STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. Building B. Wing	09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Pike Creek	3540 Three Little Bakers Blvd Wilmington, DE 19808

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 32545 Based on observation, clinical record review and interview, it was determined that the facility failed to provide R33, a resident who was blind, services with reasonable accommodation of resident needs and preferences. Findings include: Review of R33's clinical record revealed: 6/22/19 - The quarterly MDS assessment stated that R33 had highly impaired vision and an active diagnosis of cortical blindness. 8/21/19 at 9:12 AM - An observation of R33 revealed the resident sitting in a wheelchair in the resident's room on the right side of the bed. R33 was observed calling out for the nurse with the door opened. R33 responded when the surveyor knocked and asked permission to enter the room. The surveyor asked R33 why he/she was reaching out and around the wheelchair. R33 stated that he/she wanted a cup of water. The surveyor told her there was no cup of water present and then asked R33 if he/she had a call bell. R33 stated no. The surveyor observed R33's call bell wrapped around the left side bed rail on the opposite side of the bed, which was out of R33's reach. The surveyor stepped outside into the hallway and observed E23 (activity staff) talking to another resident. E23 responded to R33's room and asked R33 if he/she needed anything. R33 asked for a sweater and E23 retrieved a sweater and assisted R33 to put it on. E23 then stated that he/she will get R33 a glass of water. The surveyor asked E23 as he/she was about to exit R33's room if R33 had her call bell. E23 confirmed that R33 did not have his/her call bell. 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32545 Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for 1 (R209) out of 52 sampled residents, the facility failed to consult with the resident's physician when R209 repeatedly refused a physician-ordered treatment. Findings include: Cross refer to F695 The facility's policy entitled Refusal of Medications and Treatments, last revised on 1/18/19, stated, . Guidelines: In order for a resident to exercise their right appropriately to make informed choices about care and treatment or to refuse treatment, the facility, provider and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. Documentation pertaining to a resident's refusal of medication, treatment, or procedures should include: What the resident is refusing. The reasons for refusal, if known. Advising/educating the resident/responsible party about risks/consequences of refusal (i.e. deterioration in condition). Physician notification and response. Steps that were taken to address the resident's concerns and alternatives that were offered . Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/21/19 - A physician's order stated for R209 to wear BIPAP every night with 3 liters of oxygen. 6/22/19 at 7:22 AM - A nurse's note stated, .Resident put on CPAP some of the night and took off because (R209) felt like it was too 'heavy' on (his/her) face. Resident states (he/she) will have family bring in the mask (he/she) uses . 6/22/19 through 6/28/19 - Review of R209's eTAR revealed that nursing staff were documenting BIPAP Refused every night for a total of 6 nights. 6/21/19 through 6/27/19 - Review of 209's clinical record lacked evidence that the resident's physician was notified of R209's repeated refusals of a physician-ordered treatment of wearing BiPAP every night. 9/3/19 at 8:30 AM - Finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to consult with the resident's physician when R209 repeatedly refused a physician-ordered treatment until a critically high lab result was received and reviewed by E4 (NP). 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38827 Based on record review, interview, and review of other facility documentation, it was determined that for three (R19, R51 and R58) out of 50 sampled residents reviewed, the facility failed to develop and implement a comprehensive care plan to include: R19's family and their non compliance with transferring R19 using the Hoyer (a sling-type hydraulic lift) and ceiling lifts, R51's refusal to have labs drawn, and R58's chronic pain. Findings include: 1. Review of R58's clinical record revealed: 6/24/19 - R58 was admitted to the facility with diagnoses that included chronic pain syndrome. 8/8/19 - physician orders for R58 included: Oxycodone 10 mg every 6 hours for pain OxyContin 20 mg ever 12 hours for pain, Lidocaine pain relief patch once a day, Check pain every shift, and Non-pharmacological pain interventions attempted during each shift. A care plan for R58 with problem start dates beginning 6/25/19, and last revised 8/21/19 revealed no evidence of a care plan for pain. On 8/26/19 at 1:34 PM, during an interview, E17 (RNAC) stated the floor nurse would do a 48 hour care plan when the resident was first admitted . On 8/26/19 1:44 PM, during an interview, E8 (UM) stated that a care plan for pain should have been done and he/she would update R58's care plan. The facility failed to develop a pain management care plan for R8 who was prescribed routine narcotic pain medication. Findings were reviewed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM. 40163 Cross refer F684, example #1 2. A facility policy entitled Refusal of Medications and Treatments, (last revised 1/18/19), included: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care plan should address the refusals, non-compliance/non-adherence to the recommended care; and the approaches implemented to address the refusals. Review of R51's clinical record revealed: 10/17/14 - R51 was admitted to the facility with paraplegia, chronic respiratory failure and was dependent on mechanical ventilation related to a motor vehicle accident. 6/14/19 - R51's physician orders included the following blood tests: Ferritin, Iron, TIBC, Transferrin Sat. Folate, and B12 level. Special Instructions: low Hemoglobin. R51 refused the blood draw for these labs on 6/15/19. 6/21/19 - R51's physician' order included the following blood tests: (H&H) Hemoglobin and Hematocrit. Again R51 refused for the labs to be completed. R51's Behavioral Symptoms Care Plan Problems included: 2/5/16 - Potential for safety hazard to self: refusing prescribed medications as ordered. 2/5/16 - Resistance to care: Verbally refuses showers, wound care dressing changes, getting out of bed, prescribed weight, refusing to turn and reposition every 2 hours, and trach care. 7/13/17 - Resistance to care: Verbally refuses showers. 7/27/17 - Resistance to care: Verbally refuses showers and requires air filtration system within room. 2/6/19 - Potential for non-healing wound or worsening wounds as evidenced by non-compliance with prescribed treatment and treatment scheduled. R51's care plan did not address R51's refusal of labs, including interventions to aid in compliance to having blood work completed. The facility failed to care plan for R51's refusal of labs, including approaches implemented to address the refusals. 40264 3. Review of R19's clinical records revealed: 2/24/17 - R19 was admitted to the facility with diagnoses including weakness and inability to walk in the usual way due to problems with the legs and feet. 4/29/17 at 3:15 PM - A progress note documented that, Resident was observed on the sling above the bed. Son had disconnected the tube feeding and was using the lift to transfer his mother into the geri chair (wheelchair type- chair that reclines). A CNA (Certified Nurse's Aide) went into the room to assist and they refused. Family was aware that it is unsafe for them to transfer the resident without assistance. Supervisor made aware(sic). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/6/18 - A physician's order was entered by physical therapy for Transfer Care Plan: Resident is 2 person assist rolling side to side, Hoyer lift machine with .transfers bed to wheelchair . 8/14/18 - A physician's order was entered for R19 to be OOB (out of bed) in geri chair for 1-2 hour(s)/day as tolerated 3 times a week as tolerated on Mondays, Tuesdays and Thursdays between 3:00 PM - 11:00 PM. 8/23/19 at 8:49 AM - Review of R19's annual and quarterly MDS (Minimum Data Set) assessment in March and June 2019 revealed that R19 was totally dependent and required two + person physical assist with transfer. 8/20/19 at 3:13 PM - During an interview, R19's son revealed to the surveyor that the family has been transferring R19 from the bed to the geri chair using the hoyer and the ceiling lift machines since R19 was admitted to the facility on [DATE]. 9/4/19 at 9:22 AM - Review of R19's clinical records revealed no evidence of a comprehensive person - centered care plan that included approaches addressing R19's family and their continued non - compliance with using the hoyer and ceiling lift machines to transfer R19 9/4/19 at 10:00 AM - Findings were discussed with E1 (NHA) and E2 (DON). Findings were reviewed during the exit conference on 9/4/19 at 7:30 PM with E1 and E2.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 38509 Based on clinical record review and interview, it was determined that for two (R29 and R53) out of 52 sampled residents, the facility failed to meet professional standards of quality. For R29, the nurse failed to document an assessment after being told that the resident had a decline in status on 12/18/18. For R53, the nursing staff failed to question R53's incorrect parameters on his PRN hydralazine order during their 24-hour chart checks from 4/4/19 to 8/27/19. In addition, on 4/8/19, R53's blood pressure was 179/83, R53 did not receive his/her ordered PRN Hydralazine, and the facility failed to clarify the physician ordered parameter. Findings include: The facilities policy titled, Documentation Guidelines, Revised 5/17/19, stated, Resident care delivered is entered into the medical record legibly and timely .Progress notes should be entered during the shift care is delivered . 1. Review of R29's clinical record revealed: 11/29/09- R29 was admitted to the facility with diagnoses including persistent vegetative stated and chronic respiratory failure. 12/18/18 5:05 AM- A progress note by E25 (RT) documented that R29 was very diaphoretic and was wiped at least 3 times and each time beads of sweat immediately reappeared. R29's heart rate was noted to be elevated at 116 and his/her respiratory rate was noted to be elevated at 24. E25 stated that the nurse, E24 (RN), was notified of E25's findings. 12/18/18 5:05 AM- 7:37 AM- Review of R29's clinical record revealed no evidence that E24 (RN) performed an assessment on R29 after receiving notification of a change in R29's status by E25 (RT). 12/18/18 7:38 AM- Review of R29's progress notes revealed that E26 (RN) stated that R29 was diaphoretic with a heart rate of 128, BP 130/93, temperature of 98.1. E26 documented that R29's abdomen was distended and firm with hypoactive to no bowel sounds. E26 documented that the NP was notified and a stat EKG and KUB was ordered. 12/18/18 8:22 AM- A progress note by E26 (RN) stated that R29's respiratory rate was now 38-40 and his/her bilateral lower extremities (legs) were mottled in appearance and cold to touch. The NP was notified and assessed the resident and ordered to send R29 to the Emergency Department (ED). 9/4/19 5:01 PM- An email from E24 (RN) to E2 (DON) stated that E25 (RT) mentioned that R29 looked diaphoretic and that she (E24) went to assess R29 like always after respiratory comes to her about a resident. E24 stated that she removed R29's covers, turned down the room temperature, and repositioned R29. E24 stated that since nothing was out of the ordinary she did not chart in R29's medical record. At the end of the shift during bedside report was when E26 (RN) noticed that R29 looked different. The facility failed to meet professional standards of quality as evidenced by E24's (RN) failure to document an assessment and care provided to R29 on 12/18/18 per the facility documentation policy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). 2. Review of R53's clinical record revealed: 11/25/09- E53 was admitted to the facility with diagnoses including hypertension. 