DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Capitol

DATE SURVEY COMPLETED: March 29, 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. An unannounced annual and complaint survey was conducted at this facility from March 22, 2022 through March 29, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 105. The survey sample totaled 38 residents.		
3201.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 29, 2022: F583, F600, F623, F625, F641, F645, F657, F677, F686, F758, F812, F883 and F887.	Cross Refer to the CMS 2567-L survey completed March 29, 2022: F583, F600, F623, F625, F641, F645, F657, F677, F686, F758, F812, F883 and F887.	05/16/2022

Provider's Signature [signature] Title NHA Date 5/2/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING ______ B. WING ______	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	**1225 WALKER ROAD 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 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning March 22, 2022 through March 29, 2022, by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 105. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from March 22, 2022 through March 29, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 105. The survey sample totaled 38 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; CNO - Chief Nursing Officer; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RD - Registered Dietitian; RN - Registered Nurse;	F 000		

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

Electronically Signed — 04/22/2022

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 SSA - Social Worker Assistant; SW - Social Worker; UM - Unit Manager; AIM'S (Abnormal Involuntary Movement Assessment) - test used for side effect monitoring after use of psychotropic medications; Antipsychotic - drug to treat psychosis and other mental/emotional conditions (e.g. Risperdal), 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 BIPAP - A machine that helps with breathing problems; Braden Scale - test used to determine risk for developing pressure ulcers; COVID-19/Coronavirus - a respiratory illness that can be spread person to person; Elope/Elopement- leaving the facility without permission to do so; Foley Catheter - A tube inserted into the bladder to drain urine; Hospice- a care provider for patients with a terminal illness or poor life expectancy; Hypnotic - medication for sleep; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes PASARR - Pre-Admission Screening and Resident Review; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality.	F 583		5/16/22

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

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F 583	Continued From page 2 The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R47) out of thirty eight sampled residents, the facility failed to provide dignity for a resident with a urinary catheter. Findings include:	F 583	F583 1. R47□s urinary catheter bag was immediately changed to the covered type when identified by the surveyor. 2. All other residents with urinary	

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F 583	Continued From page 3 3/22/22 10:00 AM - A random observation from the doorway of R47's room revealed R47 had an uncovered catheter bag hanging on the bed. 3/23/22 12:08 PM - During an interview, E8 (CNA) revealed catheter bags usually have a cover and E8 was not sure why R47 didn't have a catheter cover. E8 stated that the Nurse or someone from the supply department usually gets the cover for the catheter bag. 3/23/22 1:23 PM - During an interview, E4 (Unit Manager) confirmed that all catheter drainage bags should be covered with a privacy bag for resident privacy. 3/25/22 2:50 PM - R47's catheter bag was observed on the side of her bed and it had a privacy cover on it. These findings were reviewed during the exit conference on 3/29/22 at 1:00 PM with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 583	catheters have the potential to be affected by the deficient practice. All other residents with urinary catheters were immediately assessed to ensure covers were in place. No other issues identified. 3. A root cause analysis was completed and revealed that the residents catheter bag was changed while at a urologist appointment several days prior and the type of bag used did not include a cover. The facility urinary drainage bags have a cover attached. New education provided to nurses: All nurses will receive additional education provided by the Staff Developer on ensuring urinary drainage bags are covered at all times. 4. The DON/ Designee will conduct daily audits of those resident with urinary catheters to ensure resident dignity is maintained and urinary drainage bags are covered. The audits will continue daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		5/16/22

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F 600	Continued From page 4 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that the facility failed to ensure that one (R51) out of four sampled residents for abuse was free from sexual abuse. Findings include: The facility policy on abuse, updated January 3, 2022, indicated "It is the policy of the facility to protect residents and prevent occurrences of abuse." 1/25/21 - A quarterly MDS assessment documented R154 as cognitively intact with no documented behaviors. 2/15/21 - An annual MDS assessment documented R51 as severely cognitively impaired, with memory problems and communication that was rarely or never understood by others and that R51 rarely or never understands others. R51 had multiple diagnoses including aphasia (difficulty speaking) and dementia. 3/20/21 9:12 PM - E12 (RN) documented the following behavior note, "R154 seen 3 times grabbing another resident's hand and following that resident and preventing that resident from	F 600	F600 1. After incident occurred R154 was transferred to a more appropriate setting. R 51 has no recollection of incident due to severe cognitive impairment. 2. All residents have the potential to be affected by the deficient practice. A facility wide audit was completed of all residents with behaviors to ensure appropriate interventions are in pace. No issues identified. 3. A root cause analysis of the abuse incident was completed to determine the steps that should have been taken by the facility to prevent incident. The root cause analysis revealed that the facility should have been more aggressive in their approach to prevent the abuse incident from occurring. New education program on behavior and interventions: All nursing staff will receive additional education by the Staff Developer on identifying behaviors and implementing interventions to deter behaviors. 4. The DON/Designee will conduct daily audits of resident behaviors to ensure appropriate interventions are in place to deter behaviors until 100% compliance	

