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

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

STATE SURVEY REPORT

NAME OF FACILITY: Willowbrooke Court at Manor House **DATE SURVEY COMPLETED: November 5, 2021**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from November 1, 2021 through November 5, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 36. The number of sampled residents with investigative areas totaled 24 (twenty-four) residents.		
3201.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed November 1, 2021: F550, F585, F636,		

Provider's Signature _____ Title _____ Date _____

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	F656, F657, F684, F688, F689, F695, F756, F758, F812, F842, F849, F880.		

Provider's Signature _____ Title _____ Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085009	A. BUILDING _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SKILLED CENTER AT MANOR HOUSE	1001 MIDDLEFORD ROAD SEAFORD, DE 19973

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from November 1, 2021 through November 5, 2021. The facility census was 36 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by the Division of Health Care Quality, Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS Unannounced annual and complaint survesy were conducted at this facility from November 1, 2021 through November 5, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 36. The number of sampled residents with investigative areas totaled 24 (twenty-four) residents. Abbreviations used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN- Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; SW - Social Worker.	F 000		

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

Electronically Signed | 11/30/2021

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

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F 000	Continued From page 1 Definitions used in this report are as follows: Allopurinal - medicine for gout; CDI (Clostridium Difficile Infection) - intestinal infection causing severe loose stools that is easily spread; Contact Isolation - method used to prevent the spread of infection; eMAR - electronic Medication Administration Record; Gout - inflammation/swelling of the joints caused by uric acid crystals in the joint; Magnesium - supplement that affects muscles; Uric acid - blood test for gout.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		12/24/21

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F 550	Continued From page 2 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide meal service in a dignified manner for 18 randomly observed residents in the Magnolia Dining Room, as evidenced by serving staff wearing disposable gloves to serve resident meals. Findings include: 11/1/21 12:12 PM - During a random lunch observation in the Magnolia Dining Room, serving staff were seen wearing gloves while serving residents their lunch meals. 11/2/21 12:31 PM - A random observation of 18 residents during lunch in the Magnolia Dining Room revealed the servers were wearing vinyl gloves while serving residents. An interview immediately following the observation with E8 (server) stated the facility policy included wearing	F 550	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. F550 Resident Rights and Dignity 1. Staff who assist with the delivery of meal service were re-educated by the staff educator regarding residents rights specific to dignity and not wearing plastic gloves while serving resident meals. 2. The dietary manager will complete a random audit and observe staff serving	

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F 550	Continued From page 3 gloves to serve and changing gloves between tables and hand hygiene with glove changes. 11/3/21 8:21 AM - A random observation of 12 residents during the breakfast meal in the Magnolia Dining Room revealed that serving staff were wearing gloves while serving breakfast to the residents. 11/3/21 12:45 PM - A review of the corporate policy for meal service (ACTS M-02.1), updated 5/2000, did not include wearing gloves for resident meal service as E8 suggested. 11/3/21 2:44 PM - During an interview with E7 (Nutrition Services Manger), she stated that she thought the servers were supposed to be wearing gloves to serve meals. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 550	meals. If the improper use of gloves are noted immediate re-education will occur. 3. The staff educator will re-educate staff who serve meals were re-educated on Residents Rights and Dignity and the facility meal service policy. 4. The Dietary Manager or QAPI designee will complete an audit monitoring that no staff utilize gloves during meal delivery service. The audit will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		12/24/21

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F 585	Continued From page 4 facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for	F 585		

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F 585	Continued From page 5 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585		

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F 585	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policies and procedures it was determined that the facility failed to ensure the policy and postings included the process to file a grievance anonymously and/or identifying the Grievance Official. Findings include: Review of a facility policy entitled Grievance Report (revised October 2017) revealed that, although the policy contained a statement that "A grievance may be filed anonymously", the process for how to file a grievance anonymously was not described. 11/5/21 at 10:15 AM - During an observational interview, E1 (NHA) confirmed that the posting entitled Filing a Grievance Report, did not include the Grievance Officials name and contact information or how to file a grievance anonymously. The postings were available for resident and responsible party/family viewing. Findings were reviewed with E1 and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 585	1. November 5, 2021, the facility immediately updated the proper placement of the Grievance binder, policy and contact information. The binder was prominently placed in each of the two resident living areas within WillowBrooke Court during the survey. 2. An audit of each wing was completed on 11/09/2021 by the Nursing Home Administrator. The two resident living areas were found to have the required grievance posting. 3. The Social Worker has been educated by the Nursing Home Administrator on the federal requirement of the Grievance Process and is now responsible its updates. An In-service will be conducted by the staff educator related to the federal requirement of the Grievance Process, the ability to file a grievance anonymously, the location at each resident living area and Acts Grievance Policy. The new grievance will be reviewed at the next scheduled resident council meeting. 4. The Social Worker or QAPI designee will complete an audit to ensure that the proper signage for grievance binder, policy is located on each resident living area of WillowBrooke Court. The audit will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		12/24/21

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F 636	Continued From page 7 §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with	F 636		