4/4/19- A physician's order was entered for R53 to receive Hydralazine (medication to treat high blood pressure) 25 mg 1 tab orally every 12 hours PRN (as needed) for a systolic blood pressure (BP) less than (<) 170. 4/4/19 1:42 PM- A physician's observation progress note stated that for hypertension R53 had an order for Hydralazine PRN for systolic BP > (greater than) 170. 4/4/19-4/8/19- Review of R53's EMAR/ETAR revealed that nurses signed off every night that they did a 24-hour chart check. There was no evidence in R53's clinical record that any of the nursing staff that reviewed R53's chart questioned his/her PRN Hydralazine order. 4/8/19- Review of R53's EMAR/ETAR showed on 4/8/19 at 8:00 AM that R53's BP was 179/83. R53's systolic blood pressure was greater than 170, but R53 never received his/her PRN Hydralazine and nursing staff did not question the order. 4/9/19-5/23/19- Review of R53's EMAR/ETAR revealed that nurses signed off every night that they did a 24-hour chart check. There was no evidence in R53's clinical record that any of the nursing staff that reviewed R53's chart questioned his/her PRN Hydralazine order. 5/23/19- A physician's observation progress note stated that for hypertension R53 had Hydralazine PRN for systolic BP >170. 5/23/19-8/27/19- Review of R53's EMAR/ETAR revealed that nurses signed off every night that they did a 24-hour chart check. There was no evidence in R53's clinical record that any of the nursing staff that reviewed R53's chart questioned his/her PRN Hydralazine order. 8/28/19- Review of R53's physician orders revealed that R53's PRN hydralazine order still stated to administer every 12 hours PRN if R53's systolic BP was < (less than) 170. 08/28/19 10:22 AM- During an interview, E9 (RN) stated that the hydralazine order must be a mistake and that she would talk to the ordering NP. The facility failed to meet professional standards of quality as evidenced by the nursing staff's failure to question R53's incorrect parameters on his/her PRN hydralazine order during 24-hour chart checks from 4/4/19 to 8/27/19. In addition, on 4/8/19, R53's blood pressure was 179/83, R53 did not receive his/her ordered PRN Hydralazine, and the physician was not questioned about the ordered parameters. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40163 Based on record review, interview, and review of other facility documentation, it was determined that for two (2) (R51 and R84) out of four (4) sampled residents reviewed for hospitalization and one (1) (R209) out of three (3) sampled residents for nutrition, the facility failed to ensure that residents received the treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. For R51, the facility failed to notify the physician/nurse practitioner of refusal of ordered labs, failed to re-educate R51 about the health risks of refusing labs, and failed to re-attempt to obtain the labs during a 39 day span. The facility failed to adequately assess and monitor the amount of blood loss from R51's wounds. This failure resulted in harm when R51 was hospitalized from 7/24/19 to 8/3/19 for blood transfusions and treatment for critically low Hemoglobin and Hematocrit levels. For R84, the facility failed to identify and treat a right foot wound on a resident that was susceptible to chronic wounds and infections until it was infested with maggots on 6/24/19 requiring hospital evaluation and treatment. For R209, the facility failed to follow the resident's plan of care to obtain a weight on 7/24/19 as per a 7/17/19 physician's order. For R84 and R209 there was no evidence to support harm level deficiencies. Findings include: A facility policy entitled Refusal of Medications and Treatments (last revised 1/18/19) included: Documentation pertaining to a resident's refusal of medication, treatment, or procedures should include: -What the resident is refusing. -The reasons for the refusal, if known. -Advising, educating the resident/responsible party about risks/consequences of refusal (i.e.: deterioration in condition). -Physician notification and response. -Steps that were taken to address the resident's concerns and alternatives that were offered. -For on-going refusals documentation should include: All the efforts made by the facility and the care team to render care; and encourage compliance and consideration of alternatives. The resident's care plan should address the refusals, non-compliance/non-adherence to the recommended care; and the approaches implemented to address the refusals. Review of R51's clinical record revealed: 10/17/14 - R51 was admitted to the facility with paraplegia, chronic respiratory failure and dependence on mechanical ventilation related to a motor vehicle accident. 4/19/19 - An annual MDS assessment documented that R51 was independent with decisions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	6/1/19-7/24/19 - R51's nursing progress notes lacked evidence of assessing and monitoring the resident's blood loss from his wounds. 6/13/19 - R51's physician orders included the following blood tests: CMP, Lipid Profile, HgbA1c, and CBC. 6/13/19 - R51's lab results revealed that R51's Hemoglobin was 7.0, and Hematocrit was 21.4. (Normal Hemoglobin and Hematocrit lab values per the facility contracted lab results were: Hemoglobin 13.5-17.5 and Hematocrit 37.5-55.5.) 6/14/19 - R51's physician orders included the following blood tests: Ferritin, Iron, TIBC, Transferrin Sat. Folate, and B12 level. Repeat H&H (Hemoglobin and Hematocrit) in one week. Special Instructions: low Hemoglobin. 6/15/19 - Although it was noted on the facility's contracted lab log that R51 refused to have the 6/14/19 ordered labs drawn (the following day) and the lab tech advised the facility nurse, R51's clinical record lacked evidence that: R51 refused the ordered labs to be drawn; that the facility educated R51 of the risks of refusing labs related to critical lab values; that the physician/practitioner was consulted about R51's refusal for the ordered labs; that any steps were taken to address R51 to feel more comfortable/compliant for lab draws (such as a familiar staff member was present during the procedure). The physician orders, nursing and physician/practitioner progress notes also lacked evidence of re-attempting to obtain labs from R51 after the 6/15/19 refusal. 6/21/19 - R51's physician's orders included the following blood tests: H&H (Hemoglobin and Hematocrit). 6/21/19 - It was noted on the facility contracted lab log that R51 refused to have the ordered labs drawn and that the tech notified the facility nurse. The facility's daily report and midnight census report documented that R51 refused ordered labs and stated the NP was notified. Although this information was recorded on in-house tools, R51's clinical record lacked evidence of R51's refusal to have the ordered labs drawn, re-education of consequences of refusal on resident's health status, that the physician or nurse practitioner was consulted, any steps that were taken to address the resident's concerns and alternatives that were offered, or a re-attempt to obtain the ordered labs. The facility lacked evidence of a system to ensure that the refusals that were noted on the contracted lab sign-off sheet were documented in the clinical record, and a method to ensure that the physician or nurse practitioner was consulted when blood draws were refused. Review of R51's physician orders lacked evidence of a standing order for weekly H&H's (Hemoglobin and Hematocrit blood levels). The lab orders for 6/14/19 and 6/21/19 were one time orders which resulted in not attempting to obtain another H&H in a timely fashion. 6/21/19 - The lab result from the contracted lab documented that the lab draw was refused, however, the lab sheet lacked evidence that a practitioner reviewed the result sheet or was consulted related to the refusal of the lab. The lab result paper hard copy provided by the facility was unsigned and undated. 6/22/19 - Again it was noted in the contracted lab log that R51 refused to have (H&H) Hemoglobin and Hematocrit blood tests and that the tech told nurse. The clinical record lacked evidence of consultation with the physician or nurse practitioner and further re-attempts to obtain the labs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	7/23/19 - Although a progress note written by E4 (NP) documented that R51 refused labs, the practitioner's notes and review of the June 2019 orders lacked evidence of E4's knowledge of the particular dates and labs that R51 refused, and any re-attempts to obtain R51's labs. R51 was compliant with having labs drawn on 6/13/19 and 7/24/19, one day after the 7/23/19 nurse practitioner's progress note documented that R51 refuses labs. 7/24/19 - R51's physician orders included the following blood tests: BMP, CBC, Iron, Ferritin TIBC, Transferrin sat, Folate and Vitamin B12 level. The clinical record lacked evidence of consultation with the physician or nurse practitioner regarding the status of R51's labs and R51's refusal to consent to lab draws on 6/15/19 and 6/21/19 until 7/24/19 when the labs were re-ordered by E4 (NP), 39 days after the initial refusal on 6/15/19. 7/24/19 - R51's lab results revealed a Hemoglobin of 6.0 and a Hematocrit of 18.5 (down from a Hemoglobin of 7.0 and a Hematocrit of 21.4 on 6/13/19). 7/24/19 4:30 PM - A nursing progress note documented that (R51) was sent to the ER for a critical Hemoglobin of 6.0 and a Hematocrit of 18.5. 7/24/19 5:57 PM - A progress note written by E5 (NP) lacked evidence of knowledge of the resident's previous refusals of the 6/15/19 and 6/21/19 ordered lab draws. 7/24/19 - A hospital record History and Physical physician's note revealed: (R51) is a [AGE] year old male patient with past medical history of paraplegia and ventilatory (sic) dependent, respiratory failure secondary to motor vehicle accident, . chronic anemia, .chronic decubitus ulcer who was sent from his long-term skilled nursing facility for low hemoglobin of 6.0. He was found to have blood oozing from his wounds. Acute on (sic) chronic blood loss anemia. This is likely secondary to blood loss from patient's wound. Homeostasis was achieved. Patient received 1 unit of blood transfusion. Monitor H&H (Hemoglobin and Hematocrit). 7/24/19 - A hospital record physician's note included: Skin: Numerous decubitus ulcers on his backside, with thick granulation tissue, with 2-3 areas of persistent bleeding with minimal agitation. I injected with lidocaine with epinephrine, attempted silver nitrate cautery but defaulted to hot dressing followed by 4 x 4's. This seemed to abate the bleeding. When he first came in . posterior dressings were changed and we discovered numerous clots. 8/1/19 3:40 PM - R51's hospital discharge summary included: He presents in a setting of anemia and bleeding from his chronic wounds sent from his long-term skilled nursing facility. Patient's anemia has been treated with 3 total units of blood throughout his stay. 8/3/19 - R51's discharge diagnosis from the hospital was acute on (sic.) chronic blood loss anemia bleeding from wound and multiple wounds. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	8/26/19 1:35 PM - During an interview with E6 (Corporate Nurse), it was confirmed that there were physician orders for labs on 6/13/19, 6/14/19, 6/21/19 and 7/24/19 and that R51's record lacked evidence of lab results for the 6/15/19 and 6/21/19 orders. 8/27/19 10:10 AM - During an interview with E7 (RN, UM), it was confirmed that the clinical record lacked evidence of refusals of labs in the progress notes for 6/15/19 and 6/21/19, and there were no lab results for those dates. E7 confirmed that the same labs (from 6/15/19 and 6/21/19) were re-ordered on 7/24/19. 8/27/19 10:34 AM - During an interview, E4 (NP) reported that R51 often refused care, but did not know if E51 had refused the labs or not on 6/15/19 and 6/21/19. E4 stated that the labs were re-ordered related to lack of evidence of lab results for 6/15/19 and 6/21/19 in the medical record. 