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F 600	Continued From page 5 walking. Verbally spoke with resident to let R154 know this behavior is not acceptable. Resident verbalized understanding. Gave resident a snack and redirected. Resident currently sitting in chair near nurses station." 3/22/21 1:55 PM - A Physician progress note written by E14 (NP) documented, "R154 seen today for medical review...has presented some behavioral disturbances including grabbing another resident." There was no evidence in the clinical record of a change in orders for R154 related to the documented behaviors. 3/23/21 10:02 PM - A Nurses note documented, "R154 continues to follow residents as they walk on the unit. Patient redirected for which R154 verbalized understanding but behavior continues." 3/24/21 9:12 PM - E11 (RN) documented in a Nurses note, "[E14 (NP)] notified of new behaviors, [E15 (NP)] was notified and Telehealth visit attempted but [R154] refused to discuss behaviors with NP, stating there was nothing to discuss. [E15] gave new order for psychotropic to be increased... [R154] closely monitored during shift." 3/24/21 10:23 PM - A Nurses note documented, "[R154] monitored for untoward behaviors toward residents and change in medication." 3/25/21 11:29 AM - A Physician progress note documented, "Late entry note [R154] visit for behavioral disturbances. Due to behavioral disturbances including attempts to elope patient was transferred into a locked unit last month. [R154] continues to present with behavioral disturbances including increased observation and	F 600	has been achieved for 5 consecutive days, then weekly until 100% compliance has been achieved for 4 consecutive weeks then monthly until 100% compliance is maintained for 3 consecutive months. The findings will be reviewed with the QAPI committee.	

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F 600	Continued From page 6	F 600		

'stalking of female dementia patient who wanders around the unit, including blocking [R51's] path and touching R51's clothing. Redirection by staff unsuccessful to the point that resident required one-on-one supervision yesterday." Review of the clinical record lacked evidence of one on one assignment of staff to R154.

3/25/21 7:38 PM - A Nurse Practitioner note documented,"Psychiatric consult, evaluated R154 Long term care/memory care unit per staff request secondary to psychotropic medication use and recent behavioral escalations including grabbing at other residents and following female residents closely around unit; history of elopement attempts when resided off memory care unit."

4/1/21 4 20 PM - A Nurses note documented, "[R154] reported observed following female resident seen placing hand under residents shirt. Residents separated and redirected. Resident placed on every 15 minute checks. Psychiatric and medical doctor to review medications."

4/1/21 4 37 PM - A Nurses note documented, "Reported by nursing staff [R51] wandering building followed by a male resident which was seen placing his hand under her blouse residents separated and redirected to common area for closer monitoring."

4/1/21- Every 15 minute checks were initiated at 5:15 PM and lasted through 4/22/21.

4/1/21 - The facility reported an allegation of resident to resident abuse described as "[R154] seen placing hand under [R51's] blouse, resident separated both redirected. [R154] placed on

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F 600	Continued From page 7	F 600		

every 15 minute checks psych to evaluate resident.

4/1/21 - R154's care plan for inappropriate behaviors was updated to include inappropriate touching of other residents. An intervention for every 15 minute checks was implemented with the update.

4/1/21 6:24 PM - A Nurse Practitioner note documented, " Psychiatric consult, evaluated [R154] Long Term Care/memory care unit secondary to psychotropic medication adjustment last week no further behavioral escalations until later this afternoon staff called to report [R154] was witnessed reaching under a female residents shirt after closely following female resident around unit/prior to this incident."

