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

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

STATE SURVEY REPORT

NAME OF FACILITY: Center of Eden Hill **DATE SURVEY COMPLETED: August 13, 2021**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility beginning August 5, 2021 and ending August 13, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the entrance day of the survey was 62 residents. The investigative sample totaled twenty-two (22).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed August 13, 2021: E037, F574, F624,		

Provider's Signature _____ Title _____ Date _____

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	F657, F677, F684, F686, F756, F761, F812, F842, F880, F943.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		9/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/06/2021

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

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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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E 037	Continued From page 2 arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 3 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency	E 037		

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E 037	Continued From page 4 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that for three (E10, E11, and E12) out of fifteen (15) sampled employees the facility failed to provide emergency preparedness training at least annually. Findings include: Review of facility records for emergency preparedness training revealed three (3) staff members without evidence of training within the past year: - E10's (CNA) most recent record of emergency preparedness training was 7/14/19. - E11's (CNA) most recent record of emergency preparedness training was 7/29/20. - E12's (RN) most recent record of emergency preparedness training was 1/16/20. These findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	E 037	1. No staff were adversely affected by this practice 2. All staff have the potential to be affected by this practice 3. The root cause analysis confirms 3 staff members did not complete the required training per company policy and/or facility designee did not consistently monitor for compliance. The expectations were reinforced with these associates to maintain timeliness with education requirements. All staff notified that Relias training must be completed annually. This includes Emergency Preparedness Training. 4. Executive Director/Human Resources or designee to perform weekly audits x 4 weeks on all staff until 95% or greater compliance, then audits x 2 months until 95% compliance achieved. Staff will be removed from working schedule if Relias training not completed by 9/6/21 ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility beginning August 5, 2021 and ending August 13, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the entrance day of the survey was 62 residents. The investigative sample totaled twenty-two (22). Abbreviations used in this report are as follows: ADON - Assistant Director of Nursing; DON - Director of Nursing; CNA - Certified Nurse's Aide; FM - Family Member; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; UM - Unit Manager; ADL - Activity of daily living; EMR (Electronic Medical Record) - computerized medical record; MAR (Medication Administration Record) - record of the medications administered to a patient at a facility; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; PRN - as needed; Seroquel - antipsychotic medication.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to	F 574		9/10/21

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F 574	Continued From page 6 receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State	F 574		

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F 574	Continued From page 7 Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documents, it was determined that the facility failed to ensure that residents were informed of the ombudsman including contact information and their right to file a grievance/complaint. Findings include: 8/10/21 1:21 PM - During a Resident Council Meeting, three out of three residents did not know the ombudsman's name or what the ombudsman's duties entailed and two out of three of the residents did not know how to file a	F 574	1. R9 was not adversely affected by this practice 2. All residents have the potential to be affected by this practice 3. The root cause analysis shows postings do not meet standards to adequately educate patients on process. Policy dissemination did not include the form for grievance and specific contact information for ombudsman including steps. All nursing staff were in-serviced on facility grievance policy on 8/26/21. All	

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F 574	Continued From page 8 grievance. 8/10/21 3:00 PM - A tour of the facility revealed that the ombudsman's name was posted at a level that would be difficult for a resident in a wheelchair to see. 8/10/21 3:15 PM - On a tour of the facility, a grievance form was found on the second and third floor nursing stations. They were located chest high when standing, too far up to be seen if sitting in a wheelchair. 8/11/21 9:00 AM - An interview with R9 revealed that he was not made aware of how to file a grievance with the facility. 8/12/21 1:22 PM - The facility admission package provided by E2 (DON), did not include what the ombudsman program is and how residents can file a grievance or complaint. These findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 574	admission packets include Ombudsman contact information and updated grievance form. 4. Director of Nursing/Assistant Director of Nursing or designee will perform weekly audits x 4 weeks until 100% compliant and then monthly x 2 until 100% compliance. Results of audits will be submitted and discussed monthly at QAPI to determine further interventions. ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by:	F 624		9/17/21