8/27/19 10:46 AM - During an interview, E3 (ADON) reported that sometimes the lab tech would go to nursing and report refusals for lab draws to see if staff can go in and explain the need for the labs, and encourage the resident to let the labs be drawn. The clinical record lacked evidence of that approach/intervention and/or that the nurse consulted the physician/practitioner. E3 added that the lab techs do not always report refusals to the nurse and the lab tech will make note of the refusals in the lab sign-off log. E3 confirmed that it was the expectation of facility nurses to re-attempt to complete the labs, consult the physician/practitioner, and complete a nursing progress note. 8/27/19 11:10 AM - During an interview with E1 (NHA) and E2 (DON), E2 presented the surveyor with physician, nurse practitioner and nursing progress notes, and stated there was documentation that R51 refused care and labs at times, but confirmed there were no specific dates of the lab refusals. E2 reported that it was common for R51 to refuse care. E2 confirmed there was a lack of evidence of R51's refusal of labs, physician/nurse practitioner notification, and interventions to re-attempt the lab draws in the nursing progress notes on 6/15/19 and 6/21/19. Review of the resident record revealed lack of evidence of any orders to re-attempt to draw the 6/15/19 and 6/21/19 ordered labs. E2 reported that E4 (NP) was at the facility every day, and staff report those things directly to E4 when at the facility. The clinical record lacked evidence that R51's refusals of the 6/15/19 and 6/21/19 labs were reported to E4 and or any other physician or nurse practitioner until 7/24/19 when E4 gained knowledge that there were no lab results for those days. The facility failed to notify the physician/nurse practitioner of R51's refusal of ordered labs, failed to re-educate R51 about the health risks of refusal of labs, failed to obtain further orders after the refusal of labs, failed to re-attempt to obtain the labs, and failed to accurately assess and monitor R51's blood loss from the resident's wounds (from 6/1/19-7/24/19) which resulted in R51's hospitalization from [DATE] to 8/3/19 for blood transfusions and treatment for critically low Hemoglobin and Hematocrit levels. 32545 2. Review of R84's clinical record revealed: 1/5/17 - R84 was admitted to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	4/28/19 - R84 was care planned for actual MASD of right posterior thigh to buttock and left posterior thigh (back of thigh) with approaches that included skin checks every 2 hours and turn and reposition every 2 hours and as needed. 6/24/19 - Review of R84's clinical record lacked evidence that a skin integrity issue and/or wound was identified on R84's right foot or if a current treatment was in place. 6/24/19 at 1:58 AM - Review of the CNA Point of Care History report revealed that E50 (CNA) signed off that he/she completed Skin checks every 2 hours and report any changes to the nurse AND Turn and Reposition every 2 hours during the 11 PM to 7 AM shift. It was unclear how E50 could sign off both of these tasks as Done only 3 hours after his/her 8 hour shift started. 6/24/19 at 11:41 AM - A nurse's note stated, Resident noted with maggots to right foot during am/wound care at 1000 am. Right foot flushed by wound nurse. E48 (MD's name) at facility and informed of new development. E4 (NP's name), examined resident with this nurse. One maggot still visible. Right lower extremity red with increase edema (swelling) Received order to send to ER for evaluation for maggots .to right foot . 6/24/19 at 4:22 PM - E4's (NP) progress note stated, .Asked to eval (evaluate) due to increase erythema (redness) and drainage ble .Maggots found in wound right foot . 6/24/19 at 7:41 PM - The hospital record's history and physical stated, .Patient is coming from a nursing home where (he/she) was found today to have maggots in (his/her) feet .(R84) has chronic wounds on her lower extremities secondary to bedbound state . 6/24/19 at 7:45 PM - The hospital record progress note stated, .Wound noted to bottom of R (right) foot, 6 cm x 3.5, red, hypergranulation tissue (excessive granulation filling a wound bed; tissue is raised) noted, area just above, yellow necrotic (dead tissue) skin flap, 14 maggots removed from this . 6/25/19 at 12:13 PM - The hospital's infectious disease consult stated, .Maggots in wounds .Patient has had difficulties with immobility, progressive lower body/LE (lower extremity) lymphedema and stasis ulcerations (venous wounds due to abnormal veins). Chronic ulceration right plantar lateral foot and right lateral calf more recently noted. (He/she) subsequently noted maggots on (his/her) feet yesterday .Patient notes that since admission overnight 18 more maggots were removed from (R84's) foot. (He/she) states 'I know there are flies around, I have a fly sweater (sic) at my bedside.' .Right foot .moderate-copious serous drainage . Assessment/Plan .Infestation, maggots .Important to keep wounds with drainage covered to prevent ongoing infestation .Additional Recommendation or Comments .admitted with progressive stasis ulcerations/maggot infestation, super infection (previous infection and develops another strain of infection on top of the first one) suspect right lower extremity/plantar foot . 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to identify and treat a right foot wound on a resident that was susceptible to chronic wounds and infections until it was infested with maggots on 6/24/19 requiring hospital evaluation and treatment 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	3. Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/29/19 - R209 was care planned for potential for alteration in hydration with an approach to obtain weights as ordered. 7/17/19 - A physician's order stated to obtain R209's weight on Monday, Wednesday and Friday once a day at 12:30 PM. 7/24/19 - Review of R209's clinical record lacked evidence that the resident's weight was taken on Wednesday, 7/24/19. 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to follow R209's plan of care to obtain a weight on 7/24/19. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 20883 Based on observation, record review and staff interview, it was determined that the facility failed to ensure that one (R4) out of three (3) residents reviewed for pressure ulcers, received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Findings include: The facility's undated Skin Integrity Manual stated, .Cadia Healthcare Core Standards: No lift devices for turning and repositioning .Consistent weekly wound rounds .Wound care nurse will document weekly assessment on the Weekly Wound Observation Form in the electronic health record (EHR). If the wound is assessed by a wound consultant, documentation is completed on their preferred form. Assessments are reviewed and signed by the Attending Provider and placed within the EHR .Skin Care .Resident should be turned and repositioned based upon need. A draw sheet under resident is important to prevent shearing during bed mobility or transfers . Review of R4's clinical record revealed the following: 11/09 - R4 was admitted to the facility. R4 had diagnoses that included ventilator dependent respiratory failure (VDRF), quadriplegia, anemia, protein calorie malnutrition and a Stage IV (4) pressure ulcer. 9/19/18 - A care plan for actual pressure ulcer, last reviewed 8/28/19, was developed and included interventions to measure on weekly wound rounds .skin treatments as ordered . A. 1/8/19 - The wound care consultant's note stated, Recommend checking CBC, ESR, CRP, Prealbumin. Although the note was signed by the facility NP, it was undated and there was no evidence that an order was written to obtain the recommended blood work. There was no evidence that these blood tests were drawn at this time. 1/15/19 - The wound care consultant's note stated, Recommend checking CBC, ESR, CRP, Prealbumin - results not available to me. The note was signed by the facility NP, but was undated. 2/5/19 - The wound care consultant's note stated, Please obtain CBC, ESR, CRP, prealbumin . The note was signed by the facility NP, but was undated. 2/6/19 - Review of the EHR revealed that the recommended blood tests were drawn as first requested on 1/8/19, approximately one month prior. 9/3/19 - After an interview, E2 (DON) was only able to provide blood test results from 2/6/19. There were none available from around 1/8/19. B. Review of R4's Weekly Wound Observation Forms from 12/4/18 through 8/27/19 revealed that the weekly assessments were not completed according to the facility policy and procedure, and professional standards of practice on the following dates: 2/12/19; 3/28/19; 4/25/19; 5/9/19; and 5/23/19. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/3/19 - Although other documents were provided by E21 (WCN), none were the Weekly Wound Observations Forms from the above listed dates. C. 4/9/19 - A physician's order stated to cleanse the wound bed with dakins (sodium hypochlorite solution used to kill germs and prevent germ growth in wounds), apply promogran (contains collagen which stimulates wound healing) to wound bed and cover with foam dressing three (3) times weekly and as needed. Review of R4's TARs lacked evidence that wound treatments were provided on 4/24/19 and 4/29/19. 9/3/19 10:53 AM - During an interview, E21 (WCN) stated that she did not work on 4/24/19 and 4/29/19, so she can not say why the treatment was not completed. D. On 8/28/19 from approximately 9:35 AM to 10:00 AM, R4's wound care was observed being provided by E20 (LPN) with E22 (CNA) assisting. After wound care was completed, E20 and E22 attempted to lift R4 up in the bed. Using a drawsheet, they were only able to get R4 up a short distance in the bed while causing R4's backside (area of the pressure ulcer) to slide against the mattress (shearing - sliding of tissue layers against one another). E20 and E22 did not utilize a no lift device, nor did they request more staff to assist in positioning R4 higher in bed without causing shearing. 9/4/19 8:23 AM - All of the above findings were reviewed with E1 (NHA) and E2 (DON).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38827 Based on observations, interviews, and record review, it was determined that for one (R67) out of three sampled residents, the facility failed to ensure that R67 who had limited mobility, received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Findings include: Cross refer F842 Review of R67's record revealed: A facility policy titled Documentation Guidelines, effective July 2013 and revised May 17, 2019 stated: Resident care delivered is entered into the medical record legibly and timely. CNA's document care delivery electronically. Unit managers/designees are required to review CNA documentation daily and address inconsistencies. R67 was admitted to the facility on [DATE] with diagnoses that included stroke, paralysis, and tracheostomy (an opening made in the throat to assist with breathing). 7/5/19 - A physician's order stated that R67 was to wear a left, blue resting hand splint during the day only and then off at night to prevent finger contractures. 7/5/19 - A note written by E35 (OT) stated that R67 was assessed for proper fit of the left hand splint, a splint schedule and orders were written, staff were educated on reactivating orders for the left hand splint and questions were answered regarding splint application. 7/20/19 - A quarterly MDS revealed that R67 was rarely understood and that he/she was totally dependent on staff for daily care. The number of days for splint assisstance was zero. 7/24/19 - A care plan for the problem that R67 wears a splint was edited with the approach to put on/take off the splint as ordered. 8/28/19 at 10:36 AM - It was observed that R67 did not have a left hand splint on. Review of the August 2019 Point of Care History for R67 to wear a left blue resting hand splint during the day only and then off at night, was documented as done 26 out of 28 days in August. 8/28/19 at 11:49 AM - It was observed that R67 did not have a left hand splint on. Review of R67's electronic medical record revealed that his/her hand splint was documented as on. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/28/19 at 11:57 AM - During an interview, E12 (CNA) stated he/she was familiar with R67 and had not seen R67 with a hand splint on for awhile. Upon searching R67's room, E12 was unable to find the hand splint. There were multiple days in August 2019 when E12 documented that R67's hand splint was on. When the surveyor pointed out to E12 that he/she had documented other instances of putting the splint on R67, E12 stated 'that must've been a mistake'. 9/3/19 at 9:11 AM - E36 (CNA) documented in the Point of Care documentation that R67's hand splint was on. 9/3/19 at 9:39 AM - E37 (PT Director) was observed entering R67's room and he/she applied R67's left hand splint. 9/3/19 at 9:51 AM - E36 (CNA) amended the Point of Care documentaion to read that R67's hand splint was not done at 9:11 AM. 9/3/19 at 2:29 PM - During an interview, E36 (CNA) stated that she did not put the hand splint on R67 and did not put the hand splint on yesterday either. E36 stated that he/she mistakenly logged it in the Point of Care documentation. The facility failed to ensure that R67's left hand splint was on as ordered. Findings were reviewed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40264 Based on observation, record review, and interview, it was determined that for two (R19 and R84) out of three residents sampled for accidents, the facility failed to ensure that the residents environment remained as free of accident hazards as possible and that each resident received adequate supervision to prevent accidents. For R19, the facility failed to ensure that R19's transfers were safely performed by qualified clinical staff when R19's son reported that the family had been using the hoyer (a sling-type hydraulic lift) and ceiling lifts to transfer R19 from the bed to the geri chair (wheelchair type- chair that reclines). For R84, the facility failed to ensure R84's safety on 4/13/19 when R84 was turned on the resident's left side and staff left the room; R84's right leg started to fall forward causing the resident's entire body to completely fall forward and the upper bed rail gave way; the resident fell from the elevated bed to the tiled floor, resulting in a facial contusion, a grossly large hematoma on the right shoulder and upper arm and sustained a laceration (cut) on her right elbow. In addition, a medication cart was observed unattended with a pill and a syringe with a closed needle sitting on top of the Sharps container. Findings include: 1. Review of R19's clinical records revealed: 2/24/17 - R19 was admitted to the facility with diagnoses including weakness and inability to walk in the usual way due to problems with the legs and feet requiring the use of a hoyer lift for transfers. 8/20/19 at 3:13 PM - During an interview, R19's son revealed to the surveyor that the family has been transferring R19 from the bed to geri chair using the hoyer and the ceiling lift machines since R19 was admitted to the facility on [DATE]. 8/29/19 at 10:39 AM - During an interview, E12 (CNA) stated, I see the family come in around 7PM when I work on the 3-11 shift. They want him/her out of bed by then. They are very hands on with their mother's care. If they come and he/she is not out of bed yet, they will transfer him/her by themselves using the ceiling lift. The two sons are usually there. Sometimes they call the aide for help .other times they do the transfer on their own (sic). 8/29/19 at 10:50 AM - During an interview, E13 (CNA) stated that R19's two sons usually come on the 3-11 shift and are the ones getting R19 out of bed to the geri chair. E13 further stated that the sons do not ask for help. 8/29/19 at 11:02 AM - In an interview, E14 (CNA) stated, When I work on the 3-11 shift, the son will ask me to help him transfer his mom from the bed to the geri chair. 8/29/19 at 4:27 PM - During an interview, E1 (NHA) stated that the facility has no policy on the use of hoyer and ceiling lifts. E1 further confirmed that only the clinical staff are qualified to perform lift transfers to residents and that families are not allowed to use the hoyer, ceiling and other lift machines in the facility during transfers. Findings were reviewed during the exit conference on 9/4/19 at 7:30 PM with E1 (NHA) and E2 (DON). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32545 2. Review of R84's clinical record revealed: 1/5/17 - R84 was admitted to the facility. 1/5/17 - R84 was care planned for falls with approaches that included, but were not limited to, encourage resident to use handrails or assistive devices properly and keep bed in low/lowest position that is appropriate for resident. 2/8/19 - The quarterly MDS assessment stated that R84 was cognitively intact, had active diagnoses that included, but were not limited to dependence on a ventilator, morbid obesity, lymphedema of the bilateral lower extremities, was totally dependent with 2+ staff person physical assistance for toileting, and weighed 560 lbs. (pounds). 4/13/18 at 6 PM - A late entry nurse's note entered on 4/14/19 at 1:28 AM stated, Resident found on the floor in her room by RT who went in to answer a stat call that came from (his/her) room, resident denied hitting (his/her) head on the floor, vital signs WNL (within normal limits) and no visible signs of respiratory distress noted, resident sustained skin tears B/L elbows. Head to toe assessment completed and together with the other staff we helped the resident into a sitting position, paged 911 stat for the ambulance and the resident was transferred to ER for further evaluation. pcp and poa both notified. 4/13/19 at 6:27 PM - A respiratory progress note stated, I heard a stat page to resident's room at approx (approximately) 1725 (5:25 PM). I entered the room and found resident face down on the floor. I once again paged for more staff members to report to the room due to the large size and weight of resident. Resident was turned face up and Sats (oxygen saturation- amount of oxygen in the blood) were 97%/HR (heart rate) 80. Resident was awake and alert and talking. No respiratory distress noted at this time. Resident out with 911. 4/13/19 at 7:01 PM - According to the State Survey Agency's Incident Report, the facility stated, Found resident laying on floor. Sent to hospital due to being on Coumadin (blood thinning medication). 4/13/19 at 7:37 PM - The hospital ED (emergency department) physician record stated, .This patient arrived via EMS (Emergency Medical Services) at 1839 (6:39 PM) .is at (name) nursing home today when (he/she) says they rolled (him/her) on (his/her) .side against the rail for (R84) to go to the bathroom and then the staff left the room and the rail gave way and (R84) fell about 3 feet to the floor suffering an injury to (his/her) right upper arm and contusions to her right face without loss of consciousness . has obvious contusions to her right face and a very large hematoma of her right upper arm . 4/14/19 at 12:36 PM - According to the hospital's discharge planning notes, the facility was not able to readmit R84 to the facility until his/her broken bed was fixed. 4/14/19 (untimed) - According to E40's (CNA) statement regarding the 4/13/19 incident, E40 stated, .Patient was on the floor but I didn't see (R84) falling. (R84) refused to lay on (his/her) back when the dinner trays were up . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Pike Creek	3540 Three Little Bakers Blvd Wilmington, DE 19808

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/17/19 (untimed) - According to the facility's 5-day follow up report to the State Survey Agency, the facility stated, Resident was found on the floor in (his/her) room. Resident interview conducted on 4/15/19. Resident stated (he/she) was having a bowel movement when (he/she) felt (his/her) leg sliding and .could not stop (his/her) weight from rolling and slid out the bed. Resident sent to the ED for evaluation and returned in less than 24 hours .Root cause analysis determined to be resident slid off bed because (R84) was unable to support .own weight when lying on (his/her) side. Fall interventions (1) Staff present during bowel movements. (2) Bed in lowest position during bowel movements. (3) Fall mat to sides of bed. The facility's investigation failed to address anything about how and why R84's bed rail broke. 9/3/19 at 11:26 AM - During an interview, E51 (Maintenance Director) confirmed that R84's left bed side rail on his/her bariatric bed was replaced in April 2019. Review of the manufacturer's 2015 Operation Manual for R84's bariatric low bed stated, .Cautions and Warnings .The bed should be left in the lowest position when unattended in order to reduce the risk of injury due to falls while getting into or out of bed, or while lying on the bed. 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure R84's safety on 4/13/19 when R84 was turned on the resident's left side and staff left the room; R84's right leg started to fall forward causing the resident's entire body to completely fall forward and the upper bed rail gave way; the resident fell from the elevated bed to the tiled floor, resulting in a facial contusion, a grossly large hematoma on the right shoulder and upper arm and sustained a laceration on the right elbow. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 38509 3. 8/22/19 8:42 AM- E18 (RN) was observed walking away from a second floor medication cart. On the side of the medication cart there was a sharps container that had a pill and a syringe with a capped needle sitting on top where it was accessible to residents. E18 was half way down the hallway walking towards the nurse station and the medication cart was unsupervised. The surveyor stopped E18 and showed her the pill and syringe with the capped needle sitting on top of the sharps container on the medication cart. E18 (RN) confirmed the finding and pushed the pill and the syringe with the capped needle into the sharps container. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 32545 Based on clinical record review, observations, interview and review of facility documentation as indicated, it was determined that for one (R84) out of three (3) sampled residents for catheter care, the facility failed to ensure that a resident with an indwelling catheter received appropriate treatment and services as per the plan of care, as well as facility policy. Findings include: The facility's policy entitled Appropriate Indwelling Catheter Use, last revised 1/14/19, stated, .Residents with an indwelling catheter will receive daily catheter care . Review of R84's clinical record revealed: 1/17/17 - R84 was care planned for use of an indwelling foley (brand of urinary catheter) catheter with approaches that included to check for leakage around the urethra every shift and as needed and monitor the collection bag for odor every shift and report findings to MD (Medical Doctor). 4/3/19 - The hospital urology consult progress note stated, .states (he/she) does have leakage of (his/her) foley catheter which typically happens when tension is applied to the catheter tubing which occurs when the patient is turned .Patient with long-standing history of chronic indwelling foley catheter .(He/she) has chronic leakage of urine around the catheter which is not surprising as he/she most likely has a patulous (spread widely apart)urethra with some erosion of the catheter which is an expected finding when someone has had an indwelling catheter as long as he/she has. He/she states he/she does have significant leakage around the catheter at (nursing home name) . 8/21/19 at 4:27 PM - During an interview with R84, this surveyor observed a strong urine odor. 8/28/19 at 8:33 AM - An observation revealed E47 (LPN) in R84's room wearing a PPE gown, gloves and a mask which was scrunched up under his/her nose and not covering his/her mouth. At 8:39 AM, this surveyor and another surveyor were standing in the hallway in front of R84's room and smelled a strong urine odor coming from the resident's room. 8/28/19 at 2:37 PM - An observation of this surveyor standing in the hallway revealed that a urine odor remained present, although not as strong as during the 8:33 AM observation. 