

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2019
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NAME OF PROVIDER OR SUPPLIER THE MOORINGS AT LEWES	STREET ADDRESS, CITY, STATE, ZIP CODE 17028 CADBURY CIRCLE LEWES, DE 19958
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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from October 14, 2019 through October 21, 2019. The facility census the first day of the survey was 34. 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.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 14, 2019 through October 21, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 34. The survey sample totaled twenty-six (26). NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; NP - Nurse Practitioner; WCNP - Wound Care Nurse Practitioner; PA - Physicians' Assistant; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; 1-10 Numeric Pain Scale - number scale to rate pain where 0 is no pain and 10 is the worst	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/13/2019
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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 possible pain, resident to state the number. Activities of daily living (ADL's) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Abnormal Involuntary Movement Scale (AIMS) - test to measure body movements the resident cannot control, side effect of antipsychotic medications; Antibiogram - report indicating how well an antibiotic will kill certain infections; Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Zyprexa, Haldol); Anxiolytic - medication to treat anxiety; Baker-Wong pain scale - picture of 6 faces with varying degrees of pain, resident must point to the face that represents their degree of pain. Bed mobility - how resident moves to and from lying position, turns side to side and positions body while in bed; Bilateral - both sides; CHF - congestive heart failure; Cognition - thinking, memory; Cystitis - inflammation of the bladder; Dementia - brain disorder with loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; Diabetes Mellitus type 2 - adult onset of a chronic disease associated with abnormally high levels of sugar (glucose) in the blood; Edema - retention of fluid into the tissue resulting in swelling; eMAR (electronic Medication Administration Record) - computerized list of medications to be administered; Finger Stick Blood Sugar (FSBS)- procedure in which a finger is pricked with a small needle to obtain a drop of blood to measure the amount of sugar (glucose) in the blood. Normal fasting	F 000		
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F 000	Continued From page 2 blood sugar levels 70 to 100. Gastrointestinal - refers to esophagus, stomach, large and small bowels, rectum and anus; Glucagon - medication used in an emergency to treat severe hypoglycemia; Hallucinations - something that seems real, but does not really exist; Hospice - services that provide care to the terminally ill; Hyperglycemia - high blood sugar; Hypoglycemia - low blood sugar; Ischium - lower part of the hip bone; Off-load (ed, ing) - reduction of pressure to the specific areas of the body; Medication reconciliation - process of verifying all medications a person is taking including drug name, dosage, frequency, and route, and comparing that list against the physicians' admission, transfer, and/or discharge orders, with the goal of providing correct medications to the resident; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; Metabolic encephalopathy - a medical condition in which there are abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function; Physical Monitors: entries added to orders to guide staff to perform certain assessments related to medications; Pressure ulcer/injury - localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Pressure ulcer/injury classification system: - Stage 1 Pressure Injury: Intact red skin often over a bony area that does not turn white / light	F 000			

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F 000	<p>Continued From page 3 (does not blanch) when pressed.</p> <ul style="list-style-type: none"> - Stage 2 Pressure Injury: Blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present. - Stage 3 Pressure Injury: Open sore that goes into the tissue below the skin. How deep it is depends on the amount of tissue under the skin. Fat, granulation tissue and rolled edges are often present. Little slough and/or eschar may be visible, but does not hide the extent of tissue loss. - Stage 4 Pressure Injury: Open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen. Rolled edges, undermining, tunneling often occur. Slough or eschar may be visible. - Unstageable: Actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black). Eschar is worse than slough. Once slough/eschar removed, a Stage 3 or 4 injury will be revealed. Stable eschar (i.e. dry, adherent, intact without redness or movement) on the heel or limb with impaired blood flow should not be softened or removed. - Deep Tissue Pressure Injury (DTI): Intact or non-intact deep red, maroon, purple discoloration that does not turn white/light when pressed or skin separation revealing a dark wound bed or blood filled blister. Pain and temperature change often appear before skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss; PRN - as needed; 	F 000		

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F 000	Continued From page 4 Psychoactive - class of medication that affects mental/emotional conditions; Pulse oximetry (ox) - test to measure the amount of oxygen in the blood - desired range 94 - 100%; Sepsis - potentially deadly medical condition characterized by a whole-body inflammatory state; symptoms include fever, difficulty breathing, low blood pressure, fast heart rate, and mental confusion; Severe Cognitive Impairment - unable to make own decisions; Shear/Shearing Force - friction with reduced blood flow to the tissue under the skin from sliding down in, or being pulled across the bed; URI - upper respiratory infection; UTI - urinary tract infection.	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	F 550		12/16/19	

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F 550	<p>Continued From page 5</p> <p>practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§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.</p> <p>§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.</p> <p>§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 it was determined that the facility failed to maintain dignity for one (R35) out of 16 residents sampled for investigations. Findings include: Review of R35's clinical record revealed: R35 was receiving hospice services with a nurse at the bedside 24 hours a day. R35's hospice aide and nurse (H1) were preparing to provide personal hygiene. H1 left the room to obtain linen and left the room door open: - 10/15/19 (8:18 AM): R35 was lying in bed with his/her knees bent and the disposable brief was visible from the hallway. The surveyor was not</p>	F 550	<p>F550 Resident Rights</p> <ol style="list-style-type: none"> R35 has expired. All residents have the potential to be affected by the deficient practice. All staff and privately contracted services will be in-serviced regarding privacy during care or when a resident may be at risk for exposure as staff is entering/exiting the room. New staff will be in-serviced at General Orientation and annually thereafter. Random daily audits will be completed by the DON or designee for four (4) weeks until 100% compliance is 		

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F 550	Continued From page 6 seen by the hospice aide in the room and the door remained open until H1 returned with the linens and towels.	F 550	maintained, and weekly for four (4) weeks until 100% compliance. The results will be provided to the QAPI Committee for further recommendation.		
F 656 SS=E	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 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the	F 656		12/16/19	

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F 656	<p>Continued From page 7</p> <p>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 interview, clinical record review, and review of the facility's policy and procedure, it was determined that the facility failed to develop a comprehensive person-centered care plan with measurable goals to address resident's needs for five (R7, R12, R13, R33, and R34) out of 16 residents sampled for investigations. Findings include:</p> <p>Review of the facility's policy and procedure titled Resident Care Plan, with a revision date of 9/11/17, indicated that the policy of the facility was to ensure that the care plan process was systematic, comprehensive, interdisciplinary and timely and directed toward achieving and maintaining each resident's optimal physical, psychosocial and functional status. In addition, the resident's care plan would include measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs.</p> <p>Cross refer F684, example #1</p>	F 656	<p>F656 Develop/Implement Comprehensive Care Plan</p> <p>1. R13's care plan was updated to include interventions for monitoring signs and symptoms of hypo and hyperglycemia. R13's care plan was updated to include current level of continence and ambulation status to include measurable goals as appropriate. R33's care plan was updated to include measurable goals for ambulation. R7 and R12's care plans were updated to include measurable goals for placement acceptance. R34 has been discharged.</p> <p>2. All residents have the potential to be affected by the deficient practice.</p> <p>3. All existing care plans will be reviewed for specific, comprehensive, completeness and measureable goals. The IDT will review all care plans upon</p>		

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F 656	<p>Continued From page 8</p> <p>1a. Review of R13's clinical record revealed the following:</p> <p>4/24/19 - R13 was admitted to the facility from the hospital with diagnoses including metabolic encephalopathy and diabetes mellitus type 2.</p> <p>5/11/19 through 10/17/19 - The physician's orders for this period of time, documented that R13 was ordered both fast acting and long acting insulin.</p> <p>7/18/19 through 10/17/19 - The "Resident Vital Signs Report" documented R13's FSBS and showed episodes of both hypoglycemia, as low as 48, and hyperglycemia, as high as 600.</p> <p>Although R13 experienced hypoglycemia and hyperglycemia, there was a lack of evidence of a comprehensive care plan to include interventions for monitoring specific signs and symptoms of hypo and hyperglycemia and the integration of the hypoglycemic protocol as ordered.</p> <p>Cross refer F688, example #1</p> <p>1b. Review of R13's clinical record revealed the following:</p> <p>4/24/19 - R13 was admitted to the facility from the hospital.</p> <p>8/10/19 - A physician's order documented for R13 to ambulate (walk) 200 feet with a rolling walker and staff supervision two times a day.</p> <p>8/20/19 - A care plan (initial implementation date of 5/8/19) for problem of "I am here for LTC (Long Term Care) because I need help taking care of myself. I do not always know when I need to go</p>	F 656	<p>admission, quarterly, annually and as needed for changes to best reflect the status of each resident and their identified problems.</p> <p>4. Random care plan audits will be completed weekly on three (3) residents by the DON or designee with outcomes reported to the QAPI Committee for further recommendation.</p>	