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F 624	Continued From page 9 Based on interview and record review it was determined that for one (R107) out of two residents sampled for discharge the facility failed to provide a safe and orderly discharge when R107 was discharged while at a doctors appointment, returning to the facility with belongings already packed up and her room cleaned. R107 then had to leave and later return to the facility for discharge orders, instructions and teaching during which R107 was sent home with medications that belonged to another resident (R158). Findings include: The facility policy entitled "Discharge Policy and Procedures", last updated 2/1/16, indicated, "Discharge is a coordinated effort ...occasionally an extra day is necessary to make all of the proper arrangements before a patient is discharged...all of the post discharge arrangements should be made by our staff in a pleasant and accommodating manner. " Review of R107's clinical record revealed: R107 was admitted to the facility on 6/15/21 and discharged on 6/23/21. 6/15/21 - A care plan for discharge was created and then updated 7/5/21, for R107's goal of being involved in my discharge process. Interventions included to communicate with patient and or family as needed related to progress, goals and plans. 6/18/21 11:44 AM - A social service progress note documented, "Care plan [meeting] with resident, her daughter and IDT to discuss plan of care, progress, and discharge planning... Plans to return home with her sister. "	F 624	1. R107 and R158 were not adversely affected by this practice and no longer reside at the facility 2. All residents have the potential to be affected by this practice 3. The root cause analysis was performed and determined there was lack of communication for discharge goals and transition of care for this patient. Director of Nursing in-serviced nursing on facility discharge policy on 8/26/21 4. Case Manager or designee will perform weekly audits x 4 weeks on all discharged residents until 100% compliance noted, then monthly x 2 to ensure 100% compliance that all IDT discharge papers are signed by resident or responsible party on discharge. Audits to be submitted to QAPI committee to determine if further audits are required. ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	

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F 624	Continued From page 10 6/23/21 - An order was written for R107 to be discharged to home. 6/23/21 12:19 PM - A social work progress note documented, "Was informed by R107's insurance that she is ready to go home today. She wants outpatient therapy." 6/23/21 untimed - A physicians progress note for discharge documented, "Patient seen today for discharge she was covered for services by her insurance company. Patient is very deconditioned, is high risk for fall with injury and/or rehospitalization due to being discharged home today. She would have benefited from continued rehab. Patient is to follow-up with her primary care physician and oncology within 7 days. She has been provided with all needed prescriptions, and medical equipment. Availability of home health care services questionable due to abrupt discharge. Case manager following closely." 6/23/21 - An interdisciplinary discharge summary documented R107 was discharged home at 3:00 PM. 6/23/21 4:18 PM -A discharge note documented, "Patient discharged at approximately 12:00 PM... transported via family car accompanied by her sister. Medication sent, personal belongings sent. List physician and responsible party notification of discharge. General condition alert and pleasant. Behavior, mood upon discharge pleasant, education provided. 6/23/21 11:35 PM - A progress note documented, "Patient and sister called facility follow up for	F 624		

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F 624	Continued From page 11	F 624		

discharge instruction and papers. Nurse instructed both to come to facility which they did. Nurse gave discharge instructions to both patient and sister. All questions answered and medications reviewed. Nurse instructs sister to call facility the following day to discuss her concerns about being discharged while out of facility and without paperwork."

6/24/21 1:16 PM - A nursing progress note documented "Both patient and sister were given medications prescriptions and discharge papers. They refused to sign the discharge paperwork."

During an interview on 8/11/21 at 4:21 PM with FM1, it was confirmed that R107 was discharged with medication that did not belong to R107, the medications had R158's name on them. FM1 then emailed the surveyor pictures of the medications, three white plastic bags containing a total of six of medications, which had R158's name and not R107's name on them. FM1 then explained "We didn't know she was discharging. She went to a doctors appointment and when we returned and her belongings were cleaned out. We asked a nurse what was going on and the other nurse said she's been discharged and here's some of the orders. Then they asked that we wait so we did and then asked us to come back for teaching, the rest of the orders and medications. When we came back, I said I'm not signing these because they discharged her [R107] without any knowledge in advance. We got home and so I looked at everything and they had given her [R107] someone else's [R158's] medication. So I called and E20 (RN) said the rest of the discharge papers were ready and I told them we were given the wrong medication and E20 said to bring them and when we