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F 636	Continued From page 8 licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for two (R15 and R28) out of thirteen (13) active residents sampled for an investigation of a care area, the facility failed to ensure the Admission MDS assessments were accurate. Findings include: 1. Review of R15's clinical record revealed: 8/27/21 - R15 was admitted to the facility under [name of Hospice] services. Hospice is a service that provides care to terminally ill residents. The Admission MDS assessment incorrectly documented R15's prognosis. The question "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months" was answered "No."	F 636	1. R15 and R28 were not adversely effected. The MDS coordinator updated both assessments at the time of the survey. 2. An audit of all hospice residents was completed by the MDS coordinator/designee to ensure the MDS accurately reflected the correct life expectancy. An audit of all residents triggering in the MDS for anticoagulant usage was completed. This audit was verified to corresponding physician□s order to ensure the MDS accurately reflects physician ordered anticoagulant therapy. 3. The Nurse Educator/ QAPI designee will educate the previous MDS Nurse on the necessity of accurate MDS coding	

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F 636	Continued From page 9 11/4/21 at 12:38 PM - During an interview with E1 (NHA) and E2 (DON), the Surveyor reviewed the MDS error and E1 stated she would look into it since the MDS Nurse worked the evening before. 2. Review of R28's clinical record revealed: 9/29/21 - R28 was admitted to the facility after having a stroke. 10/5/21 - The Admission MDS assessment documented that R28 received six doses of an anticoagulant (blood thinner) during the seven day look-back period. September - October 2021 - Review of physician orders and eMARs (electronic Medication Administration Record) revealed that R28 was never ordered or received an anticoagulant. 11/4/21 at 12:38 PM - During an interview with E1 (NHA) and E2 (DON), the Surveyor reviewed the MDS error and E1 stated she would look into it. 11/5/21 at 11:30 AM - The facility provided no additional information. Findings were reviewed with E1 and E2 during the exit conference on 11/5/21, beginning at 12:00 PM. During the exit conference, E2 stated the MDS assessments had been modified and the errors were fixed.	F 636	related to Hospice life expectancy and anticoagulant therapy. 4. The ADON or QAPI designee will complete an audit to ensure that the MDS coding of life expectancy on hospice residents and residents on anticoagulant therapy is accurate. This audit will be completed once daily for a week then twice weekly times one month then twice monthly times three months. The findings from the audits will be documented, reviewed, and submitted to the monthly QAPI committee for further review and any additional action if identified. If at the end of the three months, the committee is confident that the deficiency is resolved, the monitoring activity will be concluded, and any audits will be random thereafter.	
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	F 657		12/24/21

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F 657	Continued From page 10 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for one (R15) out of thirteen (13) active residents investigated for a care area, the facility failed to ensure that the required interdisciplinary team members including the Physician and Nurse's Aide, attended or provided input for development of the comprehensive person-centered care plan. Findings include: Review of R15's clinical record revealed: 8/27/21 - R15 was admitted to the facility.	F 657	1. R15 was not adversely affected. The resident no longer remains at the facility. 2. A facility wide review and audit was completed by the Social Service Coordinator of resident careplans which were scheduled over the past month. Each careplan meeting attendance sheet was reviewed to verify interdisciplinary participation occurred. 3. The NHA/QAPI designee re-educated Interdisciplinary Directors to the Acts careplan process and interdisciplinary	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 9/9/21 1:33 PM - A Care Conference Note documented that the "spouse and two sons were invited and did join via telephone, [name of Hospice] spoke with the family and staff prior to care plan ... She is on hospice due to her current diagnosis." 11/4/21 at 9:28 AM - During an interview, E14 (RN) stated that she asked the aides before the meeting. After the Surveyor commented that the regulation included those attending or providing input to the care plan, E14 said that she should document that they (CNA's) provided information. 11/4/21 at 10:02 AM - During an interview with E9 (SW), the Surveyor asked who attended the care conference since the Care Conference Note did not identify who attended or provided input to the development of the care plan. E9 stated that, besides herself, E10 (Activities) and a Nurse. E9 added that someone from Dietary would call in as needed. When asked if the Physician or CNA attended, E9 indicated that the CNA might be called in to the meeting, but the physician did not attend the care conferences. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 657	approach, highlighting who must be invited and in attendance. 4. The Social Service Worker/QAPI designee will complete an audit to ensure that all interdisciplinary team members related to residents POC are invited to each resident care conference. The audits will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		12/24/21