8/29/19 at 7:57 AM - An observation of this surveyor and another surveyor revealed a strong urine odor coming from R84's room. 8/29/19 at 10:30 AM - An observation by this surveyor revealed that even after R84 was provided morning care, there was still a strong urine odor while standing in the hallway outside of R84's door. 9/3/19 at 7:50 AM - An observation of this surveyor revealed a small puddle of fluid under the footboard of R84's bed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/3/19 at 9:52 AM - An observation of this surveyor upon entering R84's room to observe morning care revealed a strong urine odor. This surveyor observed a puddle of brown fluid on the floor at the end of the bed under the footboard. This surveyor asked E40 (CNA) what was the puddle from and R84 answered by saying it was a mixture of weeping from his/her lower extremities, blood and urine leaking. This surveyor observed E40 clean the puddle on the floor using the Microkill bleach wipes. 9/3/19 at 1:40 PM - During an interview, E29 (Housekeeper) was asked about the puddling of brown fluid at the end of R84's bed under the footboard. E29 stated that it was coming from the resident's mattress. E29 stated that he/she thoroughly cleans the resident's room and sometimes the puddle reappears after the floor was cleaned. E29 stated that staff throws linens on top of the area where the puddling occurs. E29 acknowledged there was a strong odor coming from R84's room. 9/3/19 at 2:05 PM - During an interview, when asked about the continuous puddling of brown fluid accumulating at the end of R84's bed under the footboard and the strong odor coming from the room, E33 (Housekeeping Director) acknowledged that the puddling was coming from R84's mattress. 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that a resident with an indwelling catheter received appropriate treatment and services as per the plan of care. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 32545 Based on clinical record reviews and interviews, it was determined that for 2 (R30 and R3209) out of 3 sampled residents, the facility failed to ensure that residents maintained acceptable parameters of nutritional status based on the residents' comprehensive assessments. For R209, the facility failed to ensure that the resident did not exceed the physician-ordered 1200 ml fluid restriction from 6/25/19 through 7/18/19. Findings include: 1. Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/24/19 at 8:53 AM - A history and physical stated, .start fluid restriction . 6/25/19 - A physician's order stated, .1200 mL Fluid Restriction . 6/25/19 through 7/18/19 - Review of R209's total fluid intake per day as recorded in the clinical record revealed that R209 exceeded the 1200 ml fluid restriction on 19 out of 24 days: - 6/25/19 = 1,260 ml; - 6/26/19 = 1,310 ml; - 6/27/19 = 1,680 ml; - 6/28/19 = 990 ml; - 6/29/19 = 1,320 ml; - 6/30/19 = 1,680 ml; - 7/1/19 = 960 ml; - 7/2/19 = 1,710 ml; - 7/3/19 = 1,140 ml; - 7/4/19 = 1,500 ml; - 7/5/19 = 1,560 ml; - 7/6/19 = 1,580 ml; - 7/7/19 = 1,340 ml; - 7/8/19 = 780 ml; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 7/9/19 = 1,800 ml; - 7/10/19 = 1,500 ml; - 7/11/19 = 1,560 ml; - 7/12/19 = 1,080 ml; - 7/13/19 = 1,380 ml; - 7/14/19 = 1,500 ml; - 7/15/19 = 1,540 ml; - 7/16/19 = 1,540 ml; - 7/17/19 = 1,620 ml; - 7/18/19 = 2,090 ml. 6/29/19 - R209 was care planned for the potential for systemic complications related to congestive heart failure with an approach to monitor for appropriate food and fluid intakes. 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that R209 did not exceed the physician-ordered 1200 ml fluid restriction from 6/25/19 through 7/18/19. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 38509 2. Review of R30's clinical record revealed: 6/22/16- R30 was admitted to the facility. 6/24/18- A care plan was initiated stating that R30 needed to maintain good nutrition and hydration in spite of a BMI above 80, and that no further weight gain was desired. Approaches included to obtain weights as ordered. 6/5/19-8/5/19- Review of R30's weights revealed that on 6/5/19 R30 was 409.2 lbs. On 7/8/19, R30 was 349. 8 lbs, which was a 7.45% significant weight change. R30 was not reweighed until 8/5/19 and was 440.8 lbs. 8/28/19- Review of R30's clinical record showed no evidence that E16 (Dietician) was aware of R30's significant weight change on 7/8/19, and there was no evidence that an assessment of this weight change was completed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/28/19 4:06 PM- During an interview, E16 (Dietician) stated that if a resident had a significant weight increase or decrease a reweight was completed within 24 to 48 hours. E16 stated that the nurses typically enter the monthly weights on R30's floor and nursing staff was expected to notify her (E16) if a resident had a significant weight change. E16 stated that regarding R30's weight change she would look to see if an assessment was ever done after R30's significant weight gain on 7/8/19. 8/28.19 4:29 PM- During an interview, E17 (Corporate Nurse) confirmed that she looked with E16 (Dietician) and there was no evidence that R30's significant weight gain on 7/8/19 was assessed and evaluated. The facility failed to recognize, evaluate, and address R30's significant weight change of 7.45% from 6/5/19 to 7/5/19. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 32545 Based on clinical record review, interview and review of facility documentation as indicated, it was determined that for 1 (R209) out of 3 sampled residents, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with the comprehensive person-centered care plan. For R209, the facility failed to ensure that a physician-ordered treatment for BIPAP was provided every night from 6/22/19 through 6/27/19 until a critical lab on 6/28/19 revealed that R209's CO2 was at a critically high level of 43 (normal range 22-29). The facility failed to notify the physician when R209 repeatedly refused the physician-ordered treatment for 6 nights and failed to determine the reason as to why R209 repeatedly refused. Findings include: Cross refer to F580 The facility's policy entitled Bi-level Positive Airway Pressure (BiPAP) .and Other Types of Non-invasive Ventilation Support Machine Use and Administration, last revised on 1/14/19, stated, .Procedure: The Licensed Nurse and/or Respiratory Therapist is responsible for the safe and correct usage and administration of BiPAP . Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/21/19 - A physician's order stated for R209 to wear BIPAP every night with 3 liters of oxygen. 6/22/19 at 7:22 AM - A nurse's note stated, .Resident put on CPAP some of the night and took off because (he/she) felt like it was too 'heavy' on (his/her) face. Resident states (he/she) will have family bring in the mask (he/she) uses . Despite a physician's order for BIPAP, nursing staff were documenting that R209 had CPAP. 6/22/19 through 6/28/19 - Review of R209's eTAR revealed that the nursing staff were documenting BIPAP Refused every night for a total of 6 nights. 6/23/19 at 10 PM - A nurse's note stated, pt refused c-pap machine. 6/24/19 at 21:36 PM - A nurse's note stated, pt refused to wear C-pap. 6/28/19 at 12:15 PM - Review of R209's lab result report revealed that the facility was notified by telephone regarding the resident's critically high lab result of CO2=43 (normal range 22-29). 6/28/19 at 1:25 PM - A nurse's note stated, .Patient did not have BiPAP on this AM at change of shift. 6/28/19 at 2:11 PM - A progress note, written by E4 (NP), stated, .Refuses to wear BiPAP at night. Seen by respiratory therapy who has discussed with pt and tried several masks . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/28/19 at 3:10 PM - A progress note, written by E45 (RT), stated, the NP just told me that the Resident Co2 is 44 this is due to the Resident continued to refuse to wear the bipap. I went to speak to the Resident about the increase of (his/her) co2 and asked (R209) to please use the mask, (R209) agreed and i put (him/her) on settings 10/5. (R209) tolerated it well and stable without any Respiratory Distress, Saturation is 98% on 2 liters of oxygen and HR 75. I also called the Unit Manager (name) and 3-11 supervisor (name) to the Resident room and gave them the information on what I have done for the Resident, and i also gave the NP the same information on what i have done for the Resident and (R209) is pleased with it. I also advice (sic) both (name) and (name) to make sure the incoming nurse to monitor the Resident because (R209) is on bipap. I will also sent (sic) a RT tonight through Monday night to put (R209) on the bipap. Review of R209's clinical record from 6/21/19 through 6/28/19 lacked evidence that the resident's physician was notified of R209's repeated refusals of a physician-ordered treatment to wear BIPAP every night. 9/3/19 at 8:30 AM - Finding reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure that a physician-ordered treatment for BIPAP was provided every night from 6/22/19 through 6/27/19 until a critical lab result received on 6/28/19 revealed that R209's CO2 was at a critically high level of 43 (normal range 22-29); failed to notify the physician when R209 repeatedly refused the physician-ordered treatment for 6 nights; and failed to determine the reason as to why R209 repeatedly refused BIPAP. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38827 Based on interviews and records review, it was determined that the facility failed to employ sufficient staff to provide care and services in assisting residents to attain or maintain their highest practicable level of physical and functional well being for three (R1, R48, and R56) out of 50 sampled residents. Findings include: 1a. Review of R1's clinical record revealed: Review of the July 2019 CNA documentation for urine/bowel movements revealed that R1 was changed: 7/5/19 at 10:57 AM then not again until 7/6/19 at 1:34 AM - 13.5 hours. 7/17/19 at 7:51 PM then not again until 7/18/19 at 2:13 PM - 18 hours. 7/21/19 at 3:13 AM then not again until 7/21/19 at 10:34 PM - 19.5 hours. 7/30/19 at 6:49 AM then not again until 7/30/19 at 10:50 PM - 16 hours. Review of the August 2019 CNA documentation for urine/bowel movements revealed that R1 was changed: 8/17/19 at 6:33 AM then not again until 8/18/19 at 6:28 AM - 24 hours. 8/23/19 at 10:20 PM then not again until 8/24/19 at 12:14 PM - 14 hours. 8/25/19 at 9:39 AM then not again until 8/26/19 at 5:09 AM - 20 hours. 8/31/19 at 12:58 PM then not again until 9/1/19 at 1:18 AM - 12 hours. 8/3/19 - A quarterly MDS assessment revealed that R1 was cognitively intact and was totally dependent on staff for care. On 8/21/19 at 2:49 PM - During a screening interview, R1 stated that he/she waited 23 hours to be changed. R1 stated it was three days ago (8/17/19) on the 11-7 shift, he/she put the call bell on and no one came. R1 stated he/she knew what time it was by looking at the clock on the wall. On 8/27/19 at 2:24 PM - During an interview, E34 (CNA) stated she worked day and evening shifts. E34 stated residents who do not go into the bathroom to toilet are changed in the morning when they get up, after lunch, at the start of the evening shift, after dinner, and whenever else the resident requested to be changed. 1b. Review of R48's clinical record revealed: 7/15/19 - An admission MDS assessment revealed that R48 was cognitively intact and required extensive two person staff assistance for toileting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the July 2019 CNA documentation for urine/bowel movements revealed that R48 was toileted: 7/12/19 at 10:02 AM then not again until 7/13/19 at 4:07 AM - 16 hours. 7/13/19 at 4:07 AM then not again until 7/13/19 at 9:35 PM - 17.5 hours. 7/14/19 at 2:28 AM then not again until 7/14/19 at 7:02 PM - 14.5 hours. 7/21/19 at 8:15 PM then not again until 7/22/19 at 11:42 AM - 15.5 hours. 7/24/19 at 9:01 AM then not again until 7/25/19 at 1:28 AM - 16.5 hours. Review of the August 2019 CNA documentation for urine/bowel movements revealed that R48 was toileted: 8/11/19 at 2:23 AM then not again until 8/11/19 at 7:56 PM - 17 hours. 8/11/19 at 7:56 PM then not again until 8/12/19 at 9:15 AM - 13 hours. 8/15/19 at 4:07 AM then not again until 8/15/19 at 9:26 PM - 17.5 hours. 8/23/19 at 2:57 AM then not again until 8/23/19 at 9:38 PM - 18.5 hours. 8/23/19 at 9:38 PM then not again until 8/24/19 at 1:54 PM - 17 hours. 8/26/19 at 10:25 AM then not again until 8/27/19 at 5:34 AM - 19 hours. 