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F 624	Continued From page 12 returned he didn't take them." During an interveiw on 8/11/21 at 4:14 PM, E2 (DON) confirmed the facility did not report R107 receiving another residents (R158's) medication at discharge to the state agency, and that E20 (RN) who assisted R107 with discharge, was unavailable due to an extended vacation. During an interview on 8/12/21 with E16 (RN Case Manager) it was confirmed that R107 was discharged while out of the facility at a doctors appointment. E16 stated, "R107 was cut by insurance and left before I could get to the floor. The insurance was managed care and they informed me of that day of discharge. R107 had gone to a doctors appointment. I was in a meeting when I came back to her room it was cleaned out by housekeeping." E16 confirmed the facility did not provide R107 notice and that E16 did not have contact with R107 after R107 left the facility for the doctors appointment. E16 stated, "I assisted with paperwork and gave it to the floor nurses and the nurse practitioner. I believe R107 was told by the insurance directly of discharge that morning." When asked if E16 attempted to assist R107 with discharge, E16 stated "I tried when I left my meeting, but R107 had already gone to the doctor." E16 denied knowledge that R107 then had to return to the facility for discharge orders, education and prescriptions and was unaware that R107 was given R158's medications. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 624		
F 657 SS=D	Care Plan Timing and Revision	F 657		9/17/21

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F 657	Continued From page 13 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R3 and R50) out of twenty-two residents in the investigative sample the facility failed to ensure that care plans were revised to reflect residents interventions. R3's care plan for preferences was not revised to include R3's preferred time to receive morning medications. R50's care plan for skin did not	F 657	1. R3 and R50 no longer reside at facility and were not adversely affected by this practice 2. All residents have the potential to be affected by this practice 3. The root cause analysis determined that the facility did not revise the care plan to reflect the residents interventions and	

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F 657	Continued From page 14 include the intervention for off loading, resistance to care, and refusals to off load. Findings include: 1. Review of R3's clinical record revealed: 5/31/21 - An admission MDS assessment documented R3 as mentally intact. R3's care plan for personal preferences, last updated on 6/5/21, had a goal to meet R3's personal preferences during his stay, including an intervention of permission given to wake up R3 to administer medications, therapy or other services. During an interview on 8/9/21 at 8:05 AM, R3 responded "No" when asked if he can make choices that affect his daily life such as when he receives his medications. R3 then stated, "I don't like that they interrupt you with pills while eating they should give them a different time." During an interview on 8/11/21 at 9:13 AM, E5 (RN) confirmed that R3 prefers all of his medications after breakfast. When asked how other nurses would know this information, E5 responded "I tell them in report, the regular nurses should know." E5 was then asked whether R3's preferences care plan included this intervention E5 responded "No" and stated, "I can discuss that with our supervisors and the NP." Review of R3's care plan for preferences lacked evidence of R3's preference to have medications administered after meals. 2. Review of R50's clinical record revealed: 7/19/21- R50 was admitted to the facility with a pressure ulcer to the right heel.	F 657	preferences. Director of Nursing completed in-service for all nursing staff on facility care plan policy. 4. DON/ADON will perform weekly audits x 4 weeks (or until 100% compliance) on new residents to ensure that the care plan includes the intervention to off load heels and any preferences to include permission to wake up for medication. Audits to be discussed at QAPI to determine further need.	

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F 657	Continued From page 15 7/19/21 - An order was written for R50 to have heels off loaded while in bed. 7/20/21 - A care plan for actual skin breakdown, a pressure ulcer to the right heel was created and then revised on 7/30/21. Interventions for the care plan did not include off loading of R50's heels. 8/7/21 - A care plan for being resistive to treatment/care related to mental impairment was created due to refusal of a knee immobilizer and hip abductor pillow at times. There was no documentation in the care plan regarding refusal of a pillow for off loading. During an interview on 8/11/21 at 11:03 AM, E2 (DON) reported that R59 had a care plan for resisting off loading and stated, "The nurse mentioned yesterday surveyors asked about it [off loading], but he is non-compliant. I have him care planned for that." Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for one resident (R307) out of two sampled residents for ADLs,	F 677	1. R307 no longer resides at facility and was not adversely affected by this practice 2. All residents have the potential to be	9/17/21