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F 656	<p>Continued From page 9</p> <p>to the bathroom." The goal was that "I wish to be comfortable and receive the care and support that I need to make the most of my stay at The Moorings in the Health Center." An intervention included "Monitor" with a frequency of 2 times daily starting 8/20/19.</p> <p>There was a lack of evidence that the goal was measurable because it was unclear what was to be monitored two times a day.</p> <p>10/16/19 4:03 PM - An interview with E3 (RNAC) confirmed that the 8/10/19 order to ambulate R13 200 feet using a rolling walker and staff supervision was included as an intervention.</p> <p>There was a lack of evidence of a measurable objective for R13's ambulation order as well as the timeframe to meet the objective.</p> <p>10/21/19 12:45 PM - An interview with E2 (DON) confirmed that the above care plan failed to include measurable objectives and a timeframe to meet the goal for R13's ambulation.</p> <p>Cross refer F688, example #2</p> <p>2. Review of R33's clinical records revealed the following:</p> <p>9/27/18 - R33 was admitted to the facility.</p> <p>11/9/18 - A physician's order indicated to offer assistance to R33 to ambulate 120 feet with a rolling walker and contact guard assistance or stand by assistance twice a day.</p> <p>11/10/18 (Initial implementation date of 10/19/18) - A care plan for problem of "I am not able to get</p>	F 656			

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F 656	<p>Continued From page 10</p> <p>ready for the day by myself because I have weakness." The goal was that "I will be clean, odor free, shaved, dressed, and out of bed daily over the next review period." Interventions included for a CNA to offer to assist R33 to ambulate 120 feet with a rolling walker and contact guard assistance or with stand by assistance twice daily and to document refusals in the administration note.</p> <p>There was a lack of evidence of a measurable objective, as well as the timeframe to meet the objective.</p> <p>10/21/19 12:45 PM - An interview with E2 (DON) confirmed that the above care plan failed to include measurable objectives and a timeframe to meet the goals for R33's ambulation.</p> <p>3. Review of R7's clinical record revealed:</p> <p>1/12/19 - Admission to the facility with severe cognitive impairment.</p> <p>1/19/19 - A care plan problem entitled, "I am in long term care" included the goal, "I want to have quality of life and to be made comfortable for the remainder of my days." Interventions were varied and involved attending groups, going to the beauty salon, listening to music, participating in therapy dog visits, enjoying padded reclining wheelchair and having room decorated with personal furnishings.</p> <p>This goal was not measurable.</p> <p>10/21/19 (8:41 AM) - During an interview with E3 (RNAC) about the care plan goal, E3 revealed that the goal was written by the social worker and</p>	F 656			

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F 656	<p>Continued From page 11</p> <p>"I usually won't touch (his/hers)."</p> <p>10/21/19 (9:10 AM) - During an interview with E7 (SW) to determine how the goal would be measured to determine if R7 met the goal, E7 stated, "I do observations to determine if the resident looks comfortable and has quality of life."</p> <p>The observations are subjective and not measurable.</p> <p>4. Review of R12's clinical record revealed:</p> <p>12/11/18 - A care plan problem for "I live in long term care because I am dependent on others to care for me" included the goal, " I want to live out my days in comfort and make the most of my days." Interventions involved enjoying time in the living room area next to the nurses station, napping and resting my head in my lap and don't mind being awakened to be checked on and offered repositions, snacks and drinks.</p> <p>This goal is not measurable.</p> <p>10/21/19 (8:41 AM) - During an interview with E3 (RNAC) about the care plan goal, E3 revealed that the goal was written by the social worker and "I usually won't touch (his/hers)."</p> <p>10/21/19 (9:10 AM) - During an interview with E7 (SW) to determine how the goal would be measured to determine if R7 met the goal, E7 stated, "I do observations to determine if the resident looks comfortable and has quality of life."</p> <p>The observations are subjective and not measurable.</p>	F 656			

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/21/2019
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F 656	Continued From page 12 5. A review of R34's clinical record revealed: 9/19/19 - R34 was admitted to the facility with a broken right wrist that required a cast. 10/12/19 8:47 AM - A nursing progress note included, "Resident is presenting with increasing edema (swelling) to right hand. Cast is becoming tight and her pain level is increasing. E9 (MD) notified. New order to send to (named hospital emergency room) non-emergent for cast removal and replacement." 10/21/19 11:05 AM - During an interview with E1 (NHA), E4 (Clinical Analyst) and E5 (Corporate Nurse), it was confirmed that R34 did not have a comprehensive care plan for a right wrist cast to include monitoring for hand edema, capillary refill, and skin integrity beneath the cast. Findings were reviewed with E1, E2 (DON), E4 and E5 during the exit conference on 10/21/19, beginning at 1:10 PM.	F 656			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		12/16/19	

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 661	<p>Continued From page 13</p> <p>the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R32) out of one sampled residents reviewed for discharge, R32's clinical record lacked evidence that a discharge summary to include a recapitulation of the resident's stay, a final summary of the resident's status, and a reconciliation of all pre-discharge medications with the resident's post-discharge medications was completed. Findings include:</p> <p>The following was reviewed in R32's clinical record:</p> <p>9/9/19 - R32 was admitted to the facility following a left total knee replacement.</p> <p>10/4/19 - R32 was discharged home from the facility.</p> <p>Record review lacked evidence of the required elements of a completed discharge summary.</p>	F 661	<p>F661 Discharge Summary</p> <ol style="list-style-type: none"> R32 was discharged from the facility. All discharged residents have the potential to be affected by the deficient practice. All licensed nursing and support staff will be in-serviced on completing discharge summaries for all residents, including recapitulation of stay and medication reconciliation. Each discharge chart will be audited by the DON/ADON/designee to ensure completeness within 72 hours post discharge. Final resolution will be defined immediately. Tracking and Trending will be reported to the QAPI Committee for further recommendation. 		

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 661	Continued From page 14	F 661			
F 684 SS=E	<p>10/21/19 at approximately 12:30 PM - During an interview with E1 (NHA) and E5 (RN), it was confirmed that R32's clinical record lacked evidence of a completed discharge summary to include a recapitulation of the resident's stay, a final summary of the resident's status, and a reconciliation of all pre-discharge medications with the resident's post-discharge medications.</p> <p>Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19, beginning at 1:10 PM.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record reviews, interviews and review of other facility documentation as indicated, it was determined that for one (R13) out of three sampled residents reviewed for insulin investigation, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plans. In addition, the facility failed to ensure collaboration with hospice for one (R35) out of one sampled</p>	F 684	<p>F684 Quality of Care</p> <ol style="list-style-type: none"> R13 had no adverse outcome. R35 has expired. All diabetic residents have the potential to be affected by the deficient practice. Those residents utilizing privately contracted hospice services have the potential to be affected by the deficient practice. 	12/16/19	