4/2/21 3:32 PM - E14 (NP) wrote a Physician progress note that documented, "Late entry note [R154] visit for behavioral disturbances due to behavioral disturbances including attempts to elope [R154] was transferred into a locked unit in February. R154 continued to present with behavioral disturbances including increased observation and 'stalking' of female dementia patient who wanders around the unit, including blocking [R51's] path and touching her clothing. Redirection by staff was unsuccessful to the point that resident required one-on-one supervision. Psychiatric NP increased medications on 3/24/21 (see progress note dated 3/25/2021). On 4/1/2021 R154 began again to follow the same resident and placed his hand underneath her shirt. He was then again put on one-on-one supervision. Psychiatric follow-up done the same day with new recommendations to decrease psychotropic medications dose and start patient

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F 600	Continued From page 8	F 600		

on a new medication. [R154] seen today in his room, resting in bed, awake and alert, calm, with poverty of speech, does not wish to discuss incident but endorses that he would rather be accommodated outside of locked unit and preferably be reintegrated into community with lower level of care...Awaiting recommendations for therapeutic communication and nonpharmacological nursing interventions. Recommend scheduling care conference with patient and POA to discuss options of accommodation in different area of facility and/or community reintegration."

4/6/21 - A Psych note documented, "Staff report [R154] touched a female resident inappropriately. Assess mental status and recommend interventions...Pt is still in bed and not dressed at mid morning. Pt denies this incident of inappropriate touching. [R154] acknowledges the rules about touching other residents. Patient reports no desire to get out of bed. Patient will benefit from the offer of structured activities to encourage appropriate behavior...Low motivation. Denial of responsibility."

3/25/22 3:48 PM - The above findings were reviewed with E2 (DON).

During an interview on 3/25/22 at 3:53 PM, E12 (RN) confirmed that [R51] was the resident referenced in the 3/20/21 behavior note. E12 further stated, "R51 was non-verbal, I remember seeing [R154] grab [R51's] hand and caress the hand. I let [R154] know that wasn't appropriate... [R51] was a repetitive walker and [R154] would block [R51's] path."

During an interview on 3/25/22 at 4:13 PM,

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F 600	Continued From page 9 E11(RN) stated, "[R154] was high functioning and fairly young. [R154] kept following R51, they make loops and [R154] would watch [R51]... I think we increased surveillance, my desk was moved because there was blind spots and once [R154] stood in front of [R51] to block her path." Findings were reviewed during the exit conference on 3/29/22 at 1:00 PM with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		5/16/22

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F 623	Continued From page 10 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 11 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R68 and R77) out of four residents sampled for hospitalization, the facility failed to notify the ombudsman of the transfer to the hospital. Findings include: The following residents were transferred to the hospital for emergent medical needs and the ombudsman was not notiifed:	F 623	F623 1. The Ombudsman was immediately notified that R77 and R68 had been transferred to the hospital when the omission was brought to the attention of the Social Services Director. 2. All residents who are transferred to the hospital have the potential to be affected by this deficient practice	

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	085048	A. BUILDING ______ B. WING ______	C 03/29/2022

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CADIA REHABILITATION CAPITOL	**1225 WALKER ROAD** **DOVER, DE 19904**

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F 623	Continued From page 12 1. 2/11/22 - R68 was transferred emergently to the hospital and was admitted. 3/25/22 - A review of R68's records lacked evidence that the Ombudsman was notified of R68's transfer to the hospital. 2. 2/3/22 - R77 was transferred emergently to the hospital and was admitted. 3/25/22 - A review of R77's records lacked evidence that the Ombudsman was notified of R77's transfer to the hospital. 3/28/22 9:41 AM - During an interview E3, (Regional DON) confirmed that the Ombudsman was not notified of the transfer of R68 and R77 to the hospital. 3/29/22 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (Reg onal CNO).	F 623	3. A root cause analysis revealed that the report that the Social Services Director was running to ensure that the Ombudsman was notified of all resident transfers was not all inclusive of resident transfers. New EMR report utilized: The report that the Social Services Director (SSD) is now running contains all transfers in and out of the facility to the hospital. The SSD will run the new report weekly to ensure that timely Ombudsman notification takes place. No other issues were identified when a facility wide audit was conducted. 4. The SSD/Designee will conduct daily audits of hospital transfers to ensure that the ombudsman is notified of all resident transfers. The audits will continue daily until there is 5 consecutive days of 100% compliance with Ombudsman notification of resident transfers. Then, the audits will be conducted weekly until 100% compliance is achieved for 4 consecutive weeks. The audits will continue until 100% compliance is maintained for 3 consecutive months. If 100% compliance is achieved thereafter, the deficiency will then be considered resolved. The audit findings will be reviewed with the QAPI committee.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		5/16/22