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F 677	Continued From page 16 the facility failed to help R307, who was dependent with some of his ADLs. Findings include: 7/24/21- R307 was admitted to the facility post-acute kidney injury and urinary tract infection. 7/25/21 - The baseline care plan revealed that R307 required extensive assistance for toileting, bed mobility, and was dependent for lower body dressing and transfers. Interventions in the care plan included help with grooming, bathing, and personal hygiene per the resident's preferences. The care plan also stated, "I have actual/potential decline in my ability to perform my activities of daily living." Care plan tasks included bathing on Monday and Thursday as needed. 8/8/21 - A Physical Therapy note documented R307 had right sided weakness from an old stroke. 8/11/21 10:0 AM - R307 was observed to be ungroomed and unshaven. The surveyor asked if it was his preference to have a beard, R307 replied no. R307 stated that he had not been bathed or shaved in nine days. 8/11/21 10:49 AM - An interview with E21 (CNA) revealed "Residents get bathed twice a week, however, since R307 has not been able to get in the shower, R307 would get a full bed bath twice a week." E21 further revealed that she washes R307 every morning. 8/11/21 11:00 AM - During an observation, R307 commented he had not had a bath in nine days. In an interview with E4 (RN), the surveyor asked	F 677	affected by this practice 3. The root cause analysis was completed which shows from staff interviews that though bathing attempts may have been offered, refusals were not appropriately documented. Director in-serviced all nursing staff on facility shower policy including any refusals 4. DON/ADON will perform weekly shower audits on all residents x 4 weeks until 100% compliant the monthly x 2 until 100% compliant. Audits to be reviewed by QAPI committee. ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	

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F 677	Continued From page 17 what the facility policy was on helping with the shaving of male residents. E4 stated that in the past, the facility had someone who came in and provided this service, but it hasn't been available for a long time. E4 told R307 that if his wife could bring in an electric razor, he would shave him. 8/11/21 12:51 PM - Review of documentation revealed that there were two documented baths since admission and occupational therapy provided both. There was no evidence that nursing had completed a bath on R307. 8/12/21 10:05 AM - In an interview with E2 (DON), she commented that all residents are scheduled for baths twice a week. If they cannot get in the shower for some reason, they would be washed up at the sink or in bed. She said residents get washed up every day unless they refused. 8/12/21 12:00 PM - Review of nursing documentation revealed no evidence that E307 refused bathing. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		9/17/21

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F 684	Continued From page 18 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation it was determined that for two (R9 and R39) out of 22 residents reviewed for care and services, the facility failed to provide treatment in accordance with the plan of care. For R39, the facility failed to follow a physicians order for two different dressing changes and for R9, the facility failed to complete treatments to R9's feet. Findings include: 1. Review of R39's clinical record revealed: a. 7/14/21- A physician's order was written to change R39's PICC line (IV access for long term medications) dressing every seven days and as needed. 7/20/21- An admission MDS Assessment documented R39 as receiving special treatments. 8/5/21 at 3:01 PM - An observation of R39's dressing to the PICC line was dated 7/21/21. The dressing had not been changed in fifteen days. 8/5/21- Interview with E2 (DON) confirmed the PICC line dressing had not been changed and confirmed the physicians order was to change the dressing every seven days and as needed. b. 8/1/21 - A Physicians order for R39's dressing change to the right and left heel wounds documented to cleanse, apply foam pad, abdominal pad and wrap with ace wrap (elastic compression dressing).	F 684	1. R9 and R39 were not adversely affected by this practice 2. All residents with wound care orders have the potential to be affected by this practice 3. The root cause analysis determined that the nurse did not provide treatment in accordance with the plan of care. Director of Nursing completed in-services on 8/26/21 for basic dressing change policy and central venous catheter dressing changes 4. DON/ADON will perform weekly audits x 4 weeks to observe wound dressing changes and PICC line dressing 4 weeks until 100% compliance. Audits to be submitted at QAPI to determine if further audits are needed.	

