quality Assurance; QAPI - Quality Assurance Process Improvement; RD - Registered Dietitian; RNAC - Registered Nurse Assessment Coordinator; SW - Social Worker; UM - Unit Manager; 1:1 - one on one visit, a staff member visiting with only one resident; ADLs (Activities of Daily Living) - such as bathing and dressing; Alzheimer's - type of dementia; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment; Cogentin - a drug to treat symptoms of Parkinson's; ER / ED - emergency room / emergency department; Haldol - an antipsychotic; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Naloxone - (Narcan) an antidote for opioid overdose that reverses the effects of opioids. Narcan only works if there are opiates in the body and has no effect on drugs or alcohol. Usually takes three to five minutes to work and lasts sixty to ninety minutes; Opiate - a class of medications both legal and illegal, often prescribed for pain such as morphine or oxycodone, and illegal substances such as heroin. When opioids are taken in high doses or abused, they can cause feelings of euphoria, relaxation, drowsiness, and warmth. If	F 000			

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F 000	Continued From page 2 the individual takes too many opioids or combines them with drugs or alcohol this may cause problems such as difficulty breathing, loss of consciousness, cardiac arrest and even death; Pressure Ulcer / Pressure injury - sore area of skin that develops when blood supply to it is cut off due to pressure; POC - Plan of Care.	F 000			
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)  §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:  §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to inform the resident's representative of two (R12 and R57) out of six sampled residents for immunization review that the resident refused the pneumonia vaccination after the resident's representative	F 552	A The resident representative was informed of R57's refusal of the influenza vaccine on 1/15/2020. There was no adverse effect to the resident. The resident representative was informed	4/15/20	

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F 552	<p>Continued From page 3</p> <p>consented to and signed the immunization consent form. Findings include:</p> <p>11/28/16 - Facility policy entitled Pneumococcal Vaccination documented the procedure: "The resident and/or resident's representative will receive education of the benefits and potential side effects of the vaccine. The resident and/or resident's representative will then have the right to consent or decline the vaccination by signing the immunization consent form. If the resident and/or resident's representative decline, the reason must be documented on the form [Pneumococcal and Influenza Vaccination Consent form] and then witnessed by a facility representative...Documentation in the medical record should include the education provided, the vaccination was administered, or did not receive, along with the reason they were unwilling or unable to receive the vaccine or if the vaccination is medically contraindicate."</p> <p>1. Review of R12's clinical record revealed:</p> <p>10/5/18 - R12 was admitted to facility.</p> <p>7/11/19 - The quarterly MDS assessment documented that R12 was moderately impaired for daily decision making.</p> <p>9/10/19 - Pneumococcal and Influenza Vaccination Consent form - R12's representative gave verbal consent for the pneumococcal pneumonia vaccination.</p> <p>1/15/20 2:00 PM - Review of immunization documentation in the medical record found no evidence of the resident's pneumococcal pneumonia vaccine status. This information was</p>	F 552	<p>of R12's refusal of the influenza vaccine on 1/ 16 /2020. An addendum will be made to the progress note of 1/16/2020 to reflect that this discussion did occur. There was no adverse effect to the resident.</p> <p><b>B</b> All residents have the potential to be affected by this deficient practice.</p> <p>An initial audit will be conducted by the Infection Control Practitioner (ICP) or designee to identify all refusals that were initially consented by the resident representative (RR) to ensure notification was made. If there is no evidence of the notification, the RR will be informed and the notification will be documented in the EMR immunization tab via the notes section of each specific vaccination indicated.</p> <p><b>C</b> A root cause analysis was conducted and it was determined that the facility staff were not utilizing the immunization dashboard in the EMR effectively, thus not capturing residents immunization status, declinations, notification to RR and evidence of education of a refusal to both the resident and the RR.</p> <p>1. A checkbox will be added to the Vaccination Consent to acknowledge that the order was entered if the vaccination was requested.</p> <p>2. Template for vaccination order set will</p>		

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F 552	<p>Continued From page 4 requested from E2 (DON).</p> <p>1/16/20 12:25 PM - A nurse's note documented: "Resident informed that his guardian consented to pneumonia vaccine and offered education on the same. Resident declined vaccination stating that he did not feel it would be helpful ..."</p> <p>As of 1/16/20 there was lack of evidence that R12's legal representative was made aware of R12's refusal.</p> <p>2. Review of R57's clinical record revealed:</p> <p>10/4/18 - R57 was admitted to facility.</p> <p>10/29/18 - Pneumococcal and Influenza Vaccination Consent form - R57's representative gave verbal consent for the pneumococcal pneumonia vaccination, but a nurse documented on this form that, "Resident refused [pneumococcal pneumonia vaccination]."</p> <p>7/9/19 - The quarterly MDS assessment documented that R57 was severely impaired for daily decision making.</p> <p>1/15/20 2:00 PM - Review of R57's medical record found no evidence that R57's representative was notified of the refusal. This information was requested from E2 (DON).</p> <p>1/15/20 4:31 PM - A nurse's note documented: "Resident's sister and guardian contacted states she wants her brother made comfortable as he is on hospice, states that she remembers he refused the vaccine last year and is not necessary as he already accepted influenza vaccination in the fall."</p>	F 552	<p>updated to include directions If resident refuses vaccination after Resident Representative consents notification must be made and documented in the immunization tab and Infection Control Practitioner (ICP) notified.</p> <p>3. ICP or designee will track all immunizations utilizing the vaccination dashboard in the electronic medical record (EMR) to ensure vaccinations are given when consented, notifications made when refused, and all refusals care planned appropriately.</p> <p>4. Corporate Nurse Consultant will educate ICP on the new consent form, template, and the use of the immunization dashboard in the facility's EMR.</p> <p>5. Staff Development Manager (SDM) or designee will educate all licensed nursing staff on the proper use of the immunizations dashboard in the facility's EMR.</p> <p>D ICP will conduct random audits of 5 admissions weekly x 4 weeks to ensure that residents who decline vaccination after consent provided by (RR) will have that RR notified of the refusal, until 100% compliance is achieved. Audits will continue of admission monthly x 2 months of 10 residents until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and sustained.</p>		

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F 552	Continued From page 5  R57's medical record lacked evidence that the legal representative was made aware that R57 refused pneumococcal pneumonia vaccine until after the surveyor questioned the facility.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.	F 552			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.  §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		4/15/20	