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F 684	<p>Continued From page 15</p> <p>residents investigated for hospice. Findings include:</p> <p>The manufacturer's prescribing information for Novolog, a fast acting insulin stated "...Hypoglycemia is the most common adverse effect of insulin therapy..." (https://www.novologpro.com).</p> <p>The manufacturer's prescribing information for Tresiba, a long acting insulin, stated, "... Hypoglycemia is the most common adverse reaction of insulin, including Tresiba®, and may be life-threatening. Increase monitoring with changes to: insulin dose, co-administered glucose lowering medications, meal pattern, physical activity..." (https://www.tresiba.com).</p> <p>"What is hypoglycemia - Hypoglycemia, also called low blood glucose or low blood sugar, occurs when the level of glucose in your blood drops below normal. For many people with diabetes, that means a level of 70 milligrams per deciliter (mg/dL) or less...</p> <p>- What are the symptoms of hypoglycemia? Mild-to-Moderate - shaky or jittery, sweaty, hungry, blurred vision, sleepy or tired, dizzy or lightheaded, confused or disoriented, pale, uncoordinated, irritable or nervous, argumentative or combative, behavior or personality changes, trouble concentrating, weak, fast or irregular heart beat.</p> <p>- Severe - unable to drink or eat, seizures or convulsions (jerky movements), and unconsciousness..." (https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/low-blood-glucose-hypoglycemia#symptoms).</p>	F 684	<p>3. All nursing staff will be in-serviced regarding FSBS recording and reporting parameter outcomes to MD and/or proceed with standing orders for hypo and hyperglycemia protocol. All nursing staff will be in-serviced regarding the requirement of collaboration between facility staff and privately contracted providers prior to the start of care. In addition, privately contracted providers will be required to meet with facility team to ensure a comprehensive plan of care, cohesive documentation and standards of communication.</p> <p>4. All diabetic residents with FSBS out of ordered parameters will be reviewed to ensure proper protocol was followed. All privately contracted Hospice residents will have all new orders reviewed by the IDT to ensure required interventions were addressed. FSBS out of parameters will be audited daily by the DON/designee until 100% compliance is achieved, followed by two (2) weekly until 100% compliance is achieved. The results will be provided to the QAPI Committee for further recommendation.</p>		

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

PRINTED: 12/23/2019
FORM APPROVED
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F 684	<p>Continued From page 16 Cross refer F656, example #1</p> <p>Review of R13's clinical record revealed the following:</p> <p>4/24/19 - R13 was admitted to the facility from the hospital with diagnoses including metabolic encephalopathy and diabetes mellitus type 2.</p> <p>4/24/19 - A list of Standing Orders signed by E13's attending physician included a "...Diabetic Emergency Protocol for Hypoglycemia as follows:</p> <p>A. Check Resident's blood sugar by finger stick: B. If the blood sugar is below the Resident's prescribed parameters (if no parameters have been prescribed, refer to the facility protocol parameters of 70-115) and if:</p> <p>1. Resident is alert, administer one of the following: 8 ounces of skim milk, 4 ounces of soda (not diet) or 4 ounces of juice (any kind). Recheck the blood sugar after 10 minutes. Notify physician of blood sugar and interventions immediately. Hold insulin/diabetic meds, if ordered.</p> <p>2. Resident has reduced level of consciousness. Give Glucagon 1 mg I.M. (intramuscular - into the muscle) and recheck blood sugar. If no improvement, ..."</p> <p>5/11/19 (Original date) - A physician's order was written for Novolog insulin (a rapid acting insulin) 5 units before meals three times a day.</p> <p>5/24/19 (Original date) - A physician's order was written for Novolog insulin with sliding scale coverage: if FSBS less than 70 or greater than 550, notify the physician. the range of the FSBS and the amount of Novlog insulin was included in</p>	F 684			

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

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F 684	<p>Continued From page 17 the order.</p> <p>5/28/19 (Original date) - A physician's order was written for FSBS at bedtime with no insulin coverage.</p> <p>8/29/19 (Original date) - A physician's order was written for Tresiba Flex Touch U - 100 insulin (long-acting insulin) to administer 18 units at bedtime.</p> <p>7/18/19 thru 10/10/19 - The electronic Medication Administration Record (eMAR) revealed that R13 had FSBS results less than 70 on 15 occasions, during the following dates and times:</p> <ul style="list-style-type: none"> - 7/18/19 12:40 PM: 50 - 7/30/19 12:20 PM: 64 - 8/19/19 11:54 AM: 54 - 8/22/19 8:55 AM: 48 - 8/24/19 12:25 PM: 54 - 8/29/19 8:10 PM: 66 - 8/29/19 8:48 AM: 62 - 8/30/19 12:16 PM: 62 - 9/3/19 9:22 PM: 68 - 9/5/19 12:17 PM: 52 - 9/7/19 11:58 AM: 68 - 9/25/19 9:30 AM: 52 - 9/25/19 4:42 PM: 57 - 10/10/19 5:11 PM: 67 <p>In addition, for 10/7/19 at 12:26 PM, the result was documented as "out of parameter."</p> <p>7/18/19 through 10/10/19 - A review of the corresponding progress notes lacked evidence that the facility consistently implemented the hypoglycemic protocol when R13's FSBS was below 70. In addition, there was a lack of</p>	F 684			

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 684	<p>Continued From page 18</p> <p>evidence whether facility staff identified the presence of signs and symptoms of hypoglycemia and closely monitored the resident.</p> <p>10/17/19 1:44 PM - During an interview with R13's attending physician, E9 (MD) confirmed that R13 had episodes of hypoglycemia. E9 reported that in the past, R13 required an insulin pump, however, R13 no longer had the pump and was currently on insulin; routine and sliding scale insulin.</p> <p>10/18/19 3:45 PM - E1 (NHA) provided an e-mail response from E9 (MD), dated 10/18/19 and timed 2:13 PM, in response to the surveyor's request made earlier at 2:05 PM on 10/18/19. Review of the e-mail and the three page attachment revealed the following:</p> <p>E9 (MD) documented various ways in which the facility staff can notify E9 when R13's FSBS was lower than 70. In the e-mail, E9 further elaborated " ...Regardless, nursing notes should document sugar low, insulin held, MD informed, crackers/juice given and what the repeat reading was ..."</p> <p>E9 (MD) provided a print out from the docbook electronic system (physician documentation regarding contact by the facility, not part of the facility's electronic clinical record) for three FSBS below 70:</p> <ul style="list-style-type: none"> - 8/22/19 at 7:55 AM for FSBS of 48 in which interventions were implemented, however, no repeat FSBS result was documented. - 8/29/19 at 8:47 AM for FSBS of 62 in which interventions were implemented and repeat FSBS was 119. 	F 684			

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

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FORM APPROVED
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F 684	<p>Continued From page 19</p> <p>- 8/29/19 at 9:48 PM for FSBS of 66, in which interventions were implemented and repeat FSBS was 147.</p> <p>E9 (MD) documented that he may have been informed and/or was likely informed of 3 of the FSBS results and no message was received and or "can't find anything" for 4 FSBS results.</p> <p>10/21/19 10:30 AM - An interview with E5 (Corporate Nurse) was conducted. E5 provided the surveyor additional information related to the implementation of the hypoglycemic protocol. Based on additional evidence, it was determined that the facility failed to have evidence that the protocol was implemented for the following dates and times:</p> <ul style="list-style-type: none"> - 8/24/19 12:25 PM : FSBS 54 - 9/3/19 9:22 PM: FSBS 68 - 9/5/19 12:17 PM: FSBS 52 - 9/7/19 11:58 AM: FSBS 68 - 9/25/19 4:42 PM: FSBS 57 <p>10/21/19 11:45 AM - The surveyor was informed by E5 (Corporate Nurse) that the facility was unable to provide evidence of the FSBS result for 10/7/19 at 12:26 PM, when the staff documented "out of parameter and lastly, the facility was unable to provide evidence that the protocol was implemented when R13's FSBS was 67 on 10/10/19 at 5:11 PM.</p> <p>The facility failed to ensure, when R13 experienced a FSBS below 70, that:</p> <ul style="list-style-type: none"> - R13 was assessed for the presence or absence of signs and symptoms of hypoglycemia and that close monitoring of the resident occurred. - the hypoglycemic protocol was consistently implemented. 	F 684			

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F 684	<p>Continued From page 20</p> <p>Cross Refer F697 and F881</p> <p>2. Review of R35's clinical record revealed:</p> <p>10/10/19 - A hospice recommendation written on the hospice order sheet included the antipsychotic Haldol to be given every 4 hours PRN for agitation, hallucinations and/or nausea/vomiting. The facility's physicians' orders included Haldol to be PRN for dementia with behavioral disturbance.</p> <p>10/13/19 (9:35 AM) - The facility eMAR documented the PRN morphine (pain medication) was "requested by hospice nurse for c/o (complaint of) back pain." Hospice records revealed a pre-pain rating score of 6 prior to being medicated for pain.</p> <p>10/13/19 (4:44 PM) - The eMAR did not include any assessment of behaviors indicating pain or a pain score for this dose of morphine. The hospice assessment included moaning, grimacing, restlessness with a pain score of 6 prior to the PRN pain medication.</p> <p>There was no evidence that there was collaboration with hospice staff regarding R35's pain assessment.</p> <p>10/15/19 (around 9:30 AM) - During an interview H1 (Hospice LPN) showed the surveyor the hospice documentation binder at the bedside. H1 explained that respiration rate was assessed every two hours and that detailed notes about R35's behaviors, medications and care were documented.</p>	F 684			