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F 684	Continued From page 19 8/2/21 - A wound care physician updated the order for the right and left heel wounds to cleanse, apply foam pad and wrap with gauze dressing. 8/10/21 - Review of the August TAR, last updated 8/2/21, lacked evidence that the treatment order was updated to reflect the changes. 8/10/21 11:42 AM - E19 (LPN) was observed changing R39's dressings to the right and left heel wounds. E19 asked R39 what type of dressing was being used on the right heel. R39 stated, "It's a pink square and tape (foam dressing)." E19 applied the pink square foam dressing and tape. No gauze dressing was used. 8/10/21 12:10 PM - During an interview with E19 when asked by the surveyor what type of dressings were ordered for R39's feet, E19 was unable to answer and confirmed the physician order was not verified before performing the dressing changes. 2. 6/18/21 - Resident admitted to the facility 7/7/21 12:35 PM - A physician's order for Eucerin cream was written to be applied to both feet. 8/2/21 4:24 PM - The treatment administration record documented that the Eucerin cream was not available, and the treatment to R9's feet was not completed. 8/5/21 4:00 PM - During an interview, R9 reported that he had a "treatment" ordered for his feet that had only been done three times since it was ordered.	F 684		

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F 684	Continued From page 20 8/6/21 11:56 AM - An observation revealed that R9's feet were very dry. R9 again commented that there was a cream that was ordered for his feet, but the treatment had not been done because the cream was not available. 8/6/21 12:00 PM - During an interview, E16 (RN) revealed the cream was not available and that E16 was placing a pharmacy order for it. 8/10/21 8:49 AM - An interview with E6 (LPN) revealed the cream still had not arrived four days later. 8/11/21 8:40 AM - An interview with R9 revealed that the treatment still had not been done to his feet because the cream was not available. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 684		
F 686 SS=D	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.	F 686		9/17/21

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F 686	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R50) out of two residents sampled for pressure ulcer review, the facility failed to ensure that R50 received treatment and services to promote the healing of a pressure ulcer when R50's heels where not off loaded as per physicians orders. Findings include: Review of the facility policy for Pressure Ulcers indicated, "... Physician will authorize pertinent orders related to wound treatments. " Review of R50's clinical record revealed: 7/19/21- R50 was admitted to the facility with a pressure ulcer to the right heel and a broken hip. 7/19/21 - An order was written for R50 to have heels off loaded while in bed. 7/20/21 - A physicians progress note for wound care evaluation documented, "treatment twice a day and off load in bed...Recommended use of pillows vs (versus) heel boots for off loading." 7/20/21 - A care plan for the actual skin break down and pressure ulcer to the right heel was created and then revised on 7/30/21. Interventions included skin treatments per physician orders. 7/26/21- An admission 5 day MDS assessment documented R50 as requiring extensive assistance of two people for bed mobility and being at risk for pressure ulcers with one unhealed pressure ulcer and the use of pressure	F 686	1. R50 no longer resides at facility and was not adversely affected by this practice 2. All residents have the potential to be affected by this practice 3. The route cause analysis was performed and indicated the facility failed to consistently relay patient needs to caregiver staff and/or monitoring staff understanding of care plan. Director of Nursing completed inservicing on policy for preventing/healing pressure ulcers 8/26/21 4. DON/ADON or designee will perform random weekly audits of 20% of current census x 4 weeks until 100% compliance obtained for off loading heels. ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	

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F 686	Continued From page 22 reducing devices. R50 was observed in bed without off loading on the following dates: 8/5/21 1:02 PM - R50's heels were directly on the bed. 8/6/21 8:14 AM - R50's heels were directly on the bed. 8/10/21 12:47 PM - R50's heels were directly on the bed. 8/10/21 1:49 PM - R50's heels were against the foot board. 8/11/21 9:26 AM - R50's heels were directly on the bed. 8/12/21 8:01 AM - R50's heels were directly on the bed. 8/12/21 9:12 AM - R50's heels were against the foot board. During a wound care observation on 8/10/21 at 2:01 PM, E6 (RN) completed wound care treatment to R50 and when finished, E6 left R50's heel's directly touching the bed. E6 was asked about off loading and responded, "No we just place this hip abductor pillow here for his broken hip, that's all." 8/10/21 2:18 PM - E18 (CNA) entered R50's room to obtain R50's weight. E18 then left R50's room without off loading R50's heels. When E18 was asked if R50 was to receive any other interventions to protect his heels, E18 stated, "No, I don't think so, just the hip abductor pillow." During an interview on 8/10/21 at 2:32 PM, E6 (RN) stated, "Correction, the order for offloading is a standard protocol and R50's heels should be offloaded." E6 then accompanied the surveyor to R50's room and offloaded R50's heels with a	F 686		