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F 684	Continued From page 12 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that, for two (R3 and R28) out of thirteen (13) active residents sampled for an investigation of a care area, the facility failed to follow physician orders. Findings include: 1A. Review of R3's clinical record revealed: 4/21/21 - R3 was admitted to the facility with a diagnosis of a stroke. 4/22/21 - A review of R3's care plan revealed the resident had an intervention for no straws. 4/22/21 - A physician order was written for aspiration precautions (measures to prevent liquid/food from entering the lungs), including no straws. 5/1/21 - Review of R3's diagnoses revealed that she had dysphagia (trouble swallowing). 10/27/21 - A review of R3's quarterly MDS assessment revealed choking when drinking liquids. 11/1/21 11:20 AM - An observation revealed that R3 had a water cup in her room without a straw. R3 stated she needs a straw to drink, but someone had taken it out to use it for something else. 11/2/21 9:00 AM - A random observation revealed	F 684	1. R3 was not adversely affected. The resident was screened by SLP, and the aspirations precautions were discontinued as resident deemed safe for the use of straws. 2. A facility wide review and audit was performed by the MDS Coordinator on residents within facility that require swallowing strategies/aspiration precautions related to dysphagia, to ensure strategies are outlined in resident charts for clinical staff to follow directive as per set POC. 3. The staff educator/designee will complete re-education with clinical staff related to the importance of swallowing strategies/aspirations precautions in resident□s plan of care and where they are in resident chart and point of care. 4. The ADON/QAPI designee will complete an audit to ensure the swallowing strategies/aspiration precautions are being followed as per POC. The audits will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review. 1. R28 was not adversely affected. 2. A facility wide review and audit was performed by the ADON/designee, on residents within facility and current bowel	

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F 684	Continued From page 13 that there was a straw in R3's water cup in the resident's room. 11/2/21 9:15 AM - An interview with E5 (RN) confirmed that the resident was not supposed to have straws in her drinks because of swallowing precautions and stated she would remove it. 1B. A review of R3's clinical record revealed: Cross refer F756 9/9/21 - E11 (MD) ordered a blood test for uric acid. 11/3/21 - A review of lab orders and blood test results revealed no evidence that uric acid levels were obtained over the previous six months. 11/3/21 4:00 PM - A review of physician orders revealed that E12 (RN) received a telephone order from E11 (MD) for magnesium and uric acid levels to be drawn on 11/4/21 and then repeated every six months. 11/4/21 9:30 AM - E11 confirmed in an interview that the facility called him on 11/3/21 to obtain orders for magnesium (which had previously been recommended by the pharmacist) and uric acid levels. 11/4/21 10:47 AM - Lab results revealed that R3's uric acid level was 3.1 (normal range 2.6 - 6.0) and magnesium level was 3.0 (normal range 1.6-2.6). 11/4/21 - E11 (MD) discontinued the magnesium supplement.	F 684	protocol usage. No other identified inconsistency was identified. 3. The staff educator completed re-education to licensed professional nursing staff related to Acts bowel protocol and the notification to the physician if an inconsistency is found has occurred. 4. The ADON /QAPI designee will complete an audit to ensure the bowel protocol policy is followed and that the physician is notified when inconsistencies occur. This audit will be completed once daily for a week then twice weekly times one month then twice monthly for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	

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F 684	Continued From page 14 2. Review of R28's clinical record revealed: 9/29/21 - R28 was admitted to the facility after having a stroke. 9/30/21 - The Physicians' Orders included Milk of Magnesia (MOM - a laxative) to be given for constipation if no bowel movement (BM) for three days. September - November 2021 - Review of CNA documentation and the eMAR revealed: - October 16: medium BM on day shift. - October 17, 18, 19: no BM. - October 20: MOM not administered after three days without a BM. - October 21: MOM administered at 8:19 PM. The Physicians' Order was not followed since R28 did not receive MOM until she had gone four days without a BM. 11/4/21 at 12:38 PM - During an interview with E1 (NHA) and E2 (DON), the Surveyor reviewed the BM information and asked if BMs could have been written elsewhere, like on a bowel protocol sheet. 11/5/21 at 11:30 AM - No additional BM information for R28 was provided by the facility. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		12/24/21

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F 688	Continued From page 15 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that, for one (R15) out of one resident investigated for position/mobility, the facility failed to implement care and services to prevent a further reduction of range of motion. Findings include: Review of R15's clinical record revealed: 8/27/21 - R15 was admitted to the facility with multiple diagnoses including, Multiple Sclerosis (nervous system disease that affects the brain and spinal cord), left hand contracture (joint with fixed resistance to passive stretch of a muscle and cannot straighten) and bilateral foot drop (inability to lift the front of both feet). 10/5/21 - Review of Range of Motion (ROM) measurements completed by Therapy revealed that R15 had moderate impairment (contracture)	F 688	1. R15 was initially screened and later evaluated by occupational therapy to assess resident□s limited joint mobility. 2. A facility wide review and audit was performed by the Director of therapy and MDS Coordinator of past sixty (60) day admissions. This review will identify those residents admitted with limited joint mobility and that they are screened by therapy. This audit will also review that any recommendation is timely careplanned and placed in the CNA Point of Care task list. 3. The Director of Therapy and MDS Coordinator will complete re-education with clinical and therapy staff related to identification of residents identified to have limited joint mobility and if recommendations are made that they are timely careplanned and placed in the CNA	