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

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F 684	<p>Continued From page 21</p> <p>Surveyor observations throughout the survey (10/14/19 - 10/18/19) revealed that hospice staff would directly interact with facility staff when requesting PRN medications and that the facility nurse would look in on the resident and hospice staff throughout the day.</p> <p>10/15/19 (6:16 PM) - A physician contact note documented "(hospice name) Hospice recommendations reviewed by MD (physician) and approved. Clarified with NP duration of antibiotic therapy."</p> <p>10/15/19 - The physicians' orders included an antibiotic (Augmentin) to be given twice a day for seven days for a respiratory infection starting 10/16/19.</p> <p>October 2019 - Review of vital signs and nursing notes revealed that R35's temperatures ranged from 97.2 to 98.2 and respiratory rate ranged from 15-20 between 10/12/19 - 10/15/19 which were all within normal range. In the facility record, there were no pulse oximetry readings, no assessment of lung sounds or the presence of a cough or sputum which would indicate a respiratory infection.</p> <p>10/21/19 (8:41 AM) - During an interview with E3 (RNAC) to review care plans and the presence of a respiratory infection, E3 revealed that R35 had previously been coughing and could not get out the thick sputum. The surveyor informed E3 that assessment of signs and symptoms of a respiratory infection (e.g., fever, change in pulse oximetry, respiration rate or lung sounds) was lacking in R35's clinical record.</p> <p>Findings were reviewed with E1 (NHA), E2</p>	F 684			

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

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F 684	Continued From page 22 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 684			
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation and review of other facility documentation it was determined that for three (R5, R19 and R22) out of three residents reviewed for pressure ulcers, the facility failed to ensure that the residents at risk for pressure ulcers or those with pre-existing pressure ulcers, received the care and services to promote healing and to prevent new pressure ulcers from developing. For R5, the facility failed to ensure that new interventions were consistently implemented after R5 had acquired two new pressure ulcers (PUs). For R19 and R22, the facility failed to ensure that their heels were offloaded as directed by the plan of care. Findings include:	F 686	F686 - Treatment or Services to Prevent/Heal Pressure Ulcers 1. Resident 5 has been reassessed for wound healing interventions. The CNA care maps have been updated to include all existing interventions to promote wound healing and to prevent wound development. Residents 19 and 22 continue with plan to offload heels using a wedge to offload heels to prevent contact with device and/or mattress. 2. All residents with risk for skin integrity concerns can be affected by deficient	12/16/19	

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

PRINTED: 12/23/2019
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OMB NO. 0938-0391

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F 686	<p>Continued From page 23</p> <p>A facility policy (last revised 11/23/12) entitled Wound and Skin Care, At Risk Residents included that "Heels are extremely vulnerable and must be completely off of bed surface. Utilize pillows, foot splints or heel risers."</p> <p>1. Review of R5's clinical records revealed the following:</p> <p>10/1/18 - R5 was admitted to the facility without a PU.</p> <p>10/1/19 thru 10/17/19 - Review of the Activities of Daily Living (ADL) and Caregiver documentation indicated that R5 was turned and repositioned every 2 hours and had a pressure redistribution cushion to all chairs.</p> <p>8/5/19 (Most recent revision date with an initial implementation date of 10/4/18) - A care plan for the problem of skin integrity documented interventions including weekly wound rounds with wound NP; monitor skin during weekly skin assessment and document new areas; monitor nutritional status; cushions to all chairs where R5 spent the majority of time, encourage to turn and reposition as needed and assist resident as needed, offer to assist me to lie in the bed, but R5 prefers to sleep in recliner, and application of anti itch cream.</p> <p>10/8/19 - The quarterly MDS assessment documented that R5 was moderately impaired for decision making, required extensive assistance of one staff member for bed mobility, and had no current pressure ulcer. Preventative measures for PU development included pressure redistribution to bed and chair, application of ointment or creams, and R5 was on a turn and</p>	F 686	<p>practice.</p> <p>3. All nursing staff to be in-serviced regarding devices used to offload heels in order to prevent contact with device and/or mattress. The CNA care maps will be reviewed for interventions per MD orders. All new MD or nursing orders will be reviewed for necessary interventions as needed.</p> <p>4. Audits will be done daily for four (4) weeks on all residents that are at risk for skin integrity concerns to ensure placement of devices for offloading until 100% compliance is maintained; followed by weekly for four (4) until 100% compliance is maintained. The CNA care maps for all residents with skin integrity concerns will be reviewed for MD orders to ensure continuity. The CNA Care maps will be updated PRN with MD order changes. The DON/ADON/designee will conduct audits and report to QAPI Committee for further recommendation.</p>		

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

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F 686	<p>Continued From page 24 reposition program.</p> <p>10/10/19 (Last revision date) - A review of the Resident Care Map (CNA Care Plan) documented for skin care and to float the heels.</p> <p>10/13/19 - A progress note, documented a change in condition, in which R5 was shaking, drooling, leaning to the side, and had increased respiration with confusion. E9 (MD) was notified and new orders were obtained for oral antibiotics, chest x-ray and laboratory studies to be performed.</p> <p>10/14/19 - A Weekly Wound Consultant Assessment conducted by E23 (WCNP) documented the presence of two new PUs; a sacrum DTI and a stage 2 of the right ischium. Recommendations included having the attending physician evaluate the decline and to turn frequently to offload (pressure on the pressure ulcers).</p> <p>There was a lack of evidence that the facility individualized the intervention to turn frequently to offload the affected areas of pressure and they failed to incorporate the intervention into R5's CNA care plan and/or the ADL and Caregiver documentation.</p> <p>10/17/19 11:30 AM - An interview with E22 (CNA) revealed that most of the time, R5 sat in the wheelchair during the day and only got in bed when he needed to have his leg dressings changed. E22 verbalized that R5 had a special cushion for his wheelchair and recliner and E22 encouraged R5 to offload his bottom. E22 verbalized that she was unaware, since the identification of R5's new PUs on 10/14/19, of any</p>	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	<p>Continued From page 25 new interventions.</p> <p>10/17/19 11:57 AM - An interview with E6 (RN) confirmed that the intervention to turn frequently to offload after the identification of the 2 PUs was not incorporated into the CNA electronic documentation system and/or on R5's CNA care plan.</p> <p>10/21/19 12:55 PM - The surveyor was provided a copy of the October 2019 Treatment Administration Record (TAR) by E2 (DON) which documented the following:</p> <ul style="list-style-type: none"> - 10/14/19 through 10/17/19: "Turn & Position by Shift Starting 10/14/19...Note: Turn and reposition resident frequently to offload pressure." This order was discontinued on 10/17/19. The licensed nurse signed off per shift beginning on day shift on 10/14/19 through the evening shift on 10/17/19. - 10/17/19 through 10/20/19: "Turn & Position by Shift Starting 10/17/19...Note: Turn and reposition resident every two hours. Encourage resident to decrease time OOB (out of bed), position resident to offload pressure on buttocks." The licensed nurse signed off per shift beginning on evening shift on 10/17/19 through the evening shift on 10/20/19. <p>Although the facility transcribed the above in the nurse's TAR beginning on 10/14/19, the facility failed to ensure that the CNA electronic documentation system and/or the CNA Care Plan was updated.</p> <p>The facility failed to ensure that the new interventions to turn frequently to offload areas to</p>	F 686			

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

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F 686	<p>Continued From page 26</p> <p>the two new PUs were implemented. This was a repeat deficiency from the Annual and Complaint Survey ending 10/28/18.</p> <p>Repeated deficiency from the Annual and Complaint Survey ending 10/24/18</p> <p>Deep tissue injury may be preceded by tissue that is painful, firm, mushy, boggy (soft), warmer or cooler, as compared to adjacent tissue. https://www.ncbi.nlm.nih.gov/books/NBK2650/table/ch12.t2/</p> <p>2. Review of R19's clinical record revealed:</p> <p>12/11/17 - A care plan for comfort care (last revised 8/29/19) was initiated and included "I do not like to be turned and repositioned. I prefer for (sic) be positioned on back." Interventions included several pressure ulcer prevention / relieving strategies: 2/13/18 - elevate both heels from bed, foot cradle; and 8/28/19 - apply skin prep (provides for protection).</p> <p>R19's MDS assessments recorded an intermittent pressure ulcer: - 3/3/19 Annual: 1 unhealed pressure ulcer. - 6/1/19 Quarterly: no pressure ulcer. - 8/29/19 Quarterly: 1 unstageable pressure ulcer (right heel) and R19 needed extensive assistance with bed mobility.</p> <p>10/14/19 - Wound care documentation showed that R19's right heel had been healed for 6 weeks.</p> <p>Surveyor observations between 10/13/19 - 10/21/19 of R19 wearing white booties, foot cradle in place and heels were lying on the pillow</p>	F 686			