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F 655	<p>Continued From page 6 admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R191) out of one newly admitted resident reviewed the facility failed to provide the resident representative with a summary of the baseline care that included the treatment of two pressure ulcers the resident had on admission. Findings include:</p> <p>The following was reviewed in R191's clinical record:</p> <p>12/18/19 - Nurses notes documented that R191 was admitted to the facility with two pressure ulcers and a recent leg amputation.</p> <p>12/23/19 - Review of the "Care Plan Summary Notification and Written Summary For Resident &amp; Representative" lacked documentation that R191 had two pressure ulcers that were being treated and a recent lower leg amputation. The area of</p>	F 655	<p>A R191 was discharged from the facility therefore no corrective action can be taken.</p> <p>B All residents have the potential to be affected.</p> <p>An audit will be conducted by the Nursing Home Administrator (NHA) or designee of admissions moving forward to ensure the Baseline Care Plan was completed comprehensively by the Interdisciplinary Team, capturing all aspects of the residents plan on care to include but not limited to pressure ulcers.</p> <p>C A root cause analysis was conducted and</p>		

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F 655	Continued From page 7 nursing documented "med (medication) management".  1/17/20 10:35 AM - An interview E2 (DON) confirmed the care plan summary lacked identification of the pressure ulcers and amputation that R191 was being treated for. A copy of the actual baseline care plan did include these wounds. There was no evidence that the actual baseline care plan was provided to the responsible party.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.	F 655	found the Baseline Care Plan is not being utilized comprehensively by the Interdisciplinary Team to capture all aspects of the resident's Plan of Care Plan during the meeting.  The Corporate Nurse Consultant will educate the Interdisciplinary team on completing the BCP comprehensively, including all aspects of the services the resident need, and that the BCP will include a summarized visual of the resident's plan of care.  D NHA or designee will conduct random audits of 5 admissions weekly x 4 weeks to ensure that the BCP is being utilized comprehensively, and includes a summary of all aspects of the resident's care, until 100% compliance is achieved. Audits will continue of 10 admissions monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		4/15/20	

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F 656	<p>Continued From page 8</p> <p>needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that for two (R83 and R133) out of 32 residents in the investigative sample, the facility failed to develop a comprehensive person-centered care plan based on an identified</p>	F 656	<p>A</p> <p>R 83's activities care plan will be updated to reflect a measurable goal. There was no adverse effect to the resident.</p>		

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F 656	<p>Continued From page 9</p> <p>needs and failed to ensure the care plan goals were measurable. Findings include:</p> <p>1. Cross refer F679.</p> <p>The following was reviewed in R83's clinical record:</p> <p>10/18/19 - R83 was admitted to the facility.</p> <p>1/15/20 11:00 AM - Review of R83's care plan revealed a focus area/problem of, "[R83] enjoys activities such as watching sports with his room as preferred setting" with a goal of, "Will involve self in independent activities of choice and attend group activities as chooses."</p> <p>This goal was subjective and not measurable.</p> <p>1/16/20 8:50 AM - During an interview, E15 (Activity Director) and E1 (NHA) the above finding was discussed and will be modified.</p> <p>2. The following was reviewed in R133's clinical record:</p> <p>12/2/16 - R133 admitted to the facility.</p> <p>1/20/18 - R133 was seen by a dentist and recommendations were made to see an oral surgeon.</p> <p>6/19/19 - R133 was seen by a dentist and it was recommended that R133 have loose teeth removed. The progress note documented that R133 was "unsure and wanted to think about it."</p> <p>12/27/19 - The annual MDS documents obvious likely cavity or broken natural teeth.</p>	F 656	<p>R133's dental care plan was updated on 1/17/2020 to reflect the current dental status of the resident. There was no adverse effect to the resident.</p> <p><b>B</b></p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>An audit will be conducted by the Activities Director or designee to ensure that each resident has a care plan based on their comprehensive assessments and interests. Audits will also review that each individual goal is measurable.</p> <p>An audit will be conducted by the Unit Managers or designee to ensure that all residents has dental a care plan reflecting their current dental status.</p> <p><b>C</b></p> <p>A root cause was conducted and it was determined that the Interdisciplinary team (IDT) did not initiate a plan of care based on residents comprehensive assessment.</p> <p>The plan of care will be initiated by the IDT upon the completion of a comprehensive assessment. The IDT will discuss residents who have had an assessment each week at the weekly risk meeting. The plan of care will be reviewed and care plans will be initiated/updated as applicable, with measurable goals.</p> <p><b>D</b></p> <p>The DON or Designee will conduct weekly audits x 4 weeks of the care plans of 5</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINNACLE REHABILITATION &amp; HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3034 SOUTH DUPONT BLVD SMYRNA, DE 19977</b>		
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F 656	Continued From page 10  During an interview on 1/12/20 at 11:51 AM, R133 stated he has a "bad tooth and has a lot of pain from his bad tooth."  There was no evidence that the facility developed a comprehensive care plan for the identified dental issues.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.	F 656	residents care plans to ensure their activities and dental status are present with measurable goals , until 100% compliance is achieved. Audits will continue monthly x 2 of 5 residents, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.		
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. (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	F 657		4/15/20	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	<p>Continued From page 11 or as requested by the resident.</p> <p>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review it was determined that for one (R8) out of 32 residents in the investigative sample, the facility failed to revise R8's care plans related to opiate (illegal/legal medications that may cause difficulty breathing, loss of consciousness, cardiac arrest, and even death) addiction to include the intervention of use of Narcan (an antidote for opioid overdose) . Findings include:</p> <p>Review of R8's clinical record revealed the following:</p> <p>2/28/19 - A care plan for exhibits a safety hazard to self as evidenced by history of opiate dependence, heroin addiction with active use while LOA with family, and pocketing of prescribed opiate PRN pain medication in order to take multiple doses at once was initiated and last updated on 8/29/19. Included interventions to before starting care, speak with the resident and inform them of necessity to crush PRN opiate to prevent possible adverse effects due to increased dosage, secondary to pocketing meds for later, required ahead of time. Educate R8 regarding risks of overdose and possible cardiopulmonary (heart and lung) arrest related to pocketing opiates in order to combine multiple doses to be taken together. Offer choices to enhance sense of control. Praise/reward for demonstrating consistent desired, acceptable behavior. Provide education to resident/resident</p>	F 657	<p>A Resident R8's careplan was updated to include the intervention of Narcan. There was no adverse effect to the resident.</p> <p>B All residents have the potential to be affected by this deficient practice.</p> <p>An audit will be conducted by Unit Managers or Designee to review that residents in house has an updated/revised care plan related to opiate addiction, including the applicable interventions.</p> <p>C A root cause was conducted and it was determined that although the plan of care for R8 was revised several times based on his/her changing plan of care, the intervention of Narcan was overlooked.</p> <p>1. A care plan review for residents in a high risk category such as opiate addiction will be conducted weekly in the facility's risk meeting. The Interdisciplinary team (IDT) will review and revise the care plan ensuring that it captures interventions that are in place for the resident.</p>		