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F 688	Continued From page 16 of her left elbow, left wrist, left fingers, left hip, left knee and both ankles. Recommendations included Passive ROM (extent to which a joint can be moved or straightened safely with/by staff) to upper and lower extremities for 15 minutes twice a day. 10/30/21 - A care plan was developed for having visible changes in joint mobility [contractures] with the intervention to perform PROM to arms and legs on both sides for 15 minutes twice a day. October 2021 - Review of CNA documentation revealed the task to perform PROM was not added until 10/30/21, 25 days after the Therapy recommendation. 11/3/21 at 4:15 PM - An interview with E17 (Hospice Case Manager) revealed that R15 was still on Hospice Services and that Therapy (Physical, Occupational or Speech Therapy) was not covered and that ROM would need to be completed by nursing staff. 11/4/21 at approximately 8:54 AM - During an interview, when asked if R15 had done ROM, E13 (CNA) said that R15 "Just came off of hospice" and added that "It hurts her when I open her hand." Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 688	Point of Care task list. 4. The Therapy Director/designee will complete an audit to ensure any newly admitted resident who is noted with limited joint mobility have interventions in place as per therapy recommendations and the tasks are implemented timely. The audits will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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F 689	Continued From page 17 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for one (R9) out of two sampled residents reviewed for accidents, the facility failed to ensure the resident's environment remained as free of accident hazards as was possible. For R9, an unsafe transfer was performed using a Sit-to-Stand mechanical lift with only one CNA as opposed to a Hoyer Lift (full body mechanical lift) with two CNA's per R9's plan of care, resulting in a fracture of R9's left leg. The unsafe transfer caused R9 harm. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey for F689, the specific regulatory requirement, the deficiency was determined to be past non-compliance. Findings include: A facility policy entitled "Lift/Transferring/Repositioning Resident Safely" (last revised 12/2018), included: a. Adhere to the designated lifting / transferring / repositioning technique per assignment. b. CNA's may always choose to use more help than assigned, but never less. c. Report any unsafe acts ... d. Two employees will always be available when using a lift for residents who have no weight bearing ability and cannot provide assistance or balance.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 18	F 689		

The following was reviewed in R9's clinical record:

5/8/15 - R9 was admitted to the facility with dementia.

12/27/18 - Review of the physical therapy plan of care documentation recommended that since R9 remained dependent and was an assist of two facility staff for transfers, the physician's order must remain that R9 continue to be transferred by a Hoyer lift and for the resident's care plan intervention to reflect a Hoyer transfer as well.

9/29/19 and 12/29/19 - A quarterly and significant change MDS assessment (respectively prior to the 1/14/20 incident) documented that R9 was cognitively impaired, dependent with the assist of two staff for transfers and had not walked or moved from a seated to a standing position. R9's care plan reflected the MDS documentation to use a mechanical lift for transfers with the assist of two staff.

1/14/20 11:19 PM - A progress note documented "Resident (R9) complain(ed) of pain on her left leg. Was medicated with as needed Tylenol."

1/17/20 8:00 AM - A nursing progress note documented "c/o (complained of) left knee pain, swelling present, ice applied."

1/17/20 8:06 AM - A nursing progress note included, "CNA reported to this nurse change of condition in resident. Swelling to left knee measuring 49 cm and right knee measuring 43 cm (centimeters) ...waiting to notify provider for further assessment."

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F 689	Continued From page 19 1/19/20 9:43 AM - A nursing progress note documented "Bilateral (both) knees are swollen. Resident denies any pain or discomfort at present time. She is oob (out of bed) to wheelchair. For last 2 days her left leg has been 'floppy' below her left knee. NP (Nurse Practitioner) saw resident on Friday [1/17/20] and ordered ice. Will continue to monitor." 1/20/20 9:53 AM - A nursing progress note documented "For the last 3 days her left leg has been floppy. E11 (MD) in to see her this morning." 1/20/20 10:19 AM - A nursing progress note documented "[X-ray company] in to do x-ray to the left knee." 1/20/20 4:22 PM - A nursing progress note included, "E11 (MD) called and made aware of the left knee XR (x-ray) and ordered for the resident to be sent to the ER (Emergency Room) for evaluation." 1/20/20 7:47 PM- A nursing progress note documented "Received a call from ER (name of Emergency Nurse - SS1), resident will be sent back with DX (diagnosis of) left knee fracture." The facility's investigation report and supporting documents revealed the following: -1/21/20 11:33 AM - A complaint report to the State Agency included, "The resident started on Thursday 1/16/20 with some swelling to knee. No pain or discoloration. The nurse practitioner examined on Friday 1/17/20 and ordered ice. Swelling increased over the weekend and the physician ordered an x-ray and lab work... X-ray	F 689		

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F 689	Continued From page 20 shows...left knee fracture." - 1/21/20 (untimed) - E15's (CNA) initial statement stated, "On Monday Jan (January) 13, I worked half of day for E31 (CNA) 11 AM - 3 PM. Noticed nothing on (R9). I worked Tuesday (1/14/21) 7 AM - 3 PM. I gave (R9) a shower. I did not work Jan. 15 or 16 th. I was back on the 17th of Jan., but we worked with six, so I didn't have her (R9) in my group." - 1/22/20 (untimed) - E16's (CNA) Statement stated, "On Tuesday (1/14/21) we heard a call over the 'walkie' that someone needed help in the shower room. It was E15 (CNA). She had R9 on the sit to stand (lift) and R9 was coming down (about to fall), so (E15) asked me to help her get her (R9) in the chair. So I grabbed R9 by the seat of her pants and we pulled her back in her chair. E15 was saying at least she did not fall." - 1/23/20 - E15's (CNA) second statement (after E16's statement) stated, "On Jan (January) 14, 2020 R9 was not in my group, but the aide on the end E18 (CNA) was struggling so I gave her a shower for her. I did Hoyer (a mechanical lift) her into shower chair and proceeded into shower to give her a shower. R9 had a large loose BM (bowel movement) so I was trying to clean her up. I couldn't get her bottom good, so I did use the sit to stand lift to clean her bottom well. While on the sit to stand, resident's foot slipped. I was holding on to her. I did not let her fall. I used my walkie-talkie to call for help. E16 (CNA) came and we got her back in her chair. I asked R9 if she had pain. She said no. I did not report this to the nurse because she did not fall or hit the floor." After the facility became aware of the witness statement (written by E16) and gained knowledge	F 689		