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

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F 686	<p>Continued From page 27</p> <p>placed beneath both legs/heels. (R19's heels were not offloaded with the pillow underneath the heels) on the following occasions:</p> <ul style="list-style-type: none"> - 10/14/19: 1045 AM and 1:50 PM. - 10/15/19: 8:20 AM and 2:05 PM. - 10/21/19: 10:50 AM. <p>R19's heels were offloaded on 10/16/19 - 10/18/19 during random observations throughout the day</p> <p>10/16/19 (around 9:30 AM) - During an observational interview with E13 (CNA) to look at the positioning of R19's feet, both heels were offloaded, hanging over the edge of the pillow under R19's legs. E13 removed R19's right booty and the surveyor observed normal skin color (no redness), however the heel was boggy (soft).</p> <p>10/21/19 (10:50 AM) - During an observational interview, E14 (LPN) confirmed that both of R19's heels were lying on top of the pillow placed under her legs. E14 moved the pillow upward to allow R19's heels to be elevated/floated.</p> <p>3. Review of R22's clinical record revealed:</p> <p>9/19/18 - R22 was admitted to the facility.</p> <p>10/9/18 - A wound assessment by a facility contracted (NP) documented a history of bilateral heel ulcers.</p> <p>10/10/18 - R22's care plan documented, "I have fragile skin...Float (elevate/offload) heels when in bed"</p> <p>9/6/19 - R22's Braden Scale score documented that R22 was at risk for pressure ulcers.</p>	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 28 9/9/19 - R22's annual MDS assessment documented that R22 was severely cognitively impaired, non-ambulatory (did not walk), and required assistance for bed mobility, transfers, eating and toileting. R22 was observed in bed and positioned with heels not offloaded(elevated): - 10/14/19: 10:28 AM, 10:43 AM and 2:40 PM. - 10/15/19: 8:31 AM, 9:13 AM, 1:17 PM and 2:30 PM. - 10/16/19: 9:36 AM, 10:37 AM and 2:50 PM. - 10/17/19: 9:25 AM, 11:33 AM and 2:12 PM. - 10/18/19: 9:05 AM, 10:31 AM and 11:40 AM. 10/21/19 8:28 AM - During and interview and observation E10 (CNA) confirmed that R22's heels were not properly elevated as there was only one pillow under R22's calves which was ineffective to prevent the heels from contact with the mattress/bed. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §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	F 688		12/16/19	

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

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F 688	<p>Continued From page 29</p> <p>§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.</p> <p>§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 interview and record review, it was determined that the facility failed to provide appropriate services to maintain or improve mobility for two (R13 and R33) out of three residents reviewed for limited range of motion or mobility investigations. Findings include: Repeat deficiency from the Annual and Complaint Survey ending 10/24/18. Cross refer F656, example #1b. 1. Review of R13's clinical record revealed the following: 10/24/18 - R13 was admitted to the facility. 8/20/19 - A physician's order was written to ambulate (walk) R13 200 feet with a rolling walker two times a day. 9/1/19 through 10/15/19 - Review of the Treatment Administration Record (TAR) revealed that the facility transcribed the order and scheduled ambulation during the day and evening shifts. During the periods below, the facility</p>	F 688	<p>F688 Increase/Prevent Decrease in ROM/Mobility</p> <p>1. R13 continues to have a goal to ambulate 200 feet with rolling walker with supervision twice per day. R33 continues to have a goal to ambulate 120 feet with a rolling walker with contact guard or stand by assistance twice per day.</p> <p>2. Residents with an ordered ambulation program are at risk for a decrease in mobility by the deficient practice.</p> <p>3. All nursing staff will be in-serviced regarding documentation in the EMR related to completion and/or offering ambulation per MD order. Refusals or inability to fully participate will be communicated to the nurse who will document the completion or reason for refusal/inability to complete the goal. Therapy will be notified of decline/continued non-participation to screen and/or seek MD order to evaluate and/or treat the resident.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 688	<p>Continued From page 30</p> <p>documented "0.00" for length of ambulation with no corresponding administration note, thus, there was a lack of evidence that the facility offered to ambulate R13:</p> <ul style="list-style-type: none"> - 9/1/19 through 9/30/19: 1 out of 30 day shifts and 4 out of 30 evening shifts. - 10/1/19 through 10/15/19: 2 out of 15 evening shifts <p>10/15/19 (Date of update of the documentation) - The Resident Care Map (CNA care plan) documented to ambulate R13 200 feet with rolling walker and supervision twice a day.</p> <p>10/16/19 5:00 PM - An interview with E8 (LPN) revealed that she was informed during the current survey that a corresponding note must be completed in the TAR if the length was documented as "0.00."</p> <p>The facility failed to have evidence that R13 was ambulated 200 feet twice a day with a rolling walker, as ordered.</p> <p>Cross refer F656, example #2.</p> <p>2. Review of R33's clinical record revealed the following:</p> <p>11/9/18 - A physician's order indicated to offer to assist R33 to ambulate 120 feet with a rolling walker and with contact guard assistance or stand by assistance twice a day.</p> <p>7/19/19 through 10/14/19 - Review of the TAR revealed that the facility transcribed the order on 11/9/18 and scheduled to offer the ambulation during day and evening shifts and to document</p>	F 688	<p>4. The DON/ADON or designee will audit all residents who are on an ambulation program daily for four (4) weeks, followed by weekly for four (4) weeks until 100% compliance is maintained. Results will be provided to the QAPI Committee for further recommendation.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 688	Continued From page 31 refusals in an administration note. During the periods below, the facility documented "0.00" for length of ambulation with no corresponding administration note, thus, there was a lack of evidence that the facility offered to ambulate R33: - 7/19/19 thru 7/31/19: 7 out of 13 evening shifts. - 8/19/19: 2 out of 31 day shifts and 14 out of 31 evening shifts. - 9/1/19 thru 9/19/19: 1 out of 19 day shifts and 5 out of 19 evening shifts. - 10/1/19-10/15/19 - 1 out of 15 day shifts and 5 out of 15 evening shifts. 10/16/19 4:03 PM - An interview with E3 (RNAC) revealed that on the above shifts in which "0.00" was documented, the facility had no evidence that R33 was offered to be ambulated, as per the physician order. 10/16/19 5:00 PM - An interview with E8 (LPN) revealed that at times during the evening shift, R33 was too weak to ambulate, however, E8 confirmed that he/she had not documented this in the administration note. The facility failed to have evidence that R33 was offered to ambulate with staff assistance twice a day, as ordered. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 688			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697		12/16/19	