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F 657	<p>Continued From page 12 representative/family.</p> <p>10/14/19 1:13 PM - A nurses note documented "nursing management and primary care met with [R8] to discuss evidence of substance abuse. [R8] confirmed usage of substances of abuse. At the time of meeting [E9(NP)] determined [R8] was in active withdrawal and required transfer to the ER for evaluation and treatment."</p> <p>10/15/19 1:02 PM - A nurses note documented R8 "returned from hospital via stretcher by ambulance approximately 12:50 PM this afternoon was sent to the hospital for opiate abuse."</p> <p>10/16/19 - A care plan for history of Opioid addiction with current relapse. Risk for withdrawal due to illicit substance use was initiated (last updated 10/21/19) with the goal to not harm self or others due to use of unauthorized substances included the following interventions: administer medications as ordered and observe for effectiveness. Assess strengths and positive coping skills to determine ways to utilize in current situation discuss coping strategies. If resident appears under the influence of unauthorized substance, notify physician and observe for safety/changes in condition. Instruct visitors that alcohol/drugs may not be brought onto the premises. Observe and report any decline in ADL ability or mood/behavior. Offer positive reinforcement for attempts to control addictive behavior. Offer resident outpatient services (counseling, AA/NA (alcoholic anonymous/narcotics anonymous meetings) to address substance abuse upon discharge. Provide education to the resident, representative, and family on risks of substance abuse.</p>	F 657	<p>The IDT members will be educated by the DON on this process.</p> <p>D The DON or Designee will conduct weekly audits x4 weeks of 5 residents with known opiate addiction to ensure that the care plan is updated and reflects specific interventions such the use of Narcan, until 100% compliance is achieved. Audits will continue monthly x 2 of 5 residents, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.</p>		

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F 657	<p>Continued From page 13</p> <p>Psychological or psychiatric services as indicated/ordered.</p> <p>11/2/19 6:40 AM - A progress note documented "called to assess resident for decreased responsiveness and difficult to arouse...full code status, 911 called 6:27 AM transported to hospital."</p> <p>11/2/19 - A facility incident reported "resident noted unresponsive. Resident sent to ED. no injury. At hospital resident states visitor brought [R8] morphine."</p> <p>11/3/19 1:20 AM - A progress note documented R8 was "admitted [to the hospital] diagnosis: acute respiratory failure with hypoxia [lack of oxygen] and also was positive for opiates in the urine, opiate was discontinued October 2019."</p> <p>11/23/19 - A progress note from contracted psych services documented "evaluated resident per staff request secondary to history of opioid dependence, previous history of reported drug diversion within the facility...Narcan on medication cart resident declines need for [drug] inpatient rehabilitation."</p> <p>11/27/19 - A progress note from contracted psych services documented "asked to evaluate resident post opiate overdose in facility 11/2/19. Narcan on medication cart. Resident denies need for inpatient [drug] rehabilitation."</p> <p>During a medication storage observation on 1/15/20 at 11:01 AM a house stock box of sealed Narcan was located in the medication cart lock box for the cart that contains R8's medications.</p>	F 657			

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F 657	Continued From page 14 During an interview on 1/17/20 at 9:10 AM with E8 (RN and unit manager) on R8's unit, it was confirmed that R8's care plans related to opiate use did not include the use of Narcan as an intervention.	F 657			
F 676 SS=D	Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20. Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)  §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:  §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...  §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:  §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,  §483.24(b)(2) Mobility-transfer and ambulation,	F 676		4/15/20	

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F 676	<p>Continued From page 15 including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for three (R190, R90, and R133) out of three sampled residents reviewed for ADL's, the facility failed to provide oral care for R190 and R133 and provide meal set up for R90. Findings include.</p> <p>1. The following was reviewed in R190's clinical record:</p> <p>1/3/20 - R190 was admitted to the facility.</p> <p>1/10/20 - An admission MDS documented R190 requires extensive with one-person physical assist for personal hygiene which includes oral hygiene.</p> <p>1/12/20 10:11 AM - During an interview, R190 stated, "I need to brush my teeth. I haven't brushed my teeth because I can't get up and do it myself."</p> <p>1/12/20 11:40 AM - During an interview, E17 (R190's CNA) stated that R190 was transferred back to this unit around change of shift (3:00 PM) yesterday and that he should have a tooth brush</p>	F 676	<p>A</p> <p>R 190 currently has oral hygiene products available, and is consistently receiving assistance to perform oral hygiene per resident's preference as reflected in the plan of care. There was no adverse effect to this resident.</p> <p>R133 currently has oral hygiene products available, and is consistently receiving assistance to perform oral hygiene per resident's preference as reflected in the plan of care. There was no adverse effect to this resident.</p> <p>R 90 is consistently receiving the appropriate meal set up for all meals as per the plan of care. There was no adverse effect to this resident.</p> <p>B</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>An audit will be conducted by all Unit Managers or Designee to ensure that all</p>		

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F 676	<p>Continued From page 16</p> <p>in the bag of belongings he brought with him from the other room. E17 added she had not had time to go through the bag.</p> <p>1/12/20 2:30 PM - During an interview, R190's wife was asked if she knew where his tooth brush was. She went through the bag that E17 (CNA) had referenced earlier and found an unopened box containing a tube of tooth paste and an unopened package of two toothbrushes. No opened toothbrush was found in R190's room.</p> <p>1/14/20 10:00 AM - During an observation and interview with R190 the only items found were unopened packages of toothpaste and toothbrushes.</p> <p>1/14/20 2:30 PM - During an interview, E17 (R190's CNA) stated that she was, "so busy that there was not a chance she could have helped [R190] to brush his teeth today."</p> <p>1/15/20 8:30 AM - During an interview with R190, he stated he did get assistance from the staff to brush his teeth today.</p> <p>1/16/19 2:00 PM - During an interview E3 (ADON) stated that the facility's expectation is that residents are offered oral care at least every morning.</p> <p>1/16/20 2:25 PM - During an interview E18 (R190's CNA on day shift on 1/13/20) stated that she could not remember if she assisted R190 with oral care on 1/13/20.</p> <p>1/17/20 1:00 PM - During an interview with E2 (DON) and E5 (Corporate Nurse) the surveyor reviewed above findings that after R190 stated he</p>	F 676	<p>residents are provided with oral care products, and they are receiving oral care as per their need.</p> <p>Additionally, an audit will be conducted by the Unit Managers or Designee to ensure that all residents receiving their meals in their rooms <input type="checkbox"/> have tray tables set up within appropriate distance in order for residents to eat their meal comfortably.</p> <p><b>C</b> A root cause was conducted and it was determined that staff were not taking the time to provide the care and services required for each individual resident as per their plan of care.</p> <p>1. Unit Managers or Designee will conduct daily rounds to observe for oral care being provided to residents as per their needs, and that tray tables placed within an acceptable distance for each resident to comfortably eat their meal.</p> <p>2. Education will be provided to nursing staff by the SDM on the importance of providing oral care to residents prior to meals and at bedtime or per their choice; and ensuring that a complete set up is in place such as, trays are placed within reaching distance when providing a resident his/her meal. This education will also be placed in the Health Care Academy Training System for staff to complete upon hire and annually.</p> <p><b>D</b> The Unit Managers or Designee will</p>		