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F 625	Continued From page 13 nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R47, R68, and R77) out of four sampled residents reviewed for hospitalization, the facility failed to provide the bed-hold notice upon transfer to the hospital. Findings include: According to the facility policy "Bed Holds" (revised 11/2/18), the facility must provide two notices, one on admission and then on transfer to emergency treatment at the hospital. It should accompany the resident to the hospital and the Admission Director should call the resident representative to notify them of the policy, and	F 625	F625 1. R47, R68 and R77□s were not harmed by this deficient practice. R47, R68 and R77 returned to the facility after their hospitalization. 2. All residents who are transferred to the hospital have the potential to be affected by this deficient practice. 3. A root cause analysis was completed and revealed that the facility failed to have an internal process in place to ensure all residents/responsible parties are notified of the facility bed hold policy in the event of transfer to the hospital. Education on	

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F 625	Continued From page 14 they will document conversation and mail them to the representative for review. 1. 3/7/22 - R47 was transferred emergently to the hospital and was admitted. 2. 2/11/22 - R68 was transferred emergently to the hospital and was admitted. 3. 2/3/22 - R77 was transferred emergently to the hospital and was admitted. 3/25/22 - During record review there was no evidence found that a copy of the facility bed hold policy was provided by the facility to R47, R68, or R77's representatives when they were transferred to the hospital and admitted. 3/28/22 9:41 - During an interview, E3 (Regional DON) confirmed that R47, R68, and R77's representatives were not notified of the facilities bed hold policy when they were transferred to and admitted to the hospital. 3/29/22 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 625	bed hold policy: The Staff Developer will provide additional education on the facility bed hold policy to all nurses and the Admission□s Director who will be responsible for notifying the responsible party and documentation of the notification in the medical record. A facility wide audit was completed on all residents who have been transferred to the hospital in the past 3 months to ensure that a copy of the facility bed hold policy was sent to the hospital with the resident and the responsible party. No further issues were identified. 4. The DON/Designee will conduct daily audits to ensure that all residents being sent to the hospital were given a copy of the facility bed hold notification prior to transferring to the hospital and their responsible party will be notified. The audits will continue daily until 100% compliance is achieved for 5 consecutive days. Then, the audits will be completed weekly until 100% compliance is achieved for 4 consecutive weeks. The audits will continue until 100% compliance is maintained for 3 consecutive months. The findings will be reviewed with the QAPI committee.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 645		5/16/22

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F 645	Continued From page 15 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a	F 645		

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F 645	Continued From page 16 hospital after receiving acute inpatient care at the hospital. (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R96) out of two sampled residents reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to have a PASARR on admission from the State authority. Findings include: The facility policy on PASARR, last updated January 3, 2022, indicated, "Prior to admission a Level 1 Preadmission Screening and Resident Review PASRR, is conducted to identify individuals who have or may have mental disorders, intellectual disability's, (sic) or a related condition...". Review of R96's clinical record revealed:	F 645	F645 1. The Social Services Director immediately obtained a level 2 PASRR for R96 when it was brought to the attention of the Social Services Director. that the out of state PASRR was insufficient. 2. All residents who are admitted to the facility that require a level 2 PASRR have the potential to be affected by this deficient practice. 3. A root cause analysis determined that the facility staff were unaware that an out of state PASRR was unacceptable. The Social Services Director will now review all newly admitted residents for PASRR completion and accuracy with all new	