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

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F 697	<p>Continued From page 32</p> <p>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to provide pain management in accordance with standards of practice by not assessing resident pain before and after PRN pain medication for one (R35) out of five residents sampled for medication review. Findings include:</p> <p>12/1/01 - The facility policy entitled Pain Management (last revised 5/18/12) included "If the resident is cognitively impaired, the facility shall seek information from the resident's family or other representative as needed and appropriate and utilize the Cognitively Impaired Check Off Nursing Observation form or FLAC (sic. FLACC-face, legs, activity, cry, consolability) Scale to help determine the presence of pain and the effectiveness of pain management interventions."</p> <p>2002 - Pain management standards by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.</p> <p>Cross Refer F684, Example 2</p>	F 697	<p>F697 Pain Management</p> <ol style="list-style-type: none"> 1. Resident 35 has expired. 2. All residents who are currently utilizing pain medication can be affected by the deficient practice. 3. All nursing staff will be in-serviced with Pain Management Policy to include physical monitoring for side effects, pain location, pain ratings and effectiveness of interventions. 4. Auditing of residents with a pain management protocol, as determined by the use of both routine and PRN pain medication(s), will be completed by the DON/ADON/designee to ensure that assessment, side effects, pain location, pain ratings and effectiveness of medication is completed. The daily audit will be completed for four (4) weeks followed by weekly audits for 5. four (4) weeks until 100% compliance is achieved. The results will be provided to the QAPI Committee for further recommendation. 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER THE MOORINGS AT LEWES			STREET ADDRESS, CITY, STATE, ZIP CODE 17028 CADBURY CIRCLE LEWES, DE 19958		
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F 697	<p>Continued From page 33</p> <p>Review of R35's clinical record revealed:</p> <p>10/7/19 - R35 was admitted to the facility on hospice with multiple diagnoses including advanced dementia with severe cognitive impairment.</p> <p>10/8/19 - A care plan was developed that R35 had periods of escalated behavior and could be combative and resistive to care, restless at times and difficult to redirect.</p> <p>10/10/19 - Hospice recommended the pain medication morphine to be scheduled to be given every 6 hours for pain / labored breathing.</p> <p>10/11/19 - The pain medication order entered in the computer failed to include physical monitors for side effect monitoring, pain location and pain ratings.</p> <p>10/11/19 (10:15 PM) - A physicians' order included a one-time STAT dose of morphine for continuously moving around in the bed. A physicians' order included to give PRN morphine every 2 hours if needed for pain or air hunger (labored breathing).</p> <p>10/12/19 (1:05 AM) - A nursing note documented that R35 remained "very restless, rolling in the bed and moaning" prior to another dose of morphine for pain. The pain assessment recorded 10/12/19 for night shift was 4/10 using the Baker-Wong pain scale.</p> <p>October 2019 - Review of R35's physicians' orders, eMAR and nursing notes revealed that R35 received 6 doses of the PRN pain medication:</p>	F 697			

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 697	Continued From page 34 - 6 out of 6 doses lacked an assessment of pain severity (pain score) before (pre) and / or after (post) the medication. - No post pain rating: October 12 (1:45 AM). - No pre / post pain rating: October 13 (9:35 AM), 13 (4:44 PM), 14 (9:06 PM), 15 (3:37 PM) and 16 (10:26 AM). - There was no evidence of side effect monitoring for the pain medication. - The pain scale used for the routine assessment of pain every shift varied, including the use of FLACC Scale, Baker-Wong Faces Pain Rating Scale, and the 0-10 numeric scale. The only scale appropriate for this resident was the FLACC due to severe cognitive impairment. 10/18/19 (9:26 AM) - During an interview with E6 (RN Supervisor) to review pain assessments for PRN medications, E6 confirmed that the expectation would be to assess the pain rating score before and after the PRN pain medication and record them in the clinical record. E6 looked in the computer and confirmed that the morphine order did not include to monitor for recording pain scores or identifying side effects. E6 stated he/she would fix the order today. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 697			
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	F 758		12/16/19	

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 758	<p>Continued From page 35</p> <p>processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§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;</p> <p>§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;</p> <p>§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</p> <p>§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.</p>	F 758			

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 758	<p>Continued From page 36</p> <p>§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:</p> <p>Based on record review and interview it was determined that the facility failed to adequately monitor psychoactive medications for one (R35) out of five residents sampled for medication review. Findings include:</p> <p>4/1/01 - The facility policy entitled Behavioral Management (last revised 11/22/17) included that an "AIMS test is to be completed on all elders on antipsychotic medications initially and every six months ... When an elder exhibits behavioral symptoms that are dangerous, including elder to elder altercation or abuse, these behaviors must be controlled immediately before further assessment and care planning can be done."</p> <p>The facility policy entitled Transcription of Medications (undated without company header / logo) included in the section entitled Transcription of Orders for Medication: "1. Transcription of orders means nurses or other authorized staff write the orders on the MAR or TAR. 2. Nurse/authorized designated transcriber enters the complete order onto the MAR/TAR. Second nurse/authorized transcriber reviews the order transcription by verifying that the information in the MAR/TAR is the same as the order. Note: Facility/program protocols should specify the process for the transcribing and verifying staff to sign or initial the order sheet and the MAR/TAR to establish the identify of who completed the transcription and verification process."</p>	F 758	<p>F758 Free from Unnecessary Psychotropic Medications/PRN Use</p> <ol style="list-style-type: none"> Resident 35 has expired. All residents ordered to receive antipsychotic, antidepressant, antianxiety or hypnotic medication can be affected by the deficient practice. All nursing staff will be in-serviced on the appropriate use and documentation of antipsychotic medication, including initial and every six (6) month AIMS testing, monitoring for effectiveness of the medication, side effects, appropriate use of the medications, behavioral interventions, non-pharmacological interventions and number of episodes. The DON/ADON/designee will conduct daily audits of all residents receiving antipsychotic medication to ensure AIMS testing was completed, effectiveness, side effect monitoring, appropriate use of medication, behavioral interventions, non-pharmacological interventions and frequency are recorded. The audits will continue for four (4) weeks and when 100% compliance is achieved, random audits will be completed weekly for four (4) weeks with results provided to the QAPI Committee for further 		

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

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 758	Continued From page 37 Cross Refer F684, Example 2 Review of R35's clinical record revealed: 10/7/19 - R35 was admitted to the facility on Hospice for advanced dementia with behavioral disturbance. 10/8/19 - A care plan was initiated for "I have periods of escalated behavior, I can be combative and resistive to care, restless at times and difficult to redirect." a. Antipsychotic 10/7/19 - The admission physicians' orders included an antipsychotic (Zyprexa - Olanzapine) scheduled for bedtime and PRN up to three times a day for dementia with behavioral disturbance. The order was entered into the computer without any physical monitors, including side effect monitoring. There was no evidence that a baseline AIMS test was performed when R35 was admitted on the antipsychotic Zyprexa. 10/10/19 - The physicians' orders included an antipsychotic (Haldol - haloperidol) every 4 hours PRN for dementia with behavioral disturbance and stopped the Zyprexa. The order was entered into the computer without any physical monitors, including side effect monitoring. There was no evidence that an AIMS test was performed when R35 was started on the antipsychotic Haldol. 10/11/19 - A physician's order included a one-time	F 758	recommendation.		

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

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FORM APPROVED
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F 758	<p>Continued From page 38</p> <p>STAT dose of Haldol for dementia with behavioral disturbance when R35 was combative and hitting staff.</p> <p>10/15/19 - The physicians' orders included Haldol to be scheduled to be given every 6 hours for anxiety, which was not an appropriate indication. The order was entered into the computer without any physical monitors, including side effect monitoring.</p> <p>10/15/19 - An AIMS test was completed.</p> <p>October 2019 - Review of R35's eMAR showed that R35 received numerous doses of antipsychotics prior to the AIMS test: - Zyprexa: 5 routine and 5 PRNs. - Haldol: 11 routine, 1 STAT and 12 PRNs.</p> <p>b. Anxiolytic (Anti-anxiety)</p> <p>The physicians' orders included an anxiolytic, Ativan (Lorazepam): - 10/9/19: every 4 hours PRN for dementia with behavioral disturbance. - 10/10/19: scheduled to be given every 6 hours for agitation.</p> <p>The orders were entered into the computer without any physical monitors, including side effect monitoring.</p> <p>10/17/19 (around 3:40 PM) - During an interview with E1 (NHA) about R35's behaviors, E1 stated that R35 was constantly moving and fidgety. They [hospice] said R35 had "terminal agitation" (in the final weeks before death the person experienced an internal feeling of restlessness, whereas the person could not stay still).</p>	F 758			

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F 758	Continued From page 39 https://www.hospicepatients.org/terminal-agitation.html 10/18/19 (9:26 AM) - During an interview E6 (RN Supervisor) confirmed that the orders in the computer did not have any physical monitors, including side effects. 10/21/19 (morning) - Review of R35's orders found that E6 (RN Supervisor) re-entered the orders on 10/18/19 and added physical monitors to the Haldol (side effects, behavior interventions, effective, non- pharmacological interventions, and the number of episodes). The Ativan order, however, remained without without any physical monitors. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 758			
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F 809		12/16/19	

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

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F 809	Continued From page 40 §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on review of the facility's scheduled meal times and interview, it was determined that the facility failed to ensure that the meal time, between dinner and breakfast the following day was no more than (14) hours without evidence of a substantial evening snack and resident group approval. Findings include: Review of the facility's scheduled meal times for all residents in the nursing home, it was documented that the dinner meal was served beginning at 5:00 PM and the breakfast meal was served beginning at 8:00 AM, thus, more than 14 hours from dinner to breakfast the following day. 10/14/19 4:00 PM - An interview with E1 (NHA) confirmed that the facility did not offer a substantial evening snack and confirmed there was 15 hours between dinner and breakfast the following day. 10/17/19 9:30 AM - A subsequent interview with E1 (NHA) confirmed that the facility had no evidence that the residents approved the meal time in which there was greater than 14 hours between dinner and the breakfast the following day. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19	F 809	F809 Frequency of Meals/Snacks at Bedtime 1. No specific resident was identified as being affected by the deficient practice. 2. All residents can be affected by the current meal time schedule. All residents were reviewed for the need/desire of a nutritious snack or health snack and ordered accordingly. 3. A resident survey as well as a resident council meeting was conducted on 11/08/2019 to review the posted meal times, customary community meal times and resident preferences. The resident consensus, by majority vote, at this meeting concluded that resident meal times are acceptable as posted. A nutritious snack will be available for all residents at HS. 4. Annual review of meal times will be discussed each November Resident Council meeting to determine resident preference of meal times and reported to the QAPI Committee.		