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F 686	Continued From page 23 pillow. During an interview on 8/11/21 at 11:03 AM, E2 (DON) stated, "I wanted to show you that I offloaded him." R50 was observed in bed with a heel boot to the right heel and the left heel directly on the bed; a physicians progress note written on 7/20/21 did not recommend the use of heel boots for off loading. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 686		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		9/17/21

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F 756	Continued From page 24 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy and procedure, it was determined that the facility failed to develop policies and procedures (P & P) for the monthly Medication Regimen Review (MRR) that included the time frames for different steps in the MRR process. In addition, the facility failed to ensure that the June 2021 MRR by the Consultant Pharmacist was reviewed by the attending physician for one (R12) out of five sampled residents for unnecessary medication review. Findings include: 1. Review of the facility policy entitled, "Pharmacy Services", last updated 12/3/19, failed to include the time frames for different steps in the MRR process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident and indicated, "...The attending physician will document that he/she reviewed the identified irregularity, the action taken to address the	F 756	1. R12 was not adversely affected by this practice 2. All residents that have a MRR have the potential to be affected by this practice 3. The root cause analysis performed showed 1 recommendation was not reviewed by physician. Analysis did not show any significant trend beyond the individual deficiency noted. The facility has a policy for the MRR that includes the different time frames for the steps in the process. The policy is entitled Policy 8.2 Medication Regimen and Review Director of Nursing completed inservicing with all nursing staff on 8/26/21 regarding the MRR. 4. DON/ADON will audit MMR weekly x4 and then monthly x 2 for all residents until 100% compliance achieved ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR	

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F 756	Continued From page 25 irregularity, or the reason for not changing the medication related to the identified irregularity. " 2. Review of R12's clinical record revealed: 6/30/21 - An MRR was completed for R12 by the pharmacist that included a recommendation to be responded to by the attending physician. During an interview on 8/12/21 at 12:22 PM, E2 (DON) confirmed the facility could not provide evidence that R12's 6/30/21 MRR recommendation was reviewed by the attending physician and confirmed the facility policy did not include time frame's for the MRR process. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 756	INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		9/17/21

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F 761	Continued From page 26 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store and maintain drugs in accordance with acceptable professional principles by having undated insulin pens in one out of three medication (med) carts that were inspected. Findings include: The facility policy entitled "Medication Storage Policy", last updated 7/1/16, indicated, "12. Insulin products...note the date on the label for insulin vials and pens when first used...". 8/6/21 3:30 PM - During observation of the second floor medication cart with E5 (RN), two opened and undated insulin pens were located in the first drawer. This finding was immediately confirmed by E5. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 761	1. No residents were adversely affected by this practice 2. All residents with insulin have the potential to be affected by this practice. 3. Route cause analysis was performed and indicated that the facility had updated insulin pens in the medication cart. Completion of nursing education/inservicing to nursing staff was done by Director of Nursing by 8/26/21 on "medication storage" 4. DON/ADON or designee will perform weekly audits x 4 and then monthly x 2 until 100% compliance is met. Audits to be reviewed at QAPI to determine if future audits are needed.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/17/21

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F 812	Continued From page 27 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to monitor food temperatures in accordance with professional standards for food safety for reheating/ holding food items, ensuring sanitary storage of food, protecting quality of food, and maintaining consistent food temperature logs. Findings include: 1. 8/5/21- 8:37 AM - During a tour of the kitchen, the surveyor observed an approximately three (3) inch long icicle attached to the sprinkler head on the ceiling and several patches of frost and ice on the floor of the walk-in freezer. Interview with E14 (Cook) confirmed that occasionally the seal on the door doesn't function correctly causing condensation to form in certain spots in the freezer, which later turns into ice. 2. 8/6/2021 - 10:10 AM - During a review of the food temperature logs, the surveyor observed	F 812	Freezer 1. No residents were adversely affected by this practice 2. All residents have the potential to be affected by this practice 3. The walk in freezer was evaluated by Food Equipment Service on 8/20/21 and the door heater, gasket and sweep will be replaced/installed by 9/10/21 4. Weekly audits x 4 weeks to be completed by Executive Chef/ Maintenance or designee to ensure no reappearance of visible ice on floor or sprinkler head to ensure correction was effective. Audits to be reviewed at QAPI to determine if any other interventions are needed. Temps 1. No residents were adversely affected by the practice	