8/28/19 at 10:39 AM then not again until 8/29/19 at 1:32 AM - 15 hours. 8/29/19 at 1:32 AM then not again until 8/30/19 at 4:57 AM - 26 hours. On 8/21/19 at 1:58 PM - During a screening interview, R48 stated that he/she has to wait a long time for staff to answer the call bell, especially during the night shift. 1c. Review of R56's clinical record revealed: 7/22/19 - An admission MDS assessment revealed that R56 was cognitively intact and was totally dependent on staff for care. 7/29/19 - A physician's order was written to check and change every shift. August 2019 CNA documentation for urine/bowel movements revealed that R56 was changed: 8/2/19 at 2:43 PM then not again until 8/3/19 at 1:05 AM - 22 hours. 8/4/19 at 6:58 AM then not again until 8/4/19 9:43 PM - 14.5 hours. 8/8/19 at 6:51 AM then not again until 8/8/19 at 10:34 PM - 15 hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/11/19 at 10:24 PM then not again until 8/12/19 at 2:37 PM - 16 hours. 8/15/19 at 11:47 PM then not again until 8/16/19 at 2:24 PM - 15 hours. 8/21/19 at 11:43 PM then not again until 8/22/19 at 2:38 PM - 15 hours. 8/22/19 at 11:46 PM then not again until 8/23/19 at 2:27 PM - 15 hours. 8/28/19 at 2:32 PM then not again until 8/29/19 at 4:47 AM - 14 hours. On 8/20/19 at 3:32 PM - During a screening interview, R56 stated that sometimes his/her call bell is on for over an hour and he/she has to yell to get staff attention. R56 stated weekends are the worst. The facility failed assure that there was sufficient nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Findings were discussed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38509 Based on record review and interview, it was determined that the facility failed to consistently act on irregularities identified during medication regimen reviews (MRRs) by the pharmacist for two (R30 and R53) out of five residents sampled for unnecessary medications. Findings include: 1. Review of R30's clinical record revealed: 1/3/19- Review of R30's MRR revealed a pharmacist recommendation stating that R30 had an order for an AIMS assessment and was not on any antipsychotic medication at this time. The pharmacist recommended evaluating the continued need for an AIMS assessment and to discontinue if not clinically appropriate. E4 (NP) responded to the recommendation writing D/C and checking agree. E4 signed the recommendation, however, there was no date indicating when it was signed. 3/5/19- Review of R30's MRR revealed a pharmacist recommendation stating that R30's AIMS assessment was discontinued from the 1/3/19 recommendation, but the discontinuation was not transcribed. The pharmacist wrote to cancel the AIMS assessment if appropriate. The physician responded to the recommendation writing D/C'd and signed the recommendation on 3/13/19. 3/14/19- R30's physician ordered AIMS assessment was discontinued. 6/9/19- Review of R30's MRR revealed a pharmacist recommendation stating that R30 had PRN (as needed) order for albuterol every 4 hours and the MAR did not reflect that. The pharmacist recommended changing the MAR to reflect the order. E4 (NP) signed the recommendation on 6/11/19, but did not write a response to the recommendation or check off whether they agreed or disagreed with the recommendation. 8/28/19- Review of R30's current physician orders revealed that R30's albuterol PRN order was not changed in the MAR per the pharmacist's recommendation. The facility failed to ensure the physician reviewed and took action for the pharmacists identified irregularities for R30's 1/3/19 and 6/9/19 MRRs. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). 2. Review of R53's clinical record revealed: 4/4/19- A physician's order was entered for R53 to receive Hydralazine (medication to treat high blood pressure) 25 mg 1 tab orally every 12 hours PRN (as needed) for a systolic blood pressure (BP) less than (<) 170. 4/4/19 1:42 PM- A physician's observation progress note stated that for hypertension R53 had Hydralazine PRN for systolic BP >(greater than) 170. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/10/19- Review of R53's MRR revealed a pharmacist recommendation stating that R53's PRN hydralazine order stated to administer every 12 hours PRN for a systolic blood pressure < (less than) 170. The pharmacist stated to please evaluate this parameter and questioned if it should read if > (greater than) 170. The physician checked disagree and signed the recommendation on 5/23/19. 5/23/19- A physician's observation progress note stated that for hypertension R53 had Hydralazine PRN for systolic BP >170. 8/28/19- Review of R53's physician orders revealed that R53's PRN hydralazine order still stated to administer every 12 hours PRN if R53's systolic BP was < (less than) 170. The physician failed to appropriately respond to the pharmacist's recommendation on 5/10/19 to evaluate R53's Hydralazine PRN order to administer every 12 hours if R53's systolic BP was less than 170. The physician signed off stating disagree when physician notes documented that the order was to be greater than 170. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 20883 Based on record review and staff interview it was determined that the facility failed to ensure that one (R1) out of five (5) residents, who's drug regimen was reviewed, was free from unnecessary drugs. The facility failed to discontinue two (2) medicated eye drops (Ilevro and Prednisolone) after cataract surgery according to physician's orders. Findings include: Review of R1's clinical record revealed the following: 5/14/19 - R1 had cataract surgery of the left eye. Discharge/Transfer Instructions post cataract surgery listed the schedule for eye drops (Ilevro and Prednisolone) to be administered for the subsequent four (4) weeks. The discharge instructions stated that both the Ilevro and Prednisolone were to be stopped after the fourth week. That date would have been June 11, 2019. Review of the MAR from 5/14/19 through 8/28/19 revealed that the facility continued to administer the Ilevro and Prednisolone eye drops despite the physician's order that they be discontinued after four (4) weeks. 8/28/19 at 11:28 AM - During an interview, E17 (RNAC) stated she would follow up with the physician regarding the eye drops. 8/28/19 at 2:00 PM - During an interview, E17 (RNAC) stated that she had spoken with the physician and that the eye drops should have been stopped after four (4) weeks. 8/29/19 - Review of the MAR revealed that the Ilevro eye drops had been discontinued. 9/3/19 - Review of the MAR revealed that the Predisolone eye drops continued to be administered. 9/4/19 at 8:23 AM - Findings were reviewed with E1 (NHA) and E2 (DON). 9/4/19 approximately 10:00 AM - During an interview, E2 (DON) stated that according to her review, both the eye drops should have been discontinued after four (4) weeks and as of now they have been. The facility failed to ensure that R1 did not receive any unnecessary medications when two (2) eye drops, Ilevro and Prednisolone, continued to be administered despite physician's orders that they be discontinued after four (4) weeks. The facility failed to discontinue the eye drops and administered them for approximately an additional two (2) and a half months. 9/4/19 approximately 7:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 32545 Based on clinical record reviews, interviews and review of facility documentation as indicated, it was determined that for 3 (R90, R209 and R211) out of 8 sampled residents, the facility failed to ensure that its residents are free of any significant medication errors. For R211, the facility failed to follow the pharmacy's policy, dated 1/7/19, entitled Administration Procedures for All Medications when R211, a non-diabetic, was incorrectly administered 4 units of Humalog insulin that was meant for his/her roommate, which resulted in close monitoring of R211's blood sugar levels by the administration of four (4) physician-ordered Accuchecks over 8 hours. For R209, the facility failed to ensure a physician ordered INR lab was transcribed and obtained for a resident on Warfarin, a blood thinner medication that required close monitoring of the resident's specific blood level. For R90 the facility failed to be free from significant medication errors as evidenced by on 4/19/19 R90 received a 90 mg dose of morphine Extended Release when the order was for 45 mg of morphine Extended Release. Findings include: The facility's pharmacy policy entitled Administration Procedures for All Medications, dated 1/7/19, stated, To administer medications in a safe and effective manner .Procedures: .E. Identify resident using two identification methods before administering medication . 1. Review of R211's clinical record revealed: 6/17/19 - R211 was admitted to the facility for short-term rehabilitation. 6/19/19 - Review of the physician's history and physical (timed at 11:21 AM), R211's eMAR and physician orders revealed that R211 did not have a diagnosis of Diabetes and was not ordered insulin medication. 6/19/19 - A physician's order stated, Accu-check q (every) 2 hours x (times) 8 hours. Every 2 hours (x 4) at (8:15 PM, 10: 15 PM, 12:15 AM, 2:15 AM). 6/19/19 at 9:04 PM - A nurse's note stated, Resident alert and oriented x3. New order received this shift from E46 (NP) for accu-checks q2hrs x8hrs. Order implemented . 6/20/19 at 2:52 AM - A nurse's note stated, .Accuchecks done as ordered, no s/s (signs or symptoms) of hypoglycemia . Review of facility documentation provided to this surveyor revealed the following: - Signed (undated) statement from E47 (LPN): While I was on my way to give schedule (sic) insulin to another patient, I got distracted by more than one staffs (sic) communicating with me concerning other residents. That how I ended up administering the wrong medication to the wrong patient. I did apologize to family and patient. - The facility performed a urine drug test on E47 (LPN) on 6/19/19 during 3-11 PM shift which revealed negative results. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of the In-Service Record for Medication Administration Patient Identification, dated 6/19/19 on the 3-11 PM shift, revealed that E47 (LPN) was in-serviced on when administering medications, always use two patient identifiers. - Review of the In-Service Record for Medication Administration, dated 6/24/19, revealed that 15 nurses participated in training regarding Know the Rights: right drug, dose, time, route, resident, documentation, check wrist band, check computer .compare 6 to med cards. - E47 (LPN) completed 1 hour of training on 6/27/19 for Assistance with Medication Administration. 6/27/19 at 10:27 AM - The facility reported the Medication Error incident to the State Survey Agency nine (9) days later. The incident description was: Resident received incorrect medications, family and doctor were notified. The facility failed to report R211's medication error incident to the State Survey Agency within the eight hours of the incident. 7/1/19 - The facility's 5-day follow up report to the State Survey Agency stated, .Root cause determined the nurse did not follow the rights of medication administration. Result of Investigation: Resident received 4 units of Humalog insulin on 6/19/19. (E47) LPN became distracted before administering the insulin to resident in error. Resident blood sugar was monitored every 2 hours for 8 hours .and resident reported no ill effects related to insulin administration. Root cause determined the nurse did not follow the rights of medication administration. Nurse educated on patient identifiers . 9/3/19 at 8:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON). For R211, the facility failed to follow the pharmacy's policy, dated 1/7/19, entitled Administration Procedures for All Medications when R211, a non-diabetic, was incorrectly administered 4 units of Humalog insulin that was meant for his/her roommate, which resulted in close monitoring of R211's blood sugar levels by the administration of four (4) physician-ordered Accuchecks over 8 hours. 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 2. Review of R209's clinical record revealed: 6/21/19 - R209 was admitted to the facility for short-term rehabilitation. 