DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Moorings at Lewes

DATE SURVEY COMPLETED: December 22, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. **POST IIDR** **REVISED REPORT** An unannounced Annual and Complaint Survey was conducted at this facility from December 19, 2022 through December 22, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was thirty-four (34). The survey sample totaled eighteen (18) residents.		
3201			
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed December 22, 2022: F558 and F688	The Plan of Correction submitted on the CMS2567, January 24, 2023, related to F558 and F688 with a Credible Date of Allegation of February 17, 2023 is attached in reference to the deficiencies noted here-in.	2/17/2023

Provider's Signature AW Moore NHA Title Administrator/Exec Dir Date 4/5/2023 rev as requested

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085053	A. BUILDING ______ B. WING ______	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOORINGS AT LEWES	**17028 CADBURY CIRCLE LEWES, DE 19958**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from December 19, 2022 through December 22, 2022. The facility census was 34 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from December 19, 2022 through December 22, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was thirty-four (34). The survey sample totaled eighteen (18) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0- 7: Severe impairment; CNA - Certified Nurse Aide; Contact Guard Assistance - the resident performs 100% of the activity, caregiver maintains contact	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 01/12/2023

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

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F 000	Continued From page 1 for safety only, but is not providing physical assistance; DON - Director of Nursing; Limited assistance - resident highly involved in activity and received physical help in guided maneuvering of limbs or other non-weight bearing assistance three or more times during the last 7 days; LPN - Licensed Practical Nurse; MD - Medical Doctor; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; NHA - Nursing Home Administrator; O2 - oxygen; OT - Occupational Therapy; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R3) out of one resident(s) sampled for accommodation of needs, the facility failed to ensure that R3's call bell was within reach. Findings include: The following observations were made of R3:	F 558	1. R3's call bell was placed within reach. 2. All residents are at risk for not having call bell within their reach at times. 3. All SNF staff will be in-serviced by ADON/Designee to be reminded that upon entry and exit of all occupied resident rooms for any reason, they are to	2/17/23

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F 558	Continued From page 2 3/18/21 - Record review indicated that R3 was admitted to the facility with a history of a stroke with left sided weakness. 10/18/22 - A quarterly MDS assessment documented that R3 was cognitively intact and required assistance for transfers. 12/19/22 10:03 AM - E9 (CNA) knocked on the door and asked R3 if he was ready to get up. 12/19/22 10:46 AM - R3 was sitting up in his recliner with the call bell hanging off the end of the bed out of reach. 12/19/22 10:56 AM - The call light remained hanging off the end of R3's bed. 12/19/22 1:10 PM - An interview with E9 (CNA) confirmed R3's call bell was not in reach after morning care stating, "It slipped my mind, I usually give it to him, oh I'm sorry, I forgot." 12/22/22 10:41 AM - E10 (CNA) was observed leaving the room after R3 was up in the recliner and the call bell was not in reach. The call bell was attached to the left side of the bed. The Surveyor informed E10 that R3's call bell was not in reach and E10 confirmed and stated, "I forgot." Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 12/22/22 at 3:39 PM.	F 558	verify call bell placement for appropriate proximity to the resident and to correct, if necessary. Corrections are to be reported to the assigned nurse. 4. All caregivers, upon exit of an occupied resident's room, are responsible for monitoring the appropriate placement of the call bell. Daily, ten (10) random Call Bell Placement Audits will be conducted by facility Directors/Managers/Designee for four (4) weeks until 100% compliance is achieved consecutively over the course of six (6) shifts. Subsequently, weekly, for four (4) weeks, ten (10) random audits will be conducted until 100% compliance is achieved. Audit compliance will be referred to the QAPI Committee for further recommendation. The date of credible allegation is February 17, 2023	
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	F 688		2/17/23