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

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F 809	Continued From page 41 beginning at 1:10 PM.	F 809			
F 812 SS=E	<p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</p> <p>§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, interview, and review of other facility documentation it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety and comply with the Delaware Food Code. Findings include:</p> <p>1. 10/14/19 (8:10 AM - 8:30 AM) - The surveyor observed several open, undated ready to eat food items during the initial kitchen tour: - Dry Storage: Two bags of mixed nuts (one bag not sealed with plastic wrap). a bag of walnuts, 4-6 small tortillas wrapped in plastic wrap and a</p>	F 812	<p>F812 - Food Procurement/Store/prepare/Serve Sanitary</p> <p>1. All opened and undated food items have been disposed of. All staff with facial hair have been provided with beard guards All surfaces and hand sinks have been sanitized</p> <p>2. All residents can be affected by the deficient practice.</p>	12/16/19	

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

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F 812	Continued From page 42 bag of cookies. - Walk-in #2 refrigerator: A one gallon container of Italian dressing with approximately 4-5 inches of product remaining. 10/14/19 (8:23 AM) - E17 (Cook) confirmed and discarded the opened, undated ready to eat food. 2. 10/18/19 at 12:47 PM - The surveyor observed E19 (Dining Services Employee), E20 (Dining Services Employee) and E21 (Dining Services Employee) preparing food without proper covering on facial hair. 3. 10/18/19 at 1:05 PM -The surveyor observed E20 (Dining Services Employee) placed raw pieces of poultry (chicken) onto a baking sheet with ungloved hands, then left the prep area without performing proper handwashing before touching other kitchen items. 4. 10/18/19 at 1:27 PM - The surveyor observed the handwashing sink in the Main Kitchen, adjacent to the Bistro doorway with a significant amount of shredded carrots and other food debris in the drain area of the sink. 10/18/19 at 2:45 PM - Findings number 2 - 4 were confirmed by E1 (NHA) and E33 (Director of Dining Services). Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 812	3. All Dining staff will be in-serviced on proper resealing and labeling of all food items; hand washing; use of gloves; use of beard guards and hand sink surface utilization. 4. The RD/Dining Director/Designee will perform random observations of the kitchen to ensure sanitation three (3) to five (5) times per week for four (4) weeks until 100% compliance is achieved. Random audits will continue three (3) to five (5) times per month. The QAPI Committee will be notified of the results for further recommendation.		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/16/19	

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

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F 880	<p>Continued From page 43</p> <p>§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.</p> <p>§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:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (A) The type and duration of the isolation, 	F 880			

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

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F 880	<p>Continued From page 44</p> <p>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 other facility documentation it was determined that the facility failed to maintain an infection prevention and control program by incomplete collection of surveillance data, improper linen handling and failure to conduct an annual review of infection prevention and control policies. Findings include:</p> <p>1. Surveillance</p> <p>3/1/17 - The facility policy entitled Surveillance for</p>	F 880	<p>F880 - Infection Control and Prevention</p> <p>1. Surveillance of all infections on the facility line listing will include verification of McGeers criteria including organism and origin. Facility Policy will be reviewed annually by the Nursing Home Administrator (NHA), Director of Nursing (DON) and the Medical Director.</p> <p>2. All residents can be affected by the deficient practice.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 880	<p>Continued From page 45</p> <p>Infections included...the criteria for infections are based on the current standard definitions of infections.</p> <p>February - September 2019 - Review of surveillance data (line listing) revealed incomplete and inconsistent entries:</p> <ul style="list-style-type: none"> - February: 7 out of 7 infections were missing the date of onset of the symptoms or whether infection criteria was met; and one UTI without an organism listed. - March: 6 out of 7 entries were missing whether infection criteria was met; one UTI from the hospital lacked a listed organism to monitor for spread in facility; and there was incomplete classification (where infection occurred: community (out of facility) or healthcare (in the facility). Three residents admitted from the hospital had their infections incorrectly categorized as healthcare acquired. - April: two UTIs without an organism identified and incorrectly categorized as community acquired when both residents were in the facility at least 5 days before developing the UTI. - May: one UTI without an organism and incorrectly categorized as community acquired. - July: one UTI without an organism identified; one rectal infection without an organism identified; and both infections were incorrectly identified as healthcare acquired although they were present on admission from the hospital. - August: one UTI without an organism identified from the hospital that was incorrectly listed as community acquired; one UTI without an organism identified which was incorrectly categorized as community acquired when it developed in the facility. <p>10/17/19 (9:10 AM) - During an interview. E1</p>	F 880	<p>3. Note- the newly added position and hired Assistant Director of Nursing (ADON) will serve as the Infection Preventionist. Completion of the CDC modules for certification will be completed.</p> <p>4. The ADON will record, analyze criteria, organism and origin of all line list infections as needed. The ADON will report deviation from CDC guideline to DON and/or Medical Director and NHA. The Line Listing will be reviewed monthly by the QAPI Committee for trends and provide further recommendations.</p> <p>Linens</p> <ol style="list-style-type: none"> 1. No specific resident was identified as being affected by the deficiency. 2. All residents can be affected by the practice of propping open the door between clean and soiled laundry areas; and failure to perform hand washing following tasks in the soiled area before going to clean areas. <p>The facility has purchased a rectangular trash can to be placed in the clean side of the laundry area to best fit in the area and to eliminate the need to prop open the door &.. space accommodations.</p> <p>Isolation gowns are now stored in a cabinet that was placed in the clean linen side of the laundry area for staff accessibility.</p>		

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F 880	<p>Continued From page 46</p> <p>(NHA) acknowledged that organisms had not been consistently included in the line listing.</p> <p>10/18/19 (afternoon) - E1 (NHA) provided urine culture results for several residents randomly selected from the line listing.</p> <p>10/21/19 - Review of copies of selected line listings provided by E1 (NHA) showed urine culture results (organisms) which were not originally on the line listing, were added to the February and July 2019 surveillance data. These two organisms were among the random urine cultures provided by the facility on 10/18/19.</p> <p>10/21/19 (around 8:55 AM) - During an interview E2 (DON), who conducted the surveillance, stated that E2 reviewed all infections to verify if they met McGeer's criteria.</p> <p>2. Linen 3/1/17 - A facility policy entitled Personal Protective Equipment - Gowns, Aprons and Lab Coats included that personnel must wear a gown, apron or lab coat when performing a task(s) that will likely soil the employee's clothing with blood, body fluids, secretions or excretions.</p> <p>3/1/17 - A facility policy entitled Handwashing / Hand Hygiene (last revised 7/18/18) included "Use of an alcohol-based hand rub containing 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...Before donning gloves...After removing gloves...Hand hygiene is the final step after removing and disposing of personal protective equipment.</p> <p>The following observations and interviews</p>	F 880	<p>Glove dispensers have been added to the walls of both the clean and soiled laundry areas to increase accessibility by staff.</p> <p>3. All Housekeeping and Laundry staff will be in-serviced regarding Infection Control practices specific to linen handling. In-servicing will include availability and usage of personal protective equipment, handwashing and negative air exchange standard to avoid contamination.</p> <p>4. Random audits will be conducted by Director of Facilities, Manager of Support Services or designee to determine compliance. Audits will be done daily for two (2) weeks until 100% compliance is achieved; three (3) times per week for four (4) weeks until 100% compliance is achieved; and then randomly for one (1) quarter until 100% compliance is achieved. Results will be reported to QAPI Committee monthly for further recommendations.</p>		