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F 645	Continued From page 17 2/20/21- A PASARR level I screening was completed for R96's admission to an out of state nursing facility. 3/19/21- An admission MDS assessment documented R96 as being cognitively impaired with various diagnoses including dementia, anxiety, depression, and schizophrenia and was taking antipsychotic medication. R96 was assessed as having verbal behavioral symptoms directed towards others such as threatening others, screaming at others, and cursing at others for 1-3 days during the assessment. 3/23/22 9:11 AM - Review of R96's clinical record revealed a lack of evidence that the facility received a PASARR review from the State of Delaware authority for R96 prior to admission. 3/24/22 11:57 AM- An email contact with the State PASARR unit confirmed that there was no evidence of a completed PASARR screening for R96. During an interview on 3/23/22 at 11:16 AM with E6 (SW), the absence of a PASARR from a State of Delaware authority was reviewed. During an interview on 3/24/22 at 1:30 PM, E3 (CNO) confirmed the above findings. Findings were reviewed during the exit conference on 3/29/22 at 1:00 PM with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 645	admissions. The Social Services Director will receive additional education from the PASRR TEAM regarding the requirements which will include the process for out of State admissions to the facility. A facility wide audit was conducted to ensure PASRR□s were in place for all residents. No other issues were identified. 4. The Nursing Home Administrator/Designee will conduct daily audits of resident PASRR□s until 100% compliance is achieved for 5 consecutive days, then the audits will continue until 100% compliance is achieved for 4 consecutive weeks. The audits will continue until 100% compliance is maintained for 3 consecutive months. All findings will be reviewed with the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved.	
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	F 677		5/16/22

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F 677

Continued From page 18

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 for one (R86) out of five dependent residents reviewed for Activities of Daily Living (ADL's), the facility failed to assist R86 with shaving and transferring out of bed. Findings include:

Review of R86's clinical record revealed:

3/12/22 - A quarterly MDS assessment documented R86 as being cognitively intact and requiring extensive assistance of one staff member for shaving/hygiene. R86 had one to two transfers during the assessment that were not steady.

R86's care plan for ADL's, last updated 3/16/22, indicated R86 had an ADL self-care performance deficit related to decreased mobility and history of a stroke. Interventions for R86's care plan were for staff to assist R86 with daily hygiene, toileting, dressing, grooming, and oral care as needed.

During an interview on 3/22/22 at 10:23 AM, R86 stated, "They don't shave me, they don't like to get me up in the wheelchair. I only get up when therapy helps me, its been about a month." The resident was observed unshaven and up in the wheelchair at that time.

3/25/22 10:02 AM - R86 was observed in the bed unshaven. When asked if he was offered a shave or to get out of bed to the wheelchair, R86 stated "No, they don't do that."

F 677

F677

1. R86 was offered assistance with shaving and getting out of bed when it was brought to the attention of the staff that he was requesting assistance. While R86 did accept assistance with shaving, he declined to get out of bed.
2. All residents who require assistance with activities with daily living have the potential to be affected by this deficient practice.
3. A root cause analysis revealed that CNA staff were not notifying nurses of resident refusals of care timely. New process: A new system has been put into place to ensure that all refusals of care are immediately reported, followed up, and documented by a nurse. All care refusals will be documented in the medical record and reviewed daily in the morning meeting: Nursing staff will receive additional education provided by the Staff Developer on providing ADL care to dependent residents and the process for care refusals (immediately notifying nurse, nurse intervention and documentation of refusal when appropriate). A random audit was completed of all dependent residents who were in bed to ensure that anyone who wanted to be out of bed was given the required assistance. An audit of facial hair was immediately conducted to ensure that all residents received the required

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F 677	Continued From page 19 During an interview on 3/25/22 at 2:16 PM, E4 (RN) and Unit Manager on R86's unit stated, "To my knowledge, R86 refuses to get up. I am not aware that R86 refuses shaving." Review of R86's clinical record lacked evidence of refusals for shaving or getting out of bed. A thirty day review from 2/27/22 - 3/27/22 of R86's record of transfers revealed R86 was assisted out of bed to the wheelchair eleven out of thirty days. There were no documented refusals of R86 getting out of bed to the wheelchair. A thirty day review from 2/27/22 - 3/27/22 of R86's hygiene indicated R86 received hygiene completion, however, observation of R86 did not support the documentation. There were no documented refusals of R86 receiving a shave. 3/28/22 2:57 PM - R86 was observed in bed unshaven and stated, "I don't want to get up today, but they still did not help shave me." Findings were reviewed during the exit conference on 3/29/22 at 1:00 PM with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 677	assistance with grooming and facial hair removal. No other issues identified during the facility wide audit. 4. The DON/Designee will conduct daily audits to ensure all residents are receiving the required assistance with ADL□s and that all refusals of care are reported to the nurse to intervene and document. The audits will continue until there is 100% compliance for 5 consecutive days with residents receiving the required ADL assistance, refusal of care notification, intervention, and documentation. The audits will reduce to weekly until 100% compliance is maintained for 4 consecutive weeks. Then, the audits will be conducted monthly until 100% compliance is maintained for 3 consecutive months. The audit findings will be reviewed with the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved.	
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	F 686		5/16/22