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F 812	Continued From page 28 numerous meals out of five hundred forty-three (543) reviewed for temperatures had no temperatures recorded for the mechanical soft and pureed foods. Temperatures of cooked foods and cold ready to eat foods with alternative food preparation were not being consistently recorded prior to being served. According to the Delaware Food Code regulation 3-501.16 fish, meat, poultry, and vegetables must be heated and held at or above one hundred thirty-five (135) degrees Fahrenheit (F), and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. 8/10/2021 - 11:50 AM - Findings were reviewed and confirmed with E13 (Executive Chef). These findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 812	2. All residents on a mechanical soft or puree diet have the potential to be affected by this practice 3. The root cause analysis was performed and results will be reviewed at QAPI. Executive Chef will in-service dietary staff on the monitoring of food temperatures in accordance with professional standards. 4. Executive Chef or designee will perform weekly audits x 4 weeks until 100% compliance with consistent food temperature logs are maintained. ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		9/17/21

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F 842	Continued From page 29 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F 842		

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F 842	Continued From page 30 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the accuracy of resident records for one (R3) out of one resident reviewed for dialysis. R3 had admission orders to receive injections on Tuesdays, Thursdays, and Saturdays at dialysis. R3 goes to dialysis on Mondays, Wednesdays and Fridays. Findings include: Review of R3's clinical record revealed: 5/24/21 - Admission physician orders for R3 included an order for injections at dialysis on Tuesdays, Thursdays, and Saturdays. 5/26/21 - R3's dialysis days were scheduled for Mondays, Wednesdays and Fridays. During an interview on 8/11/21 at 10:50 AM, E17 (RN, UM) on R3's floor confirmed the discrepancy for R3's injections to be given at dialysis and stated, "I believe there was a change, and it was not updated." 8/16/21 - R3's orders were changed to reflect injections to be given at dialysis on Mondays, Wednesdays and Fridays.	F 842	1. R3 no longer resides at facility and was not adversely affected by the practice. 2. All residents that go to dialyses have the potential to be affected by this practice 3. R3 orders were changed to reflect injections to be given at dialysis on Monday, Wednesday and Friday. All nurses completed education on 8/26/21 to ensure that medication given at dialyses has been profiled in orders to reflect the correct day to be given. 4. Weekly audits x 4 weeks by DON/ADON for all dialyses residents to ensure 100% compliance is achieved. Results to be shared at monthly QAPI to determine if additional audit and or interventions required.	

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F 842	Continued From page 31 Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 842		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the quality assessment and assurance committee (QAA) met at least quarterly and included all of the required members. Findings include: Review of the facility's undated QAPI (quality assurance and performance improvement) framework indicated the facility "Will conduct quality assurance meetings on a monthly basis. "	F 868	1. No residents were adversely affected by this practice 2. All residents could potentially be affected by this practice 3. The root cause analyses was performed and indicated the medical director was absent from the quarterly meeting per QAPI requirements. The appropriate members for committee appeared to be included in invite but did not adhere in attendance. Previous sign in sheets indicate just the one event	9/17/21

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F 868	Continued From page 32 Review of the facilities QAPI meeting sign in sheets revealed the facility conducted quarterly QAPI meetings on the following dates: 7/23/20, 10/20/20, and 4/16/21. There were 6 months between the October 2020 and April 2021 meetings and there were no subsequent meetings following April 2021. During an interview on 8/12/21 at 3:12 PM, E1 (NHA) confirmed the facility was not conducting quarterly QA meetings with the required members and stated, "The next meeting would have been July." Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 868	deficient without significant trend. All committee members notified to report for QA as required 4. The Executive Director or designee will plan monthly QA meeting and ensure the required committee members are in attendance and participation documents/retained with committee signatures. 100% Compliance to be immediate and ongoing. Ongoing sign in sheet(s) will maintain continued audit and assurance to the standard.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		9/17/21