6/21/19 - R209 was care planned for the potential for excessive bleeding related to anticoagulant therapy use with an approach that included labs as ordered. 6/24/19 at 2:03 PM - A nurse's note stated, .INR 3.6; per (E4) NP: hold warfarin 6/24/19; recheck labs in am. 6/25/19 - Review of R209's clinical record lacked evidence that E4's 6/24/19 order to recheck R209's INR lab the next day was transcribed as a physician's order and the INR lab draw was not obtained on the morning of 6/25/19. 6/27/19 - R209's next INR lab result revealed a critically high level of 5.3 (recommended range 2.0 to 3.0). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/3/19 at 4:56 PM - Findings were confirmed with E2 (DON). The facility failed to ensure a physician ordered INR lab was transcribed and obtained for R209, who was on Warfarin, a blood thinner medication that required close monitoring of the resident's specific blood level. 9/4/19 at 7:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON). 38509 3. Review of R90's clinical record revealed the following: 12/2/16- R90 was admitted to the facility with diagnoses that included chronic pain. 4/19/19 10:02 PM- A progress note stated that around 7:30 PM E19 (LPN) was asked by E33 (Nursing Supervisor) to help pass medications on the long term care section of the facility. E19 stated that she initially declined, but later changed her mind and went to help. E19 stated that she mistakenly gave R90 the wrong dose of Morphine. R90 was to receive 3 tabs of Morphine 15 mg Extended Release (45 mg total), but instead R90 received 3 tabs of Morphine 30 mg Extended Release (90 mg total). E19 noted that safety precautions were initiated immediately with vital signs every 15 minutes, neuro checks, and 2 liters of oxygen via nasal cannula. The on call NP was notified and ordered to send R90 to the ED (Emergency Department) for further evaluation. R90 was sent to the ER around 9:50 PM. R90 was noted to be stable with no signs/symptoms of respiratory issues, he/she was alert, and was able to make his/her needs known. 4/19/19 10:23 PM- A progress note stated that R90 was sent to the ED (Emergency Department) for evaluation status post administration of morphine 90 mg. It was noted that prior to transfer to the ED, R90 was in no acute distress, was alert and oriented times three, cooperative, and had stable vital signs. 4/21/19 10:59 AM- A progress note stated that R90 was readmitted back to the facility from the hospital around 10:00 AM. R90 was noted to be alert and oriented with no signs of distress noted. 4/29/19 9:00 PM- Review of the facilities follow up to the incident revealed that R90 returned from the ED with no new orders and remained stable during his/her ED visit. Upon return to the facility, the NP evaluated R90 and R90's pain medication was increased. The root cause analysis determined that the medication error occurred because the 5 rights of medication administration were not performed before R90 received the medication. The primary nurse was educated on the rights of medication administration and medication observation was completed with E19 (LPN). The facility failed to ensure that R90 was free from significant medication errors as evidenced by on 4/19/19 R90 received a 90 mg dose of morphine Extended Release when the order was for 45 mg of morphine Extended Release. 9/4/19 7:30 PM- Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40264 Based on observations and interviews, it was determined that for four out of four medication carts, the facility failed to date and discard expired medications. Findings include: 9/4/19 at 10:25 AM - An observation of the first floor medication cart #4 revealed one opened Lantus insulin multi - dose vial that was undated. This was immediately confirmed by E9 (RN). 9/4/19 at 10:35 AM - An observation of the first floor medication cart #2 revealed one opened bottle of Vimpat oral solution that was undated. This was immediately confirmed by E10 (LPN). 9/4/19 at 11:15 AM - An observation and inspection of the second floor medication cart #2 revealed two opened multi - dose vials of Lidocaine; one of the vials was undated and the other vial was dated 5/31/19 (expired). An undated insulin pen was also found in the top drawer of the medication cart. These were immediately confirmed by E11 (RN). 9/4/19 at 11:23 AM - An observation of the second floor medication cart #1 revealed one opened Humalog insulin multi - dose vial that was undated. This was immediately confirmed by E11 (RN). Findings were reviewed during the exit conference on 9/4/19 at 7:30 PM with E1 (NHA) and E2 (DON).

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 40264 Based on record review and interviews, it was determined that for one (R76) out of one resident sampled for radiologic/diagnostic services, the facility failed to provide and obtain the x-rays that were ordered. Findings include: Review of R76's clinical records revealed: 7/22/19 - R76 was admitted to the facility with diagnoses including a broken right elbow and right arm. 7/29/19 - A physician's order from the orthopedic specialist prescribed a follow up x-ray of the right elbow and right humerus (arm) and to send x-ray CD (compact disc used for storage of data)) with R76 for his/her follow up appointment on 8/12/19. 8/2/19 - A physician's order was entered into the EHR (Electronic Health Record) for x-rays of the right elbow and right femur (thigh bone). 8/20/19 at 10:16 AM - During an interview, R76's spouse reported to the surveyor that the facility made an error in obtaining an x-ray of her husband's right femur (thigh) instead of an x-ray to the right arm. R76's spouse also stated that R76 had to have an x-ray of the right arm at the ortho clinic on the follow up visit on 8/12/19. 8/28/19 at 11:24 AM - During an interview, E8 (RN) confirmed there was a transcription error when entering the physician's order into the EHR. 9/4/19 at 8:45 AM - Findings were discussed with E1 (NHA) and E2 (DON). Findings were reviewed during exit conference on 9/4/19 at 7:30 PM with E1 and E2.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 38827 Based on observation, interview and record review, it was determined that for one (R30) out of 3 sampled residents, the facility failed to provide the opportunity for routine dental services. Findings include: 6/22/16 - R30 was admitted to the facility with diagnoses that included respiratory failure. R30 is ventilator dependent. 6/18/19 - R30's annual MDS indicated he/she was cognitively intact and had no broken teeth or mouth pain. 6/19/19 - R30's dental care plan was edited. Care plan approaches included arrange for dental consult as needed. 8/20/19 at 3:54 PM - During an interview, R30 stated he/she had a broken tooth. R30 stated he/she called the nurse's desk approximately 2 months ago and asked to see the dentist. R30 stated his/her sister also went to the nurse's desk to request a dental visit. 8/26/19 at 8:35 AM- During an interview E3 (ADON) stated she was unaware of R30's request to see the dentist. 8/27/19 at 9:16 AM - During an interview, E1 (NHA) provided documentation that R30 was seen 4/18/18 for a routine dental visit. E1 stated that since R30 is ventilator dependent he/she is seen by a special dentist, and not by the dental provider offered to facility residents. E1 stated he/she would arrange for dental services for R30 due to his/her broken tooth. The facility failed to obtain annual routine dental services for R30, and failed to obtain dental services when requested by R30 for a broken tooth. Findings were discussed with E1, E2, and E3 on 9/4/19 at 11:00 AM.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36017 Based on observations and interviews, it was determined that the facility did not store food and utensils in a sanitary manner. Findings include: The following were observed on 8/20/19 from 8:00 AM to 9:00 AM during the initial kitchen tour: 1. The ice machine in the kitchen was dirty; 2. The cooking utensil drying mat by the 3 compartment sink was dusty. Findings were reviewed and confirmed with E15 (food service director) on 8/20/19 at approximately 9:00 AM.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38827 Based on record review and interview, it was determined that the facility failed to maintain medical records for one (R67) out of 50 sampled residents that were in accordance with accepted professional standards and practices. Findings include: Cross refer to F688 A facility policy titled Documentation Guidelines, effective July 2013 and revised May 17, 2019 stated: Resident care delivered is entered into the medical record legibly and timely. CNA's document care delivery electronically. Unit managers/designees are required to review CNA documentation daily and address inconsistencies. Review of R67's clinical record revealed the following: R67 was admitted to the facility on [DATE] with diagnoses that included stroke, paralysis, and a tracheostomy (an opening made in the throat to assist with breathing). 7/5/19 - A physician's order stated that R67 was to wear a left, blue resting hand splint during the day only and then off at night to prevent finger contractures. Review of the August 2019 Point of Care History for R67 to wear the left blue resting hand splint during the day only and then off at night, was documented as done 26 out of 28 days in August. 8/28/19 at 11:49 AM - It was observed that R67 did not have a left hand splint on. Review of R67's electronic medical record revealed that his/her hand splint was documented as on. 8/28/19 at 11:57 AM - During an interview, E12 (CNA) stated he/she was familiar with R67 and had not seen R67 with a hand splint on for awhile. Upon searching R67's room, E12 was unable to find the hand splint. There were multiple days in August 2019 when E12 documented that R67's hand splint was on. When the surveyor pointed out to E12 that he/she had documented other instances of putting the splint on R67, E12 stated 'that must've been a mistake'. 9/3/19 at 9:11 AM - E36 (CNA) documented in the Point of Care documentation that R67's hand splint was on. 9/3/19 at 9:39 AM - E37 (PT Director) was observed entering the room to apply R67's left hand splint. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/3/19 at 9:51 AM - E36 (CNA) amended the Point of Care documentaion to read that R67's hand splint was not done at 9:11 AM. 9/03/19 at 2:29 PM - During an interview, E36 (CNA) stated she did not put the hand splint on R67 and did not put the hand splint on yesterday either. E36 stated he/she mistakenly logged it in the Point of Care documentation on 9/2/19. The facility failed to to ensure that R67's hand splint was recorded accurately in the Point of Care documentation. Findings were reviewed with E1 (NHA) and E2 (DON) on 9/4/19 at 11:00 AM.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32545 Based on review of clinical records and facility documentation, observations and interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to identify and implement corrective actions with respect to infection control practices occurring in the facility. Findings include: Cross refer to F880 9/4/19 at 3:44 PM - During an interview, E1 (NHA) was asked if the facility's QAPI program identified and corrected any quality deficiencies with respect to infection control practices in the facility. E1 stated that prior to this survey, the facility's QAPI program identified that PPE gowns were not being tied. The facility ordered new PPE cloth gowns that arrived right before the survey started. The facility did not implement the new PPE gowns and did not in-service the staff on the new gowns. E1 stated that audits were being done to check isolation carts for PPE supplies and appropriate equipment and to ensure that staff know the reason residents are on isolation. E1 stated this had being going on for about one month and the audits are ongoing. E1 confirmed that the QAPI program did not identify the improper cohorting of 2 residents with 2 different transmittable MDRO organisms, lack of or improper use of PPE by staff and visitors, lack of or improper sanitizing/handwashing of hands and medical equipment, and lack of or improper housekeeping and laundry practices. 9/4/19 at 7:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).