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F 686	Continued From page 20 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 observation, record review and interview, it was determined that for one (R50) out of three sampled residents reviewed for pressure ulcers, the facility failed to initiate a treatment to a pressure ulcer behind R50's right ear. Findings include: Review of R50's clinical record revealed: 2/7/22 - R50 was admitted to the facility with a broken back. 3/14/22 - R50's Braden scale was 14 indicating moderate risk for the development of pressure ulcers. 3/22/22 11:04 AM - During an observation and interview, R50 complained of pain behind her right ear from her oxygen tubing. R50 pulled her ear back and a small open pressure area was observed behind her right ear. 3/22/22 11:10 AM - E7 (LPN) was informed of the resident complaint of pain behind her right ear and that there was pressure from the oxygen tubing. E7 stated that she would take care of it and was observed at the treatment cart getting gauze to pad the oxygen tubing. 3/24/22 - A Physician's order included: Cleanse	F 686	F686 1. A treatment order was obtained for R50 when the open area was identified. R50 was discharged home 2. All residents who are on supplemental oxygen via nasal canula have the potential to be affected by this deficient practice. No other issues were identified with like residents. 3. New procedure: All new skin impairments will now be reviewed in the facility morning meeting to ensure that an appropriate and timely wound treatments are obtained and in place. Licensed nurses will receive additional education from the Staff Educator on wound identification as well as timely provider notification and treatment implementation. A facility wide audit was conducted with like residents and no other issues were identified. 4. The DON/Designee will conduct daily audits to ensure all skin impairments are reported to the MD and an appropriate treatment order is obtained timely. The audits will continue until 100% compliance is achieved for 5 consecutive days, then weekly until 100% compliance is achieved for 4 consecutive weeks. Then, monthly	

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F 686	Continued From page 21 opened area behind right ear with normal saline, pat dry, apply antibiotic ointment to opened area and leave opened to air once daily for 7 days. Monitor for signs and symptoms of worsening condition and notify MD/NP. 3/24/22 10:10 PM - A Nurses note documented, "Small opening noted behind patient's right ear. Area cleanse (sic) with normal saline, pat dry, bacitracin ointment applied." 3/25/22 11:49 AM - R50 was observed in bed with gauze on her oxygen tubing behind both of her ears. 3/25/22 12:40 PM - A Dietician note documented, "Skin trauma noted behind ear related to oxygen tubing." 3/25/22 1:26 PM - During an interview, E10 (UM) confirmed that the area to the right ear was observed there on 3/22/22 and the nurse who assessed it did not obtain an order for a treatment until 3/24/22. E10 added that the CNA's had spoken to her about the issue and reported that the resident has been "tugging" on the oxygen tubing and making it tight and rub. Although the facility was aware of the condition of R50's right ear on 3/22/22, the facility failed to obtain a treatment order until two days later on 3/24/22. 3/29/22 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 686	until 100% compliance is achieved for 3 consecutive months. The findings will be reviewed with the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		5/16/22

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F 758	Continued From page 22	F 758		

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended

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F 758	Continued From page 23 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R151) out of six sampled residents reviewed for unnecessary medications, the facility failed to have an adequate indication for use of a psychotropic mediation. Additionally, the facility failed to monitor for behaviors and side effects associated with the medication use, including an assessment of abnormal movements (AIM's). Findings include: Review of R151's clinical record review revealed: 6/16/21 - R151 was admitted to the facility. 6/16/21 - A physicians order included: Quetiapine Furmarate (an antipsychotic medication) for depression and anxiety when the medication was indicated for major depressive disorder and bipolar disease and not for anxiety. 6/16/21 - A physicians order included: Doxepin (an antidepressant medication) for depression. 6/17/21 - A physicians order included: Temazepam (a hypnotic medication) was to be given in the morning every other day for anxiety. The indication for the medication is for sleep, not anxiety.	F 758	F758 1. R151 had been discharged from the facility. R151 was not harmed by this deficient practice. 2. All residents who are receiving psychotropic medications have the potential to be affected by this deficient practice. 3. Licensed nurses will receive additional education from the Staff Educator on psychotropic medications, their indication, appropriate diagnoses for use, side effects, target behaviors and AIMS assessments. New review process implemented: Psychotropic medication orders will now be reviewed in the morning meeting to ensure appropriate diagnosis, indication for use, side effect monitoring, and target behaviors are in place for each psychotropic medication that is ordered. All antipsychotic medications will also be reviewed in the morning meeting to ensure that an AIMS assessment has been completed. A facility wide audit was conducted to ensure that all residents receiving psychotropic medications had the	