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F 676	<p>Continued From page 17</p> <p>had not had any oral hygiene since admitted to the facility, unopened toothbrushes and tooth paste were found in his room on 1/12/20 and 1/14/20.</p> <p>2. The following was reviewed in R90's clinical record:</p> <p>A care plan last revised on 8/26/18 for R90's self-care deficit documents an intervention that R90 requires assistance with daily hygiene, grooming, dressing, oral care and eating as needed.</p> <p>12/6/19 - A quarterly MDS documented R90 requires supervision and set up for eating.</p> <p>1/12/20 8:38 AM - During an observation of a breakfast tray being delivered to R90's room by E8 (CNA) the tray was placed on bedside table more than an arm's length away from the resident. R90 was unable to reach her meal to eat.</p> <p>1/12/20 9:04 AM - The surveyor notified E9 (LPN) that the tray was more than an arm's length away and R90 could not reach her meal. E9 went to the resident's room and positioned R90 up to the table so she could reach her meal. R90 ate 100% of the meal.</p> <p>During an interview with R90's family on 1/12/20 at approximately 1:30 PM, revealed that just a week ago the family spoke with staff about R90 sitting too far away from tray and being unable to reach her food to eat.</p> <p>3. The following was reviewed in R133's clinical record:</p>	F 676	<p>conduct daily audits during rounding x4 to observe that oral care is being provided for 5 residents, and ensure that residents <input type="checkbox"/> trays set up in appropriate distance for residents to eat their meal comfortably until 100% compliance is achieved. Audits will continue monthly x 2 of 10 residents, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.</p>		

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F 676	Continued From page 18  12/2/16 - Admitted to the facility.  A care plan last revised 10/10/19 documents ADL self-care deficit with interventions to assist with daily hygiene and oral care and encourage to participate in self-care.  12/27/19 - An annual MDS documented R133 requires extensive one-person physical assist for personal hygiene.  During an interview on 1/15/20 at 1:37 PM with R133 it was revealed that the resident had not had oral care today and he did not think he had a toothbrush. E9 (CNA) looked for R133's toothbrush and could not find one in the resident's room. E9 revealed that R133 did not get his teeth brushed today. It was further revealed that it was not E9's practice to set R133 up for daily oral care.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.	F 676			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		4/15/20	

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F 679	<p>Continued From page 19</p> <p>each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, clinical record review, and interview, it was determined that for three (R49, R67 and R83) out of three sampled residents reviewed for activities the facility failed to ensure activities were provided, based on the comprehensive assessments and residents' interests. Findings include:</p> <p>1. Review of R49's clinical record revealed:</p> <p>5/7/19 - An annual MDS documented listening to music as a preferred activity.</p> <p>8/21/19 - 12/3/19 - R49 had a care plan goal to "participate in 1:1 activities/week that are consistent with patient's likes and interests such as listening to music."</p> <p>8/21/19 - A quarterly activities note documented that "Resident continues to receive 1:1 room visits from the activity staff. Staff provides music and reading to promote sensory stimulation. Staff will continue to provide 1:1 sensory stimulation."</p> <p>There was no plan to address R49's music interest beyond 1:1 visits with staff.</p> <p>12/3/19 - R49 had a care plan goal to "observe in 1:1 activities/week that are consistent with patient's likes and interests such as listening to music."</p> <p>October - December 2019 - R49's Activities Detail Report documented that R49 was invited to a total of 12 activities including eight 1:1 visits. One</p>	F 679	<p>A</p> <p>1. R49 was discharged from the facility therefore no corrective action is needed.</p> <p>2. R67's television is being turned on daily as per the resident wishes; additionally R67 is invited to attend other activities that are offered within the facility. Additionally a reassessment of the residents' preferences for activities will be completed by the Activities Director and the plan of care will be revised based on the assessment. There is no adverse effect to the resident.</p> <p>3. R83 is being invited to activities of choice daily as per the resident's wishes. Additionally a reassessment of the residents' preferences for activities will be completed by the Activities Director and the plan of care will be revised based on the assessment. There is no adverse effect to the resident.</p> <p>4. The regional Director of Operations provided 1:1 education to the Director of Activities on the regulations specific to providing, and having residents engaged in meaningful activities on 1/16/2020.</p> <p>B</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>An audit will be conducted by the Nursing</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 679	<p>Continued From page 20</p> <p>1:1 visit was in October, six in November and one in December.</p> <p>October - December 2019 - The activity calendars contained a total of 14 music related activities and 21 total scheduled times for room visits.</p> <p>1/12/20 12:58 PM, 1/15/20 10:30 AM and 1/16/20 3:00 PM - Observations were made of R49 comfortably resting in bed, R49's eyes closed, without visitors or music.</p> <p>1/16/20 11:25 AM - During an interview E15 (Activities Director) confirmed that there was not a music player in R49's room. During 1:1 visits, the staff use their phones to listen to music with R49.</p> <p>There was no evidence that the facility considered placing a musical device in R49's room or that an assessment was completed to determine R49's music preferences.</p> <p>2. Review of R67's clinical records revealed:</p> <p>8/28/19 - An annual MDS documented that interests were reading, listening to music, being around pets, spending time away from facility, spending time outdoors and religious activities.</p> <p>9/2/19 10:45 AM - A full assessment activities note documented that "Resident enjoys being in...bedroom watching television, going to the beauty shop every other week and attending some group activities. Staff will continue to encourage resident to participate in group activities of choice. Continue POC."</p>	F 679	<p>Home Administrator via resident interviews, to determine whether residents are being offered, or are attending activities based on comprehensive assessments and their interests.</p> <p>C</p> <p>A root cause was conducted, and it was determined that the Activities Department lacked the awareness of the importance of providing, And documenting activities provided to all residents, based on their comprehensive assessments and their interests.</p> <p>1. A plan of care will be initiated by the Activities Director for each individual resident after the completion of a comprehensive assessment and resident or resident representative interview. The Activities Director will work collaboratively with the Nursing Department daily to ensure that residents are attending or involved in meaningful activities. Each interaction will be documented in the Care Tracker system.</p> <p>1a. The Resident's profile will be updated by the Activities Director in the Care Tracker system to include the resident's preference of activities to communicate to care staff the resident's choice of activities.</p> <p>2. The Activities department will be educated by the SDM, on the importance of ensuring that residents are receiving activities based on the comprehensive assessment, and their interests. This</p>	