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F 689	Continued From page 21 of the improper/unsafe transfer (using the wrong lift and being alone), E15 was immediately suspended pending the incident investigation. 1/28/20 - E15 was terminated from the facility based on results of the investigation for serious misconduct and neglect of a resident's safety. 11/3/21 10:35 AM - During an observation and interview of R9's transfer to her wheelchair, 2 CNA's completed the correct transfer for R9 and reported that they found the transfer status of all residents in the CNA documentation. 11/4/21 at approximately 2:30 PM - During an interview with E1 (NHA), findings were reviewed. The facility confirmed that an unsafe transfer with the improper lift was performed by E15 (CNA) resulting in a left leg fracture above the knee. E1 showed that the facility conducted a thorough investigation, identified the failure, and immediately initiated a Performance Improvement Plan with multiple interventions as evidenced by the facility referenced sign-in sheets, including the following: 1. A review of all resident transfer status' with therapy and nursing was completed by 1/30/20. 2. Education was provided and content was signed off by employees to ensure patient safety during mechanical lift transfers was completed by 1/30/20, as dated on the inservice sheets. 3. All resident's transfer status' were reviewed to ensure they were correct and available in the computer for nursing, including CNA documentation by 1/30/21. Based on review of the aforementioned facility corrective actions, it was determined that the facility regained substantial compliance with F689	F 689		

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F 689	Continued From page 22 on 1/30/20. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy and procedure, it was determined that for two (R25 and R337) out of two residents reviewed for respiratory care, the facility failed to provide respiratory care consistent with professional standards of practice. Findings include: A facility policy entitled Use and Care of Equipment (last revised 11/20) included, "Nasal cannulas ...which are used to deliver oxygen ...should be dated when changed." 1. 11/1/21 1:39 PM - During an observation and interview it was noted that R337's oxygen tubing did not have a date on it. This was confirmed by E29 (LPN). 2. 11/2/21 12:26 PM - During an observation and	F 695	1. R337 and R25 were not adversely affected by this practice. The tubing was discarded at the time of the survey and new dated and labeled tubing was applied. 2. ADON/QAPI designee will complete an audit of residents who are ordered respiratory therapy to ensure all tubing or oxygen tank is correctly dated and labeled. 3. The staff educator/QAPI designee will complete re-education with clinical staff related to the Acts policy on the specific Use and Care of Respiratory Equipment highlighting the need to properly label and document the tubing when applied. 4. The DON/ QAPI designee will complete an audit on current residents receiving respiratory treatments/therapy to	12/24/21

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F 695	Continued From page 23 interview it was noted that R25's oxygen tubing on a portable oxygen tank did not have a date on it. This was confirmed by E5 (RN). E5 stated that they usually date the tubing when it is changed. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 695	ensure that all tubing is labeled and dated correctly. This audit will be completed once daily for a week then twice weekly times one month then twice monthly times three months. The audits shall be conducted for 3 months or longer if deemed appropriate by the IDT.	
F 756 SS=D	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	F 756		12/24/21

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F 756	Continued From page 24 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for two (R2 and R3) out of five residents reviewed for unnecessary medications, the facility failed to ensure that irregularities identified by the pharmacist were reviewed by the physician in a timely manner and/or include a response. Additionally, the facility's drug review policy did not include the time frame for the pharmacist to provide the facility with results of the drug reviews. Findings include: 1. Review of the facility policy entitled Pharmacy Services (dated 7/2018) stated, "The licensed pharmacist will conduct a monthly medication regime review ... Irregularities noted by the pharmacist during the review will be documented on a separate, written report ... The report will be reported to the attending physician, community's medical director and the director of nursing. These reports must be acted upon monthly or within the states (sic) physician visit guidelines. Any irregularities that require urgent action will be promptly reported to the attending physician and director of nursing by fax, email or phone by the consultant pharmacist. The attending physician must document in the resident's record that the identified irregularity has been reviewed, and	F 756	1. R2 & R3 pharmacy recommendations were reviewed by the medical director at the time of the survey. The recommendations were completed. R2 had no adverse effect. R3 had no adverse effect. 2. The ADON/designee completed an audit of the pharmacy consultant recommendations for the last 60 days. Review that timely follow up by was completed by the medical provider. 3. The NHA completed re-education to the licensed nursing professionals and the medical providers regarding the facility policy on timely completion of pharmacy recommendations. 4. The DON/QAPI designee will complete an audit of pharmacy recommendations will be complete an audit to ensure all recommendations are addressed timely and completed by the medical provider. The audits will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	