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F 758	Continued From page 24 Doxepin, Quetiapine and Temazepam require monitoring for behaviors and medication side effects. Quetiapine requires that a baseline AIM's test must be conducted. The clinical record lacked evidence that the AIMS assessment was completed. 3/28/22 10:16 AM - During an interview, E3 (CNO) confirmed that R151's clinical record lacked evidence of monitoring for behaviors or medication side effects related to receiving psychotropic medications. E3 also confirmed that R151's clinical record lacked evidence of a baseline AIMS assessment being completed. 3/29/22 1:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 758	appropriate diagnosis, side effect and behavior monitoring as well as an AIMS assessment for those residents receiving antipsychotic medications. No other issues were identified. 4. The DON/Designee will conduct a random audit of 5 psychotropic medications daily to ensure that appropriate diagnosis, indication, side effect monitoring, target behaviors and appropriate assessments (AIMS) are in place until 100% compliance is achieved for 5 consecutive days. The audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks. Then, the audits will continue monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed with the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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	F 812		5/16/22

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F 812	Continued From page 25 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 observations and interview, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: The following were observed during the kitchen tour on 3/22/22 from approximately 9:20 AM to 10:30 AM: - The Facility failed to ensure the hand washing station closest to the dining room was adequately accessible by not removing the clutter (trash can and dish rack); - The Facility was using moisture trapping material (paper) as padding for the food storage rack in the walk-in refrigerator. Findings were reviewed during the exit conference on 3/29/22 at 1:00 PM with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 812	F812 1. The handwashing station closest to the dining room was immediately made accessible upon discovery. The moisture trapping material was removed from the food storage tray upon discovery. No residents were harmed by this deficient practice. 2. All residents and kitchen staff have the potential to be affected by this deficient practice. 3. A root cause analysis was conducted and it was determined that the facility did not have an internal process in place to assure that handwashing stations were not blocked by kitchen equipment. New audits implemented: The Food Service Director will conduct daily audits to assure that all handwashing stations are accessible to staff with no equipment blocking the access. Kitchen staff will be educated by the staff educator regarding accessibility to handwashing stations. A root cause analysis was conducted and it was determined that the kitchen staff will be educated on not using any material on all food storage racks when storing food. The Food Service Director will educate kitchen staff on not using any material when storing food on food storage racks. 4. The Food Service Director/Designee	

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F 812	Continued From page 26	F 812	will conduct daily audits of those resident with urinary catheters to ensure resident dignity is maintained and urinary drainage bags are covered. The audits will continue daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		5/16/22

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F 883	Continued From page 27 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R55 and R95) out of five residents reviewed for immunizations, the facility failed to provide evidence that influenza immunizations were offered or declined for the current influenza season. Additionally, the facility	F 883	F883 1. R55 was offered the influenza vaccine when it was brought to the facilities attention. R55 declined the vaccine. The declination was obtained.	

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F 883 Continued From page 28

failed to provide evidence that Pneumococcal immunizations were offered or declined for R95. Findings include:

The facility policy on influenza, last updated January 4, 2022, indicated, "Influenza immunization is offered to all residents annually."

The facility policy on Pneumococcal immunizations, last updated January 4, 2022, indicated, "It is the policy of the facility to follow CDC guidelines in offering pneumococcal immunizations to residents."

1. Review of R55's clinical record revealed:

9/15/20 - R55 was admitted to the facility.

Review of R55's electronic medical record (EMR) lacked evidence that R55 was offered or declined the influenza immunization for the current flu season. R55's last declination for influenza vaccine was dated 11/2/20.

2. Review of R95's clinical record revealed:

7/28/17 - R95 was admitted to the facility.