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F 679	<p>Continued From page 21</p> <p>10/7/19 - 12/3/19 - R67 had a care plan focus of enjoying "observing group activities listening to music and watching television with...room or dining room as preferred setting."</p> <p>12/3/19 10:45 AM - A quarterly activities note documented that the resident "enjoys attending group [activities] and enjoys activities such as trivia. Staff will encourage resident to continue to participate in group activities. Continue POC."</p> <p>12/3/19 - R67's activity care plan focus was revised to "enjoys observing and participating group activities such as trivia with the dining room as preferred setting."</p> <p>October - December 2019 - R67's Activities Detail Report documented that R67 was invited to a total of 15 activities including 1 reading activity, 1 musical activity and 1 trivia activity.</p> <p>October - December 2019 - The activity calendars contained a total of 3 television activities, 14 music related activities, 11 activities outdoors and 44 religious' activities.</p> <p>December 2019 - The activity calendar documented two planned trivia activities.</p> <p>1/12/20 1:59 PM - Several observations were made of R67, alone, in bed, all morning, with the privacy curtain closed. R67 has been alert for each observation. There was a television on R67's side of the room, but it was not on.</p> <p>1/14/20 11:16 AM and 1/15/20 10:30 AM- Observations were made of R67 in bed and alert. The television was not on, and no activity items were seen. The resident was alone.</p>	F 679	<p>education will be incorporated in orientation for all new activities staff.</p> <p>2b. The nursing staff will be educated by the SDM on the importance of reviewing each resident's profile in Care Tracker to obtain the awareness of, the resident's choice of activities i.e. turning the television on, or leaving the radio on a favorite channel. This education will be included in the new employee orientation.</p> <p>D The Nursing Home Administrator or Designee will conduct daily rounds x 4 weeks to audit 5 residents' involvement in activities, through observation and interviews to ensure that they are involved in activities based on their comprehensive assessment and documented interests, until 100% compliance is achieved. Audits will continue monthly x 2 of 5 residents, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.</p>	

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F 679	<p>Continued From page 22</p> <p>1/16/20 11:10 AM - An observation was made of R67 in bed holding two stuffed animals and a baby bible. The resident was alone.</p> <p>There was no evidence that the resident's television was being turned on for him/her.</p> <p>There was no evidence that the resident was invited to group activities, which had taken place daily.</p> <p>1/16/20 8:50 AM - During an interview, E15 (Activities Director) explained that most of the documentation found on the Activities Detail Report is entered by aides. At this time E15 confirmed that staff do work in the Activities Department every day.</p> <p>1/16/20 11:25 AM - During an interview E15 (Activities Director) confirmed that the surveyor was provided with all information pertaining to E49 and E67's activities for October through December 2019. E15 confirmed that the activity care plans are written by E15 and that the residents are to be offered activities that they prefer.</p> <p>3. The following was reviewed in R83's clinical record:</p> <p>10/18/19 - R83 was admitted to the facility.</p> <p>10/22/19 - An admission recreational evaluation documented that, "[R83] is alert and oriented, Resident is able to make his needs known. [R83] enjoys watching sports on television, working on jigsaw puzzles and listening to rhythm and blues on television. Resident also enjoys reading his</p>	F 679			

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F 679	<p>Continued From page 23</p> <p>bible. Staff will encourage resident to participate in group or individual activities of his choice."</p> <p>11/11/19 - 1/14/20 - Review of R83's Activities Detail Report documented that he was invited to a total of six group activities of which three he was unavailable and three he refused. It is documented that R83 was watching TV alone on 11/25/19 and 11/28/19 and that he received visits to deliver mail or newspapers on 12/18/19 and 1/4/20. Therefore of 63 days, activity staff only documented interaction with R83 on 10 days. (R83 was going to radiation therapy five day a week from admission through the first week in November.)</p> <p>12/4/19 - A significant change MDS documented that R83 had a BIMS of 15 (completely cognitively intact) and that it was very important to him to go outside when the weather was good and somewhat important to him to participate in religious services or practices, do things with people or groups, listen to music and have books and magazines to read, but not important to keep up with the news or be around animals.</p> <p>1/15/20 11:00 AM - Review of R83's care plan revealed a focus area/problem of, "[R83] enjoys activities such as watching sports with his room as preferred setting" with a goal of, "Will involve self in independent activities of choice and attend group activities as chooses." Interventions were to: encourage participation in group activities of interest; familiarize with center environment and activity programs on regular basis; gather information from patient and/or representative about past leisure likes/dislikes (resolved) and reassess as needed; and assist in planning and/or encourage to plan own leisure time</p>	F 679			

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F 679	Continued From page 24 activities.  1/13/20 1:30 PM - An observation was made of R83 resting in bed, awake with TV on, but no activity staff or items seen.  1/14/20 11:45 AM - During an interview, R83 stated that he does not get out of bed anymore because he lost the use of his legs and it hurts to get up into a wheelchair. R83 stated he does not remember any staff offering him books, magazines or puzzles or anything to do one on one activities in his room (such as card games) since he has been at the facility.  1/15/20 9:00 AM - An observation was made of E15 (Activity Director) going into R83's room and placing the facility's "Morning Bulletin" on his bedside table. E15 only said, "Good morning" to R83 then left the room (did not engage him in any conversation or offer any activity).  1/16/20 11:25 AM - During an interview E15 (Activities Director) confirmed that the surveyor was provided with all information pertaining to R83's activities for October 2019 through January 2020. E15 confirmed that the activity care plans are written by E15 and that the resident is to be offered activities that they prefer.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.	F 679			
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2)  §483.30 Physician Services	F 710		4/15/20	