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F 756	Continued From page 25 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 the rationale in the health record." The policy did not specify the time frame for the pharmacist to report non-urgent irregularities to the facility. 2. Review of R2's clinical record revealed: 3/8/21 - The Pharmacist recommended to increase the dose of Carello (blood thinner). The Pharmacy Consultation Report was signed by E11 (MD) on 9/20/21, six months after the irregularity was identified. E11 did not indicate a response. 5/9/21 - The Pharmacist recommended to start a Vitamin D supplement twice a day. E11 signed the report on 9/20/21, four months after the pharmacy review. E11 did not indicate a response. 3. Review of R3's clinical record revealed: 4/21/21 - R3 was admitted to the facility after a stroke. 4/22/21 - Physicians' Orders included Allopurinol for the treatment of gout (joint pain, especially in the feet) and Magnesium as a supplement. 6/6/21 - A Pharmacy Consultation Report suggested that R3 have two blood tests (magnesium and uric acid) on the next blood test day and repeat every six months since R3 was receiving Magnesium and Allopurinol. There was no evidence in R3's record that these tests were	F 756		

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F 756	Continued From page 26 acknowledged by the physician. July 2021 - August 2021 - No Pharmacist recommendations were made although the June 2021 recommendations were not reviewed. 9/3/21 - The Pharmacist recommended for the second time, that a uric acid level be obtained. E11 (MD) signed and accepted the recommendation on 9/9/21, approximately three months after it was first recommended by the Pharmacist. 11/3/21 4:00 PM - A review of physician orders revealed that E12 (RN) received a telephone order from E11 (MD) for magnesium and uric acid levels to be drawn on 11/4/21 and then repeated every six months; approximately five months after it was first recommended by the Pharmacist. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		12/24/21

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F 758	Continued From page 27 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for two (R22 and R25) out of five residents reviewed for unnecessary medications,	F 758	1. R22 and R25 were not adversely affected. 2. The MDS Coordinator completed a	

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F 758	Continued From page 28 the facility failed to have evidence of a duration period for an as needed antianxiety medication. Findings include: 1. The following was reviewed in R22's clinical record: 6/14/21 - R22 was admitted to the facility with dementia. 8/18/21 - A physician's order included: Ativan 0.5 mg (an antianxiety medication) every 6 hours as needed for anxiety for 14 days. 8/25/21 - Although a psychological progress note documented to continue R22's Ativan past the 14 days related to anxiety, there was no duration or stop date. 9/5/21 - A physician's order included: Ativan 0.5 mg every 12 hours as needed for agitation. 9/8/21 - A physician's order included: Ativan 0.25 mg every 6 hours as needed for agitation. The order was in place 22 days during the month of September 2021 and 31 days in October. This order should have been re-evaluated and either discontinued or a rationale should have been given to continue the medication with a duration/stop date on 9/22/21. 2. The following was reviewed in R25's clinical record: 1/13/15 - R25 was admitted to the facility with dementia. 8/4/21 18:15 - A physician's order included: Ativan 0.5 mg every 4 hours as needed for anxiety,	F 758	facility wide review and audit of PRN psychotropic medications to assess for duration period on drug order is in place, and that there was supporting documentation if order was deemed to need to continue after initial 14 day period. 3. The staff educator or QAPI designee will complete re-education with clinical nursing staff (RN/LPN) related to need for stop date of 14 days with all PRN psychotropic medications. 4. The ADON or QAPI designee will complete an audit to ensure that any new PRN psychotropic medication orders have a set duration for stop/need for review after 14 days. This audit will be completed once daily for a week then twice weekly times one month then twice monthly times three months. The findings from the audits will be documented, reviewed, and submitted to the monthly QAPI committee for further review and any additional action if identified. If at the end of the three months, the committee is confident that the deficiency is resolved, the monitoring activity will be concluded, and any audits will be random thereafter.	

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F 758	Continued From page 29 restlessness or agitation, related to encounter for palliative care (on Hospice services). 9/3/21 - A pharmacy review of R25's medications documented that R25 was on an antianxiety medication as needed, which had been in place for greater than 14 days without a stop date. Please discontinue. 9/9/21 - E11 (MD) declined the pharmacy recommendation to discontinue R25's as needed Ativan with a rationale "Hospice pt. (patient). Need prn (as needed) Ativan." The clinical record lacked evidence of a duration/stop date for R25's Ativan and for the order to be re-evaluated to determine whether R25 continued to require Ativan. 10/21/21 8:34 AM - Ativan 0.5 mg was administered with the order date from 8/4/21. 11/2/21 9:15 PM - Ativan 0.5 mg was administered with an order also from 8/4/21. 11/4/21 at approximately at 2:15 PM - During an interview, E2 (DON) confirmed that residents with as needed orders for Ativan should have a stop date. Findings were reviewed with E1 (NHA) and E2 during the exit conference on 11/5/21, beginning at 12:00 PM.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/24/21