Review of R95's EMR lacked evidence that R95 was offered or declined the influenza immunization for the current flu season. R95's last declination for the influenza vaccine was dated 12/3/20.

Review of R95's EMR lacked evidence that R95 was offered or declined the Pneumococcal immunization.

During an interview on 3/28/22 at 1:17 PM, E3

F 883

2. All residents have the potential to be affected by this deficient practice.
3. A root cause analysis was conducted, and it was determined that the facility did not have an internal process in place to track consents/declinations for influenza and pneumonia vaccines. New tracking procedure implemented: The staff educator will receive education from the Director of Nursing on the new process for tracking consents and declinations for the influenza and vaccines, obtaining consent or declination signatures and inputting this information into the electronic medical record. A facility wide audit was conducted, and no other residents were identified for this deficient practice.
4. The staff educator/designee will conduct daily audits for current residents and new admissions to ensure that consents/declinations are obtained for influenza and pneumonia vaccines. The audits will continue daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved.

1. R95 was offered the influenza and pneumonia vaccine when it was brought to the facilities attention. R95 declined both vaccines. Declinations were obtained.
2. All residents have the potential to be

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F 883	Continued From page 29 (CNO) confirmed the facility was unable to provide evidence of the offering or declination of the above immunizations for R55 and R95. Findings were reviewed during the exit conference on 3/29/22 at 1:00 PM with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 883	affected by this deficient practice. A facility wide audit was completed to ensure all residents were offered the influenza vaccine. 3. A root cause analysis was conducted, and it was determined that the facility did not have an internal process in place to track consents/declinations for influenza and pneumonia vaccines. The staff educator will receive education from the Director of Nursing on the new process for tracking consents and declinations for the influenza and pneumonia vaccines, obtaining consent or declination signatures and inputting this information into the electronic medical record. A facility wide audit was conducted, and no other residents were identified for this deficient practice. 4. The staff educator/designee will conduct daily audits for current residents and new admissions to ensure that consents/declinations are obtained for influenza and pneumonia vaccines. The audits will continue daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved.	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The	F 887		5/16/22

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F 887	Continued From page 30 LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative	F 887		

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F 887	Continued From page 31 was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R85 and R199) out of five residents reviewed for COVID-19 immunizations, the facility failed to provide evidence that the COVID-19 vaccines were offered or declined. Findings include: The facility policy on COVID-19 vaccination, last updated January 27, 2022 indicated "COVID-19 vaccinations will be offered to all residents." 1. Review of R85's clinical record revealed: 3/7/22 - R85 was admitted to the facility. Review of R85's electronic medical record (EMR) lacked evidence that R85 was offered or declined	F 887	F887 1. R85 and R199 was offered the covid vaccine when it was brought to the facilities attention. R85 was offered and declined the covid vaccine. The declination was completed. R199 is no longer in the facility 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis was conducted, and it was determined that the facility did not have an internal process in place to track consents/declinations for covid vaccines. New tracking procedure implemented: The staff educator will receive education from the Director of	

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F 887	Continued From page 32 any COVID-19 vaccinations. 2. Review of R199's clinical record revealed: 3/10/22 - R199 was admitted to the facility. Review of R199's EMR lacked evidence that R199 was offered or declined any COVID-19 vaccines. During an interview on 3/28/22 at 1:17 PM, E3 (CNO) confirmed the facility was unable to provide evidence of offering COVID-19 vaccines to R85 and R199. Findings were reviewed during the exit conference on 3/29/22 at 1:00 PM with E1 (NHA), E2 (DON) and E3 (Regional CNO).	F 887	Nursing on the new process for tracking consents and declinations for the covid vaccines, obtaining consent or declination signatures and inputting this information into the electronic medical record. A facility wide audit was conducted, and no other residents were identified for this deficient practice. 4. The staff educator/designee will conduct daily audits for current residents and new admissions to ensure that consents/declinations are obtained for covid vaccines. The audits will continue daily until 100% compliance is achieved for 5 consecutive days. Random audits will continue weekly until 100% compliance is achieved for 4 consecutive weeks, then monthly until 100% compliance is achieved for 3 consecutive months. The audit results will be reviewed by the QAPI committee. After 3 months of substantial compliance, the deficiency will be considered resolved. After substantial compliance, the deficiency will be considered resolved	