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F 710	<p>Continued From page 25</p> <p>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.</p> <p>§483.30(a) Physician Supervision. The facility must ensure that-</p> <p>§483.30(a)(1) The medical care of each resident is supervised by a physician;</p> <p>§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 record review and interview it was determined that for one (R191) out of 32 residents in the investigative sample, the facility failed to ensure the medical care of the resident was supervised by the physician in the area of pressure ulcers. Findings include:</p> <p>The following was reviewed in R191's clinical record:</p> <p>12/18/19 - Nurses notes documented that R191 was admitted to the facility with two pressure ulcers and a recent leg amputation.</p> <p>12/19/19 - Review of the physician's history and physical lacked the presence of and assessment of the two pressure ulcers that R191 had on admission.</p> <p>12/30/19 - A progress note written by E9 (NP)</p>	F 710	<p>A Resident R191 was discharged from the facility; therefore no corrective action can be taken.</p> <p>B All residents have the potential to be affected by this deficient practice.</p> <p>Practitioners <input type="checkbox"/> progress notes written on all residents admitted within the past 30 days with a pressure ulcer and/or a recent amputation, will be audited by Team Health Physician <input type="checkbox"/>s Services or designee to ensure that the progress notes addresses the skin integrity status of the resident, as well as the care and treatment of the wound.</p> <p>C</p>		

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F 710	<p>Continued From page 26</p> <p>documented R191 would not allow a physical examination. The note did not acknowledge the presence of pressure ulcers being assessed and treated by nursing staff.</p> <p>1/2/20 - A progress note written by E9 (NP) documented R191 would not allow a physical examination. The note did not acknowledge the presence of pressure ulcers being assessed and treated by nursing staff.</p> <p>1/17/20 10:23 AM - An interview with E9 (NP) revealed that R191 would swat and hit E9 so that she could not do a full examination. E9 also revealed that the wound consultant visits the facility around 6 AM before she arrived so she has been unable to see the wound.</p> <p>1/17/20 10:35 AM - During an interview with E2 (DON), the lack of physician/NP assessment of the pressure ulcers was reviewed. No further information was provided.</p> <p>1/17/20 10:47 AM - A follow-up interview with E9 (NP) revealed that she had gone through her notes and found that there was nothing written about the wound. E9 stated that since R191 would not allow examination of the area she did not write anything about it. It was agreed that E9 could have evaluated the notes and assessments done by nursing to evaluate the care and treatment of the wounds.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.</p>	F 710	<p>A root cause analysis was completed, and it was determined that a medical practitioner did not utilize other available methods to evaluate the care and treatment of a resident's wounds, and effectively collaborate with the facility's wound nurse when a resident demonstrated resistive behaviors to having his/her wounds assessed by the practitioner.</p> <p>1. Each week after wound rounds, the medical practitioner will review wound documentation, and, meet with the facility's wound nurse to collaborate, and discuss the care, progress, and treatment for the wounds of residents who have demonstrated resistive behaviors to care. The medical practitioner will then include this information in his/her progress notes, at time of the visit.</p> <p>2. The facility's Medical Director will provide education to all current medical practitioners, as well as to any medical practitioner new to the facility, to ensure that their progress notes evaluates and addresses the care and treatment of the wounds, for resistive residents.</p> <p>D Team Health Physician's Services or designee will conduct audits x 4 weeks of medical practitioners' progress notes of 5 residents with wounds who are resistive to being assessed to ensure that their progress notes evaluates, and addresses the care and treatment of the wounds. Audits will continue monthly x 2 of 10</p>		

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F 710	Continued From page 27	F 710	residents, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)  §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.  §483.45(c)(5) The facility must develop and	F 756		4/15/20	

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F 756	<p>Continued From page 28</p> <p>maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to develop a policy that included time frames for the different steps of the monthly drug regimen review process, specifically a timeframe for physician response, failed to include steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Additionally, for one (R82) out of five residents reviewed for medication review the physician failed to document in the resident's medical record that the identified irregularity had been reviewed and what, if any, action has been taken to address the two irregularities identified by the pharmacist. Findings include:</p> <p>1. The facility policy entitled "Pharmacy Services: Consultant Monthly Drug Regimen Reviews" last revised on 11/28/17 with a "purpose to ensure medication reviews are conducted as required to meet the intent of both Federal and State guidelines" indicated that:</p> <ul style="list-style-type: none"> <li>- Charts will be reviewed at least monthly by consultant pharmacist.</li> <li>- Documentation will be made by Consultant Pharmacist on Drug Regimen Review (DRR).</li> <li>- Consultant Pharmacist will provide a report comprised of DRR findings requiring responses/action.</li> <li>- Individual pages will be generated and provided for any comments requiring physicians'</li> </ul>	F 756	<p>A</p> <p>1. No residents were identified as a result this deficient practice. No corrections are required.</p> <p>2. Resident R 82's irregularities were addressed in a progress note by the Certified Registered Nurse Practitioner on 1/20/2020. The resident will continue on his/her drug regimen. There was no adverse effect to the resident.</p> <p>B</p> <p>1. All resident have the potential to be affected, however none were identified and therefore no corrective action is required.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>Pharmacy consultation reports received within the past 30 days will be reviewed by Assistant Director of Nursing (ADON) or designee to ensure that there is clear evidence that the physician has addressed the pharmacist consultant recommendation. This audit will include a review that the practitioner has dated the form, and has indicated either an agree or disagree in the check box; followed by a</p>		