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F 688	Continued From page 3 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R3) out of one resident reviewed for positioning, the facility failed to ensure that appropriate treatment and services were provided to maintain and/or increase range of motion. Findings include: The following was reviewed in R3's clinical record: 3/18/21 - R3 was admitted to the facility with a history of a stroke with left sided weakness. 1/26/22 - A Quarterly Occupational Therapy screen for services documented there were no changes and therapy services were not indicated at this time for R3. 2/21/22 - Record review of Rehab functional status form documented that R3 was to receive PROM (passive range of motion) to the left upper	F 688	1. Range of motion programming is completed daily to best meet the needs of R3s schedule and preferred method of care delivery. It is not referred to as "exercise" to R3 and ROM is greater than 15 minutes in a 24H day. There has been no functional decline since admission 3/18/21 lending to practiced based evidence that all programming occurs as ordered. TAR reflects completion of 15 minutes of range of motion each 24 hours. 2. All long-term care residents will continue to be screened by PT/OT for changes in range of motion and/or mobility quarterly and/or upon change in condition to determine appropriate services, equipment, and assistance to maintain their status or to improve. Those residents with conditions that make	

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F 688	Continued From page 4 extremity, AAROM (active assisted range of motion) to the left lower extremity, and AROM (active range of motion) to the right upper and lower extremity for 15 minutes one time a day and signed by nursing. 2/22/22 - A physicians order written for R3 included PROM to the left upper extremity, AAROM to the left lower extremity and AROM to the right upper and lower extremity for 15 minutes one time a day. 4/13/22 - A physicians order documented that a left palm protector was to be applied in the morning after AM care check for signs for ill fit every shift. Remove after PM care or as per resident request patient may remove ad-lib. 10/18/22 - A quarterly MDS assessment documented R3 as having upper and lower impairment to his left upper arm and left hand. 12/19/22 10:46 AM - R3's left hand was observed to be contracted and R3 was not wearing a palm protector. 12/19/22 11:56 AM - R3's left hand was observed resting on his lap and R3 was not wearing palm protector. 12/20/22 1:50 PM - During an interview, R3 revealed, "Nobody comes in to do any exercise to my hand." 12/20/22 1:25 PM - During an interview, E9 (CNA) stated, "Usually the ROM is getting done when I'm getting him up to go to the bathroom and with his bathing he likes to get washed up in the bathroom, I raise his left arm up to put his	F 688	decline unavoidable will have plans of care implemented that reflect modifications for accommodations of needs and services. Those residents that refuse suggested interventions are offered alternatives to best meet the goal of improvement, maintenance or prevention of decline. 3. Certified staff will be in-serviced on Passive and Active range of motion technique by PT/OT, how to appropriately and effectively incorporate ranging into ADLs and accurately documenting the time that the activity was provided over the course of the day. All resident's range of motion programming will be added to CNA Care Maps by the ordering therapist. The assigned nurse will verify with CNA that ordered range of motion programing has been completed, as required, on each resident, as ordered. 4. OTR/COTA/PT/PTA will observe 10% of all ordered range of motion sessions three (3) times per week for four (4) weeks until 100% compliance has been achieved for three (3) consecutive observations independent of therapist's intervention. (Technique, duration, documentation). Subsequently, said licensed therapists will then observe 10% of the ordered programming once (1) per week for four (4) weeks until 100% compliance is achieved. Audit compliance will be referred to the QAPI Committee for further recommendation.	

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F 688	Continued From page 5 shirt on and move his legs to put his pants on." 12/20/22 2:00 PM - During an interview, E7 (Physical Therapy Aide) stated "CNA typically does the range of motion." 12.20/22 3:04 PM - During interview, E4 (Certified Unit Manager) stated "the nurse signs off that the range of motion is being done." E4 showed the Surveyor where the nurse signs off that the range of motion, was done December 7 through December 20, 2022. 12/21/22 3:45 PM - During an interview, E8 (RN) stated, "I don't guide the CNA in how to do range of motion, they have already been educated on how to do it and I can't say how long the range of motion is being done because I don't watch them, but I know it's being done because I know my staff." 12/22/22 9:59 AM - During interview, the Surveyor asked E10 how she does his range of motion E10 (CNA) stated, "He has his own way of doing things, he doesn't want you to do a lot for him, but I lift his legs and put a rolled-up washcloth in his left hand." The interviews identified that staff were considering delivering care, including dressing, bathing and toileting to be ROM. There was no evidence that R3 was receiving 15 minutes of ROM (exercise) daily as prescribed. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 12/22/22 at 3:39 PM.	F 688	The date of credible allegation is February 17, 2023	