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F 880	<p>Continued From page 47</p> <p>occurred during the laundry room tour on 10/17/19 between 10:10 AM - 10:30 AM:</p> <p>a. After placing dirty incontinence pads into the washer, E15 (Laundry Aide) removed his/her now-soiled gloves and walked into the clean side of the laundry room to obtain a clean pair of gloves. E15 donned the new pair of gloves without performing hand hygiene. Additionally there were no gowns, aprons or gloves in the dirty side of the laundry.</p> <p>b. The door between the dirty and clean side of the laundry was observed to be propped open. Negative pressure was not maintained in the dirty side to prevent organisms from blowing into the clean side, contaminating the bed linen and towels/washcloths.</p> <p>During an interview on 10/17/19 around 10:15 AM with E15 (Laundry Aide) the surveyor explained the purpose of maintaining negative pressure in the dirty side. E15 admitted the door should be closed, but stated "it's easier" with it open. After E15 closed the door, the surveyor observed that when the two rectangular clean linen carts and a round container were lined against the wall across from the dryers, around 3-4 inches of a linen cart was in front of the door. In order to open the door from the clean side, the linen cart would have to be moved. If the door was opened from the dirty side, the linen cart would be displaced and pushed further into the room.</p> <p>Additional observations throughout the survey when the door between the clean and dirty sides was propped open.</p> <p>- 10/16/19: 2:18 PM, 2:55 PM and 4:45 PM. - 10/17/19: 9:05 AM and 5:25 PM.</p>	F 880			

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F 880	Continued From page 48 - 10/18/19: 7:48 AM, 10:01 AM and 3:56 PM. 10/17/19 (11:45 AM) - During an interview E11 (Support Services supervisor) confirmed that hand hygiene should be performed after removing gloves and that the door should be closed between the clean and dirty rooms. E11 added, "When I am in there, they do the right thing." 3. Policies 10/17/19 (9:10 AM) - During an interview with E1 (NHA) to review the infection control program, the surveyor asked for evidence of the last time infection control policies were reviewed. E1 (employed at the facility for several months) stated the review should occur annually, but E1 would check with corporate staff who were in the facility for the survey. No evidence about the review of the infection control policies was provided during the survey. Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 880			
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program	F 881		12/16/19	

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F 881	<p>Continued From page 49</p> <p>that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation it was determined that the facility failed to adequately monitor for appropriate antibiotic use. In addition an antibiotic without adequate indication was prescribed for one (R35) out of five residents sampled for medication review. Findings include:</p> <p>10/23/17 - A facility policy entitled Antibiotic Stewardship (last revised 11/21/17) included "Practitioners are requested to prescribe antibiotic therapy only when likely to be beneficial to the elder. Culture and sensitivity reports are reviewed routinely as part of the surveillance of infection. Obtain and review antibiogram for trends of resistance on a routine basis from the facility's laboratory provider. Feedback is given to the physician regarding their individual prescribing patterns of cultures ordered and antibiotics prescribed, as indicated."</p> <p>Cross Refer F684, Example 2, F880</p> <p>1. Surveillance</p> <p>February - September 2019 - Review of surveillance data (line listing) revealed the following UTIs were treated with antibiotics without organisms identified to assist with monitoring infections:</p> <ul style="list-style-type: none"> - February: one UTI and one cystitis. - April: two UTIs - May: one UTI. - July: one UTI. - August: two UTIs. 	F 881	<p>F881 Antibiotic Stewardship Program</p> <ol style="list-style-type: none"> 1. Resident 35 has expired. 2. All residents with signs and symptoms of infection are at risk by the deficient practice. 3. The newly added position and hired Assistant Director of Nursing (ADON) will serve as the Infection Preventionist. Completion of the CDC modules for certification will be completed. 4. The ADON will record, analyze criteria, organism and origin of all line list infections as needed to ensure criteria warrants the use of an antibiotic. The ADON will report deviation from CDC guidelines to the DON and/or Medical Director and Nursing Home Administrator. The Line Listing will be reviewed monthly by the QAPI Committee for trends and provide further recommendations. The contract pharmacist will be consulted for all requests for deviations. 		

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F 881	<p>Continued From page 50</p> <p>10/17/19 (9:10 AM) - During an interview, E1 (NHA) confirmed that organisms were now being included in the line listing and recently contacted the lab to see about getting the information.</p> <p>10/21/19 (8:55 AM) - During an interview with E2 (DON) about antibiotic stewardship, E2 stated that E2 looked at the criteria for each infection to verify it met McGeer's criteria. E2 added that the criteria and care paths were available at the nursing station to guide nurses. When asked if there had been any inappropriate antibiotics prescribed and how E2 addressed it with the prescriber, E2 replied there had "not been any initiated here, only the hospital."</p> <p>10/21/19 (9:10 AM) - The surveyor observed, at the nursing station, that McGeer's criteria was in a folder in the front of the file cabinet drawer and the care path binder was on the counter. Review of the binder revealed that each care path provided guidance for the nurse when assessing residents and when the provider should be contacted. Care paths included the areas of: CHF, Fall, Shortness of Breath, Lower Respiratory, Behavior Change, Dehydration, UTI, Gastrointestinal, Fever, Mental Status Change, and Sepsis.</p> <p>Cross Refer F684, Example 2 2. McGeer's criteria for lower respiratory tract infection included: a. Chest x-ray negative for pneumonia or not performed. b. At least two of the following respiratory symptoms: New/increased cough; New/increased sputum production; Oxygen saturation (pulse oximetry) under 94% on room</p>	F 881			

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F 881	<p>Continued From page 51</p> <p>air or a reduction of over 3% from baseline; New/changed lung examination abnormalities; Pleuritic (lung) chest pain; Respirations 25 or more breaths per minute.</p> <p>c. At least one of the following: Fever; Leukocytosis (increased white blood cells indicating infection); Acute change in mental status from baseline; Acute functional decline.</p> <p>Review of R35's clinical record revealed:</p> <p>10/7/19 - 10/16/19 - Review of vital signs, nursing notes and test results revealed:</p> <ul style="list-style-type: none"> - No chest x-ray or blood test results. - Temperatures obtained by tympanic (ear) or temporal (forehead) method ranged from 95.8 to 98.5 indicating no fever). - Respirations ranged from 15-20 breaths per minute. - No pulse oximetry readings after October 10. - No documentation of lung sounds. <p>10/15/19 - Physician / NP / PA Contact note included "(hospice name) Hospice recommendations reviewed by MD (physician) and approved. New orders for ...(name of antibiotic)" to be given twice a day for respiratory infection for seven days.</p> <p>October 2019 - Review of the eMAR showed that R35 started on the antibiotic beginning October 16.</p> <p>R35 did meet criteria for lower respiratory infection according to assessments in the facility's clinical record.</p> <p>10/21/19 (8:45 AM) - During an interview E3 (RNAC) stated that R35 had had some coughing</p>	F 881			

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F 881	Continued From page 52 and was "unable to get up thick sputum (a mixture of saliva and mucus)." 10/21/19 (around 9:05 AM) - During an interview E2 (DON) stated that since a hospice nurse was at R35's bedside around the clock, it "would be their observations and not ours." Findings were reviewed with E1 (NHA), E2 (DON), E4 (Clinical Analyst) and E5 (Corporate Nurse) during the exit conference on 10/21/19 beginning at 1:10 PM.	F 881			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality,
Office of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Moorings at Lewes

DATE SURVEY COMPLETED: October 21, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from October 13 2019 through October 21, 2019. The facility census the first day of the survey was 34. The survey sample totaled 26 residents.</p> <p>For the Emergency Preparedness survey, no deficiencies were cited.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed October 21, 2019: F550, F656, F661, F684, F686, F697, F809, F812, F880, and F881.</p>	<p>Please reference CMS2567-L for Plan of Correction regarding F550, F656, F661, F684, F686, F697, F809, F812, F880 and F881.</p>	<p>01/07/2020</p>

Provider's Signature *[Signature]* Title Administrator Date 11/13/19