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F 756	<p>Continued From page 29 responses.</p> <ul style="list-style-type: none"> <li>- These individual pages will be provided to nursing administration along with report. Nursing will ensure that these individual pages requiring responses are addressed by the physician. After being addressed, action physician ordered will be taken.</li> <li>- Completed form with physician will be placed in section of chart with DRR.</li> <li>- If physician disagrees with Consultant Pharmacist suggestions, they are required to include an explanation as to why they disagree and sign, bottom of the form.</li> <li>- If physician disagrees, physician must write action taken and sign form informing physician of finding requiring response.</li> </ul> <p>During an interview on 1/16/20 at 8:50 AM with E3 (DON), it was confirmed that "there is no set time frame for physician response to pharmacist medication regimen reviews." During the same interview, E3 confirmed that the facility's policy on monthly drug regimen reviews did not explain the steps the pharmacist must take when an irregularity requiring urgent action is identified versus a non-urgent recommendation/suggestion.</p> <p>2. The following was reviewed in R82's clinical record:</p> <p>11/20/19 - The Consultant Pharmacist Report from the Monthly Medication Review (MMR) documented for R82 "please evaluate the benefit/risk of use for Haldol dose." The form contained space for written documentation and boxes to check "agree" or "disagree". All areas were blank. The ADON did initial the form and the NP did sign the form but did not date the signature.</p>	F 756	<p>progress note addressing the recommendation.</p> <p>C A root cause analysis was completed and it was determined that the Pharmacy Services: Consultant Monthly Drug Regimen Reviews Policy last revised on 11/28/17 did not include all required components; and, the consultation report response was not completed in its entirety.</p> <p>1. The Pharmacy Services: Consultant Monthly Drug Regimen Reviews Policy will be revised with the appropriate language and components. The revised policy will be reviewed at the next Quality Assurance meeting.</p> <p>2. Upon receipt the practitioner will indicate agree or disagree, then date and sign the form. If the practitioner agrees with the recommendation, and an order is needed, the practitioner will write the order on the pharmacy recommendation sheet, and present the sheet to the ADON on the same day, for the order to be initiated into the EMR. If the practitioner disagrees with the recommendation, the practitioner will document in a progress note the rational for the decline.</p> <p>2a. Pharmacy recommendations completed by practitioners will be taken to the morning clinical meeting on a weekly basis and reviewed by the ADON to ensure that the recommendations are completed and addressed entirely.</p>	

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F 756	<p>Continued From page 30</p> <p>12/11/19 - The Consultant Pharmacist Report documented for R82 "please evaluated the benefit/risk of use for Cogentin." The form contained space for written documentation and boxed to check "agree" or "disagree". All areas were blank. The ADON did initial the form and the NP did sign the form but did not date the signature.</p> <p>1/16/20 - Review of MD and NP notes lacked evidence that the benefit/risk of the use of Haldol and Cogentin was conducted. There was no evidence of what if any action would be taken and no documentation of the rationale if no change was to be made.</p> <p>1/16/20 10:52 AM - During an interview with E2 (DON), the above reports and notes were reviewed. There was no evidence that the physician / NP documented what if any action would be take based on the pharmacist recommendation.</p> <p>1/16/20 1:30 PM - During an interview with E9 (NP) about the response to the MMR, it was confirmed that there was no evidence that the MMR was addressed beyond signing the form. E9 did provide notes that she reviewed R82's medications during her visits but no evidence that the MMR was evaluated.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.</p>	F 756	<p>3. The medical practitioners, the pharmacist consultant, and licensed nurses will be educated by the SDM on the added components of the updated policy, as well as the process for addressing pharmacy recommendations. Any new practitioners, pharmacist consultants or licensed nurses hired thereafter will be educated on the added components and process.</p> <p>The Pharmacy Services: Consultant Monthly Drug Regimen Reviews Policy will be reviewed annually at the facility <input type="checkbox"/> QAPI meeting.</p> <p>D The Unit Managers or Designee will conduct audits x 4 weeks of 5 residents with pharmacy recommendations. This audit will include a review that the practitioner has dated the form, and has indicated either an agree or disagree in the check box; followed by a progress note addressing the recommendation until 100% compliance is achieved. Audits will continue monthly x 2, of 10 residents with pharmacy recommendations, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.</p>	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/15/20

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 31</p> <p><b>§483.80 Infection Control</b> 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.</p> <p><b>§483.80(a) Infection prevention and control program.</b> The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p><b>§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;</b></p> <p><b>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</b></p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p>	F 880		

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F 880	<p>Continued From page 32</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 observation, interview and review of facility policy and procedures, it was determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the transmission of communicable diseases and infections. A tour of the laundry facilities revealed the facility failed to prevent contamination of clean laundry and resident clothing. Additionally, the facility failed to review their Infection Prevention and Control</p>	F 880	<p>A</p> <p>1. No residents were identified as a result this deficient practice. The observed, inappropriately placed items were immediately removed from the clean laundry room.</p> <p>2. No residents were identified as a result this deficient practice. No corrections are required</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 33 Program (IPCP) yearly. Findings include:</p> <p>1. Laundry:</p> <p>1/14/20 - An observation of laundry rooms beginning at 1:15 PM revealed:</p> <p>a. Clean side of laundry (dryers): Four card board boxes filled with resident clothing were sitting directly on the floor. One box was labeled "Sierra", and another box was labeled "Seaside" (two of the facility's nursing units).</p> <p>b. Dirty side of laundry (washers): A pillow and a foam heel boot sitting on a shelf.</p> <p>1/14/20 1:40 PM - During an observational interview in the laundry area, E12 (Laundry aide) stated that the pillow and foam heel boot in the dirty side of the laundry had been washed and were drying, and that the card board boxes were full of clean resident clothes waiting to be returned to the residents.</p> <p>1/15/20 12:25 PM - During an observational interview in the laundry area, E13 (Environmental Services District Manager) confirmed that the above findings were against facility policy and she will provide staff education.</p> <p>2. Review of the facility's infection control program and QAPI notes provided by the facility it was determined that the facility had no evidence of a yearly review of their Infection Prevention and Control Program (IPCP).</p> <p>1/15/20 around 2:30 PM - An interview with E10 (staff education and infection control nurse) included reviewing the infection control data that</p>	F 880	<p>B</p> <p>1. All residents have the potential to be affected by this deficient practice however none have been identified.</p> <p>2. All residents have the potential to be affected by this deficient practice, however none were identified. The facility will incorporate a review of the required yearly Infection Prevention and Control Program (IPCP) at the next scheduled QAPI meeting.</p> <p>C</p> <p>A root cause analysis was completed and it was determined that the facility laundry staff did not adhere to the facility's infection control policy regarding storage of residents' belongings; and did not consistently conduct the required annual review of its IPCP program.</p> <p>1. The Director of Environmental Services will provide education to all environmental services staff of the correct infection control practices, with emphasis on the appropriate storage of residents' belongings. This education will also be provided to all new environmental services staff during their orientation period.</p> <p>2. The IPCP yearly review will be placed on the agenda to be reviewed annually at the facility's QAPI meeting.</p> <p>The IPCP will be reviewed annually at the facility's QAPI meeting.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 34 was evaluated monthly and revealed no collective yearly review was completed. E10 stated that he had only been doing the infection control data for a few months.  1/15/20 3:00 PM - An interview with E1 (NHA) in the presence of E3 (NHA) and E4 (corporate nurse) revealed that policies are revised as standards change. The program including policy and procedures would be reviewed as part of QA. A short time later, E1 provided notes from the QA meeting where the policy and procedures were reviewed however there was no mention of an evaluation of the IPCP program.  1/15/20 4:32 PM - An interview with E1 and E2 (DON) revealed the need to provide evidence that the IPCP is reviewed yearly.  1/17/20 8:33 AM - An interview with E2 and E10 revealed that the year of IPCP data was reviewed in the 1/8/20 QAPI meeting and the policy and procedures were reviewed with no changes. There was no evidence of how the IPCP program and a year of data were discussion. E2 stated that it was the middle of January and they have not had time to analyze the data. The surveyor stated that the review of the 2018 IPCP program could be provided for review. As of 1/21/20 at 4:00 PM the information had not been provided.  Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.	F 880	D The Director of Environmental Services will conduct daily audits x4 weeks of the status of the laundry room to ensure that there is no contamination of clean laundry or resident clothing until 100% compliance is achieved. Audits will continue monthly x 2 three times per week, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		4/15/20	