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F 812	Continued From page 30 §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, it was determined that the facility failed to ensure safe and sanitary storage of food in one out of two unit nourishment refrigerators. Findings include: During numerous tours of the two nutrition rooms throughout the day on 11/1/21, the surveyor observed the following: 11/1/21 10:26 AM - The unit refrigerator in the nutrition room on the Lewes Short hall had five (5) undated, unlabeled black plastic food containers and a white plastic bag containing two (2) additional undated, unlabeled black plastic food containers identified by E7 (Nutritional Service Manager) as food brought in by family members for a specific resident. The top shelf of the refrigerator had a large unsanitary area covered with a light purple, sticky substance. Findings were reviewed with E1 (NHA) and E2	F 812	1. All unlabeled food was discarded immediately during the survey. The appliance was thoroughly cleaned. 2. Dietary Manager/designee will complete overall audit of properly labeled food, sanitation, and safe food handling practices. 3. The Staff Educator will complete re-education with Culinary Director, Dietary Manager, Culinary and Nursing staff regarding sanitation, safe proper food handling, labeling, storage and procurement of food and resident food brought from home. 4. The Culinary Director or designee will complete an audit of refrigerators in WBC to ensure the proper labeling, procurement and storage of food is occurring under proper sanitary conditions. The audits will be conducted once daily for a week then twice week for	

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F 812	Continued From page 31 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 812	one month then once weekly for for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		12/24/21

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F 842	Continued From page 32 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for six (R2, R3, R11, R22, R25 and R31) out of six residents investigated for unnecessary medication review, the facility failed to ensure records were accurate and complete.	F 842	1. R 2, 3, 11, 22, 25, 31 were not adversely affected. 2. The Director of Nursing/designee completed a facility wide review and audit of all resident pharmacy and laboratory	

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F 842	Continued From page 33 Findings include: 1. 11/2/21 at approximately 12:40 PM - During an interview with E1 (NHA), the Surveyor requested copies of the monthly pharmacy review reports for the previous twelve months for the five residents (R2, R3, R11, R22 and R25) selected for unnecessary medication review. 11/3/21 at approximately 10:30 AM - During an interview, E2 (DON) informed the Surveyors that they (the facility) were trying to locate all of the information requested for drug reviews since they were not in one location. 11/4/21 at 9:30 AM - E11 (MD) confirmed in an interview that he responded within 30 days of receiving the pharmacy recommendations, but was not sure why the facility could not locate the records (paper copies) of his response. 11/3/21 at 3:43 PM - E1 (NHA) provided copies of the pharmacy drug review reports and stated that documents had not been scanned into the clinical records for the past three months since the staff member who used to do the scanning was reassigned to do scheduling. 11/4/21 at 10:23 AM - During an interview, E1 stated that, as of yesterday, the pharmacy reports were now being keep in a binder until they get scanned into the records. 2. Review of R31's clinical record revealed: 10/10/21 - Physicians' Orders included blood tests for the next day. 11/2/21- There were no laboratory results in the	F 842	medical records still needing scanned into the electronic medical record. The Administrator reviewed with the medical record clerk timeliness of resident scanned medical record in the electronic health record. 3. The staff educator will complete re-education with all clinical staff related to the policy of Documentation, Scanning and storage and reference guide. 4. The Director of Nursing/designee will complete audits to ensure the resident pharmacy and laboratory medical records are scanned in accordance to the Acts policy - Documentation, Scanning, storage and reference guide. The audits will be conducted twice weekly for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	

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F 842	Continued From page 34 scanned records nor the paper chart. 11/2/21 at approximately 10:05 AM - During an interview, after the Surveyor asked E14 (RN) where the lab results would be located, E14 stated they would be in the scanned into the record. E14 confirmed the blood test results were not in the electronic record and left the room. Within a few minutes, E14 presented a paper copy of the results to the Surveyor and stated they had to be printed. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/5/21, beginning at 12:00 PM.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/24/21

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F 880	Continued From page 35 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 36 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide appropriate infection surveillance for one resident (R11) out of two residents reviewed for constipation and diarrhea. The facility failed to isolate R11 when the resident continued to have symptoms of Clostridium Difficile Infection (infectious loose stools). Additionally, the facility failed to follow the core principles of COVID-19 infection prevention for staff use of PPE (personal protective equipment) in the kitchen area. Findings include: According to the Centers for Disease Control (https://www.cdc.gov/cdiff/clinicians/faq.html): Isolation for C-Diff should continue until loose stools cease. The organism that causes the loose stools continues to be present in the stool even though antibiotics have been completed. According to the CDC, source control referred to well-fitting masks to cover the person's mouth and nose to prevent the spread of respiratory secretions when they breathe, talk, sneeze or cough. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html (Accessed 11/2/21) 1. 7/14/21 - R11 was admitted to the facility. 9/22/21 - The Resident was placed on isolation	F 880	1. At the time of the survey the dietary manager re-educated E7,21,22, 23,24, 25,35 on the proper wearing and use of a facemask. No adverse effect to residents occurred. 2. The Director of Nursing/designee completed a facility wide audit and review of staff monitoring for the proper wearing and use of a facemask. The Culinary Director was re-educated by the Nursing home administrator related to the requirement of the proper wearing and use of a facemask. 3. The staff educator will complete re-education with WillowBrooke Court staff related to the requirement of proper wearing and use of a facemask. 4. The Infection Preventionist/designee will complete audits to ensure that staff adhere and wear facemasks properly. The audits will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review. 1. R11 contact isolation was implemented at the time of the survey. No adverse effect was noted. 2. ADON/designee will complete an audit of reviewing past month infections to ensure appropriate transmissions-based	