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F 880	Continued From page 33 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 34 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation it was determined that for one (R39) out of one resident reviewed for wound care, the facility failed to ensure proper infection control practices and handwashing during a dressing change. The facility failed to follow a physician's order for weekly dressing changes and apply protective caps to prevent a PICC line (IV access for long term medications) infection. Findings include: 1. Observation and review of R39's clinical record revealed: a. 7/14/21- A physicians order included to change R39's PICC line dressing every seven days and as needed. 8/5/21 at 3:01 PM - During an observation of R39's dressing change to the left upper arm, a double lumen PICC line was dated 7/21/21. The dressing was ordered to be changed every seven days and as needed to prevent infection. R39's dressing had not been changed in fifteen days. 8/5/21 - During an interview, E2 (DON) confirmed the PICC line dressing had not been changed and confirmed the physicians order was to change the dressing every seven days and as needed.	F 880	DPOC for F880 will be submitted by 9/11/21 1. R39 was not adversely affected by this practice 2. All patients that have wound care orders and a PICC line could potentially be affected by this practice 3. The root cause analysis determined nursing staff require further and ongoing education regarding infection control practices and staff development effort(s) to monitor these practices. Further DPOC regarding this area will be required. Inservicing was completed for nurses on 8/26/21 by Director of Nursing. Education included policy for wound care, PICC line changes and hand washing. Protective caps are on all PICC lines with order to change weekly. 4. DON/ADON or designee to perform weekly audits x 4 until 100% compliance with PICC line dressing and protective cap. Audits to be included in QAPI.	

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F 880	Continued From page 35 b. 8/10/21 11:25 AM - E19 (LPN) was observed performing a dressing change to R39's left foot. E19 entered the room and put on a pair of gloves without performing hand hygiene and then picked up the trash can, contaminating her gloved hands. E19 did the dressing change, removed the gloves and left the room for approximately 30 seconds without performing hand hygiene. 8/10/12 11:42 AM - During a second observation of the right foot dressing change, E19 returned to the room and put on a pair of clean gloves without performing hand hygiene. After the treatment was completed, E19 removed the gloves and exited the room without performing hand hygiene. 8/10/21 12:10 PM - Interview with E19 confirmed that hand hygiene was not performed before or after the dressing changes on the left and right foot. c. 8/10/21 2:25 PM - An observation of R39's PICC line revealed that only one out of the two lines was covered with the required cap. The uncovered line placed R39 at risk for infection. The facility failed to utilize protective IV caps to ensure a sterile IV PICC line was maintained to prevent infection. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation.	F 943		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 943	Continued From page 36 In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required training on abuse, neglect, exploitation, misappropriation of resident property and dementia was completed for three (E9, E10 and E12) out of 15 randomly sampled staff members. Findings include: The facility policy entitled " ... Abuse Investigations", revision indicated, "... In-Service Training ... All employees are required to attend our facility's resident rights and abuse prevention program in-service training sessions prior to having any resident contact...". 1. Review of the facility's staff training log revealed: E10's most recent abuse training was 7/14/19 and dementia training was 7/11/19. E9's most recent abuse training was 11/14/19 and dementia training was 11/8/19.	F 943	1. No staff were affected by this practice 2. All staff could potentially be affected by this practice 3. Root cause analysis was performed and it was determined staff did not appropriately complete education timely per policy and/or facility designee did not consistently monitor staff completion reports for ongoing compliance. All staff must complete required training via Relias by 9/16/21. 4. Executive Director/Human Resources or designee to audit training records weekly x 4 weeks until 100% compliance. Report audits and evaluated need for additional action at QAPI ATTACHMENTS, AUDIT SHEET(S), APPLICABLE POLICY AND/OR INSERVICE CONTENT SENT ELECTRONICALLY TO DHSS_DHCQ_POC@DELAWARE.GOV	

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F 943	Continued From page 37 E12's most recent abuse training was 1/16/20 and dementia training was 1/16/20. 8/12/21 at 1:30 PM - During an interview with E3 (Human Resources Director), E3 confirmed the absence of training for the employees listed above. No further evidence of training was provided. Findings were reviewed during the exit conference on 8/13/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 943		