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F 883	<p>Continued From page 35</p> <p>§483.80(d) Influenza and pneumococcal immunizations</p> <p>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has</p>	F 883		

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F 883	<p>Continued From page 36 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure for two (R106 and R110) out of six sampled residents for immunization review that the resident was offered and had the opportunity to refuse or receive an influenza vaccination in the fall of 2019. Findings include:  11/28/16 - Facility policy entitled Influenza Vaccination documented the procedure: "Resident's and/or resident's representative will be provided with written education regarding the benefits and potential side effects of the vaccine at the time of offering. The immunization consent will be reviewed and signed as per the resident's choice to accept or decline the immunization. If the resident and/or resident's representative gives consent for the vaccine, it will be administered as ordered by the physician. If the resident and/or resident's representative declines the vaccine, the reason will be documented on the consent form [Pneumococcal and Influenza Vaccination Consent form]. The medical record must include</p>	F 883	<p>A Resident R106 was educated on the risk versus benefits of refusing the influenza vaccine on 1/15/20. There was no adverse effect to this resident  Resident R110 was educated on the risk versus benefits of refusing the influenza vaccine on 1/15/20. There was no adverse effect to this resident  B All residents have the potential to be affected by this deficient practice.  An audit will be completed by the Infection Practitioner of all residents within the facility, to determine if all residents had the opportunity to refuse or receive the influenza vaccine.  C A root cause analysis was conducted and</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>PINNACLE REHABILITATION &amp; HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3034 SOUTH DUPONT BLVD</b> <b>SMYRNA, DE 19977</b>		
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F 883	<p>Continued From page 37</p> <p>the education provided to the resident / legal representative regarding the benefits and potential side effects of the vaccine, signed consent or declination of the vaccine as well as the signed consent form..."</p> <p>1. Review of R106's clinical record revealed:</p> <p>12/12/18 - R106 was admitted to facility.</p> <p>9/18/19 - A quarterly MDS assessment documented that R106 had a BIMS of 15 (cognitively intact).</p> <p>12/19/19 - An annual MDS assessment documented that R106 had a BIMS of 15 (cognitively intact).</p> <p>1/15/20 2:00 PM - Review of R106's medical record found no evidence of the resident's influenza vaccine status for the fall of 2019. This information was requested from E2 (DON).</p> <p>1/16/20 1:30 PM - During an interview, E2 (DON) stated that R106 is alert and oriented and had refused the influenza vaccine on 11/15/19, but there was no documentation at that time that the resident was educated of the benefits and potential side effects of the vaccine.</p> <p>2. Review of R110's clinical record revealed:</p> <p>6/28/18 - R110 was admitted to facility.</p> <p>9/19/19 - A quarterly MDS assessment documented that R110 had a BIMS of 14 (cognitively intact).</p> <p>12/20/19 - A quarterly MDS assessment</p>	F 883	<p>it was determined that there was no process in place to track residents who did not immediately received the influenza vaccine when first offered. The facility staff did initially address/offer the influenza vaccine, however, did not follow up with the residents when they were indecisive about receiving the influenza vaccine.</p> <p>1. All residents' influenza status will be entered on the immunizations portal in the facility's electronic medical record. During the influenza season (October-March), the facility's IP or designee will conduct a weekly review during the weekly risk meeting to capture residents that may have declined or those residents that do not reflect receiving the vaccine. The facility's IP or designee will follow up to ensure that risk versus benefit education has been provided, with the supporting documentation reflected in the medical record.</p> <p>2. The facility's SDM will educate all licensed nurses on the importance of offering all residents the influenza vaccine unless contraindicated, entering the information in the EMR's immunizations tab, and documenting education upon refusal. This education will be incorporated in new employee orientation.</p> <p>D The IP or Designee will conduct weekly audits x 4 weeks of 5 residents influenza immunization status, until 100% compliance is achieved. Audits will</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINNACLE REHABILITATION &amp; HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3034 SOUTH DUPONT BLVD</b> <b>SMYRNA, DE 19977</b>		
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F 883	<p>Continued From page 38</p> <p>documented that R110 had a BIMS of 14 (cognitively intact).</p> <p>1/15/20 2:00 PM - Review of R110's medical record found no evidence of the resident's influenza vaccine status for the fall of 2019. This information was requested from E2 (DON).</p> <p>1/16/20 1:30 PM - During an interview, E2 (DON) stated that R106 is alert and oriented and had refused the influenza vaccine on 1/15/20, but there was no documentation of the influenza vaccine being offered prior to 1/15/20.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E4 (NHA) and E5 (Corporate Nurse) during the exit conference beginning at approximately 3:00 PM on 1/17/20.</p>	F 883	<p>continue monthly x 2 of 5 residents, until 100% compliance is achieved and sustained. Findings will be reviewed in the QAPI meetings monthly x 3 months.</p>		



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**STATE SURVEY REPORT**

**NAME OF FACILITY:** Pinnacle Rehabilitation and Health Center **DATE SURVEY COMPLETED:** January 17, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual and complaint survey was conducted at this facility from January 12, 2020 through January 17, 2020. The facility census the first day of the survey was 146. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed January 17, 2020: F552, F641, F655, F656, F657, F676, F679, F710, F756, F880 and F883.</p>	<p>Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>This plan represents the facility's credible allegation of compliance as of 4/15/20.</p> <p>Cross Refer to the CMS 2567-L survey completed January 17, 2020: F552, F641, F655, F656, F657, F676, F679, F710, F756, F880 and F883.</p>	<p>4/15/20</p>
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Provider's Signature

*Juliet Dunbar* Title NHA

Date

2/26/2020