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F 880	Continued From page 37 precautions for Clostridium Difficile Infection (CDI) and started an antibiotic by mouth. 10/6/2021 10:59 AM - R11 received the last dose of the antibiotic, completing the CDI treatment. 10/6/21 1:04 PM - A Physician Order was written to discontinue isolation precautions. 10/7/21 - A physician order was written by E11 (MD) to obtain a stool sample for CDI because of continued loose stools. 10/8/21 12:57 PM - A progress note revealed the lab called to inform staff that R11's stool sample was formed and could not be tested for CDI. The note stated the Physician was made aware of this. 10/8/21 - 10/28/21 - CNA documentation revealed R11 was having 2-3 loose stools daily. 10/28/21 - A Doctor's Order written by E11 (MD) revealed that another stool sample was ordered for CDI. 10/31/21 7:22 AM - A progress note revealed that another stool sample was obtained for CDI testing. 11/1/21 1:42 PM - During an interview, R11 stated that he had been having stools that were black and loose. 11/2/21 - Record review did not reveal any results from the stool sample sent for testing on 10/31/21. 11/2/21 - Record review showed no evidence that	F 880	precautions were ordered and followed in accordance with the Acts policy. 3. Staff Educator will complete re-education to licensed nursing staff on the facility policy regarding infection control standards and standard transmission-based precautions and specific education related to CDiff If the toxin screen is negative contact isolation should be discontinued. If the toxin screen is positive contact isolation for 48 hours after the completion of antibiotic therapy, if diarrhea is still not present. If diarrhea is still present after the 48-hour window, continue contact isolation and inform the physician. 4. The DON/QAPI Designee will complete an audit of resident with active infections ensuring the appropriate transmission-based precautions are implemented at time of onset of symptoms. The audits will be conducted for 3 months or longer if deemed appropriate by the IDT. Each month these audits will be reviewed at the monthly QAPI review.	

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F 880	Continued From page 38 isolation precautions were ordered when R11 was having loose stools and waiting for CDI sample results. 11/2/21 2:00 PM - An observation confirmed that R11's room was not set up for isolation precautions. 11/3/21 3:55 PM - In an interview, E20 (NP) stated that R11's stool sample was run as another kind of test in error so CDI results were not obtained. E20 stated she was ordering another stool sample for CDI since R11 was still having watery stools daily and was not on any stool softeners. 11/3/21 4:00 PM - A progress note written by E20 revealed she had spoken with E11 (MD) about R11's stool results. E20 obtained records from the lab that a stool specimen was collected on 10/31/21, but the lab ran the incorrect test on it. 11/3/21 5:00 PM - E20 ordered another stool sample be collected to test for CDI. 11/3/21 - A record review of CNA documentation revealed three incontinent stools in a 24 hour period and two were loose. 11/4/21 2:40 AM - A progress note revealed that a stool sample was collected for CDI. The note also stated that R11 was placed on isolation precautions. 11/4/22 4:22 AM - R11's record documented a large loose incontinent bowel movement. 11/5/21 3:44 AM - A nursing progress note revealed that R11's stool sample was positive for	F 880		

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F 880	Continued From page 39 CDI and the Physician ordered an antibiotic. 11/5/21 10 :00 AM - A review of R11's record revealed that he was not in isolation for 29 days without a negative CDI sample. 2. 11/1/21 - During the initial and follow-up kitchen observations throughout the day, numerous staff were seen wearing their facemasks inappropriately, with either their nose and/or mouth exposed: - 9:19 AM - E22 (Cook) was preparing food with no facemask leaving her nose and mouth exposed. - 9:22 AM - E25 (Cook) was preparing food during the initial kitchen tour and three (3) follow-up kitchen tours with his facemask pulled down below his chin, leaving his nose and mouth exposed. - 9:49 AM- E23 (Cook) was observed with his facemask pulled down below his chin, leaving his nose and mouth exposed. - 10:08 AM - During an interview, E22 (Cook) stated, "I don't wear a mask because I stay in my area and I am fully vaccinated." - 10:09 AM - E35 (Kitchen Staff) was observed with her facemask pulled down below her chin leaving her nose and mouth exposed. - 10:17 AM - E24 (Cook) was observed with his facemask pulled down below his chin, leaving his nose and mouth exposed. 11/1/21 11:46 AM - During an interview, E7	F 880		

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F 880	Continued From page 40 (Nutrition Services Manager) stated, "The mask wearing policy is from gate to gate for all employees, which means you wear your mask all day unless you are eating." 11/1/21 12:27 PM - During an interview, E21 (Dining Manager) stated, "I believe vaccinated non-direct care staff are requested to wear masks, but it is not required." Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate DON) during the exit conference, beginning at 12:00 PM.	F 880		