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	085054	A. Building B. Wing	09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Pike Creek	3540 Three Little Bakers Blvd Wilmington, DE 19808

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20883 Based on observations, staff interviews, review of hospital records, and review of facility policy and procedures, it was determined that the facility failed to ensure that it's infection control program was implemented in regards to isolation and cohorting (a group of people who share a characteristic, in this case the same microorganism) of residents with transmittable organisms, staff and visitor use of personal protective equipment (PPE), sanitizing of hands and medical equipment, and housekeeping and laundry practices. Findings include: The facility policy titled Standard and Transmission-Based Precautions, revision date July 23, 2019, stated . Types of Precautions: 1. Standard precautions should be used in the care of all residents at all times to reduce the risk of transmission of microorganisms. Clean, non-sterile gloves when touching or coming into contact with blood, body fluids, secretions or excretions. Remove gloves after use. Discard before touching non-contaminated items or environmental surfaces, and before providing care to another resident. Wash hands after removing gloves. 2. Contact precautions are used for residents that have an infection that can be spread by contact with the person's skin, mucous membranes, feces, vomit, urine, wound drainage, or other body fluids, or by contact with equipment or environmental surfaces that may be contaminated by the resident or by his/her secretions and excretions. In addition to standard precautions wear a gown and gloves upon room entry of a resident on contact precautions. 3. Droplet precautions are used for residents with an infection spread through close respiratory or mucous membrane contact with respiratory secretions. In addition to standard precautions wear a mask upon room entry . 5. Special Situations: Carbapenem-Resistant Enterobacteriaceae (CRE): Residents with known CRE should continue on contact precautions if they are in one of the following high risk categories: Tracheostomy; Vent (ventilator) dependent; Wounds requiring dressing changes more than once a day; Active antibiotic therapy . Resident Placement: Whenever possible, place residents that require transmission-based precautions in a private room, to reduce opportunities for transmission of microorganisms. When a private room is not available, cohort the resident with an appropriate roommate. Residents infected by the same microorganism can usually share a room provided the residents are not infected with other transmissible microorganisms and the likelihood of re-infection with the same organism is minimal. If a private room is unavailable and an appropriate roommate is not possible, consult with the infection control provider, prior to placement . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident Care Equipment and Articles: Equipment contaminated with blood, bodily fluids, secretions, or excretions is cleaned and disinfected after use. Disposable resident care equipment should be used when available. Linen and Laundry: Melt-away laundry bags are used for collection of contaminated laundry and linen . Routine and Terminal Cleaning: The room and bedside equipment of residents on isolation precautions are cleaned using the same procedures used for other residents, unless the infecting microorganism (s) and the amount of environmental contamination indicates special cleaning. The methods, thoroughness and frequency of cleaning and the products used are determined by facility policy . The facility's contracted environmental services provider's policy and procedure titled Contaminated Isolation Room Cleaning MRSA (Methicillin Resistant Staphylococcus Aureus - a type of staph bacteria [types of germs commonly found on the skin or in the nose of even healthy individuals. Most of the time, these bacteria cause no problems or result in relatively minor skin infections] that's become resistant to many of the antibiotics used to treat ordinary staph infections) stated, .Scrub hands and arms for 3 minutes with disinfectant soap. Dress in isolation clothes: 1st Booties, 2nd Cap, 3rd Mask, 4th Gown, 5th Gloves .Begin the Isolation Room Cleaning using the guidelines below: 1. Empty trash .7. Damp mop .If using Microfiber flat mop - Use a new pad for every room, never re-insert pad into mop bucket .Remove your mop head and double bag so there is NO CROSS CONTAMINATION Exit Room: Take off all isolation clothes and double bag and properly dispose as you exit the room. Take all double bagged linens, mops and curtains to the dirty linen room and let the laundry employees know you have just completed an Isolation Room cleaning. Mop water MUST be changed after completing the isolation room procedure. Disinfect all tools utilized to clean the MRSA room using the EPA (Environmental Protection Agency) approved solution. Wash hands and arms using the proper hand washing technique . The CDC Guideline for Hand Hygiene in Healthcare Settings, October 25, 2002, recommends: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using hot water, to prevent drying of skin.Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times (https://www.cdc.gov/handhygiene/providers/index.html). 1. Review of R29's and R94's clinical records, hospital records and observations revealed the following: A. R94 was originally admitted to the facility in 11/09. R94 has diagnoses that included chronic vegetative state, quadriplegia, and tracheostomy with ventilator dependence. 7/3/19 - Review of the hospital record revealed R94's past medical history included MDR (Multi-Drug Resistant) Acinetobacter baumanii carrier (an opportunistic pathogen in humans, affecting people with compromised immune systems, and is becoming increasingly important as a hospital-derived [nosocomial] infection). 7/9/19 - The hospital Interagency Discharge Orders and the Interagency Nursing Communication Record did not state or identify that R94 was on any type of isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7/10/19 - R94 was re admitted to the facility post hospitalization . 7/24/19 - A physician's order stated R94 required Contact/droplet isolation precautions due to being a carrier of carbapenem resistant acinetobacter baumannii (CRAB) in the lungs. B. R29 was originally admitted to the facility in 11/19. R29 has diagnoses that included persistent vegetative state and tracheostomy with ventilator dependence. 5/23/19 - A hospital Interagency Nursing Communication Record noted that R29 was on isolation precautions for CRE (Carbapenem-Resistant Enterobacteriaceae, a family of germs that are difficult to treat because they have high levels of resistance to antibiotics). 5/27/19 - R29 was readmitted to the facility post hospitalization . A physician's order stated R29 was to be on contact isolation precautions for CRE in the urine. 8/4/19 - A culture of R29's trachea secretions revealed heavy growth of an organism. The organism was not CRE or CRAB. 8/20/19 at approximately 9:05 AM - Observation of R29 and R94 revealed that they shared a room. An isolation sign was posted at the entry way into the room and PPE was stored outside of the room. Review of R29's and R94's Resident Census Lists revealed that they have been roommates since 11/20/18. Review of written data contained on the isolation cart revealed that R29 was on contact precautions for CRE in the urine and R94 was on droplet precautions for CRAB in the lungs. 8/27/19 - During email communications, S1 (State Epidemiologist) stated that these two (2) residents should not have been cohorted together, but that they've been together for so long not sure it will make a big difference to separate them at this point. The facility failed to ensure that residents with different organisms were not cohorted. 9/4/19 at 7:56 AM - During an interview, E26 (Staff Educator/Infection Control Nurse) was asked about the cohorting of R29 and R94. E26 stated that she asked the same question and that the facility had consulted with someone about this issue and that she would look for the information. 9/4/19 at 8:23 AM - The findings were reviewed with E1 (NHA) and E2 (DON). 9/4/19 - E1 and E2 provided a printed copy from a text message from facility staff and the facility's Infectious Disease physician regarding the cohorting of the residents. The physician's reply was .Yes we can cohort them together .Acinetobacter is considered MDRO-hence can be cohorted with CRE. The following observations were made; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. 8/20/19 at 8:55 AM - E27 (RT) was observed providing care to R7. R7 had a trachesotomy, was ventilator dependent, and was on contact precautions for CRE in the urine. E27 was wearing an isolation gown that was not secured at the neck causing it to fall down to near E27's waist, exposing E27's uniform scrub top. E27 was also wearing a mask and gloves. After providing care to R7, E27 was observed removing the gloves, applying new gloves and proceeding to provide care to R50, the roommate who was on droplet precautions for CRE in respiratory secretions. E27 failed to change the gown, mask and gloves before going from R7 to R50 to provide care. E27 also failed to handwash or sanitize his/her hands before applying new gloves. 8/20/19 at approximately 9:05 AM - During an interview, E27 was questioned about failing to sanitize his/her hands after removing and reapplying gloves. E27 stated, Oh, I'm sorry. 3. 8/20/19 at 10:22 AM - Observation revealed R101 had a visitor who was wearing an isolation gown and gloves. The isolation gown did not fit the visitor properly exposing their upper body clothing. R101 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. 4. 8/21/19 at 11:26 AM - During a resident interview with R101, who was on contact precautions for CRE in the urine, E28 (RT) entered the room to provide respiratory care wearing an isolation gown and gloves. E28 checked R101's ventilator tubing, and suctioned the resident, who had a tracheostomy and was on a ventilator. E28 removed a stethoscope that was under his/her isolation gown and listened to R101's lungs. After assessing the lungs, E28 placed the stethoscope back on his/her neck after touching it with his/her contaminated gloved hands. E28 removed his/her PPE, washed his/her hands and then left the room to enter data for R101 on a rolling computer terminal. E28 failed to sanitize the stethoscope after using it to assess R101's lungs. 5. 8/23/19 at 1:13 PM - E31 (Housekeeper) was observed in R4's (who was on contact precautions for MRSA in a wound) room wearing gown and gloves. E31 used the mop and water/cleaner that was on the housekeeping cart to mop the bedroom and bathroom floor. E31 discarded the PPE, came out of the room and used hand sanitizer that was on the wall in the hallway. E31 then proceeded to gown and glove and went into R95's room, who was on contact precautions for CRE in the urine. After cleaning the bathroom, E31 used the same mop and water/cleaner that had been used to clean R4's room to mop R95's bedroom and bathroom. E31 was then observed removing the mop head and placing it into a large, clear plastic bag that contained used cleaning rags, hanging on the side of the housekeeping cart. E31 then discarded the isolation gown and gloves, used hand sanitizer, took the cart into the janitor closet where running water could be heard through the closed door. E31 came out of the janitor's closet approximately 10 minutes later and went to R51's, who was on contact precautions for CRE in wounds, applied PPE and began cleaning the room. 6. 8/27/19 at 10:17 AM - E30 (RT) was observed in R4's room (on contact precautions for MRSA in wound) providing repiratory care. R4 had a tracheostomy and was ventilator dependent. E30 discarded his/her PPE into the red container inside R4's room then proceeded into the bathroom. E30 came out of the bathroom after approximately two (2) seconds (suveyor counting 1-1000, 2-1000) and then came out into the hallway. E30 stood in the hallway looking for any call lights that needed to be answered and then proceeded into the respiratory therapy office. E30 did not sanitize his/her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. 8/27/19 at 11:46 AM - Observation revealed E30 in R4's room (who was on contact precautions for MRSA in a wound) wearing an isolation gown, gloves and mask. The isolation gown was not tied at the neck causing it to slip down exposing E30's scrub top. E30 was observed pulling the isolation gown up to his/her shoulders then pulling the privacy curtain. After several minutes of providing respiratory care, E30 pulled the privacy curtain open and went into the bathroom wearing the PPE. E30 remained in the bathroom for approximately 9 seconds (surveyor counting 1-1000, 2-1000 .9-1000). E30 came out of R4's bathroom and proceeded directly to room [ROOM NUMBER], which did not have any isolation precautions. E30 failed to wash his/her hands adequately (if hand washing occurred while E30 was in the bathroom) and failed to sanitize his/her hands, as there was no hand sanitizer in R4's bathroom. 8. 8/27/19 at 12:12 PM - E30 (RT) was observed entering R4's room wearing an isolation gown, mask and gloves. R4 was on contact isolation for MRSA in a wound and had a tracheostomy and was on a ventilator. E30's isolation gown was not secured at the neck causing it fall down off the shoulders exposing his/her uniform scrub top. After providing respiratory care, E30 went into the bathroom where he/she discarded the PPE and exited after approximately 10 seconds (surveyor counted 1-1000 to 10-1000). If E30 performed handwashing while in the bathroom it was inadequate. 9. 8/28/19 at 9:35 AM - Wound care was observed for R4 provided by E20 (LPN) with E22 (CNA) assisting. R4 was on contact precautions for MRSA in a wound, had a tracheostomy and was on a ventilator. Both E20 and E22 wore isolation gowns and gloves. After completion of R4's wound care, E20 and E22 applied a clean brief and changed a drawsheet that was under R4. E22, still wearing his/her contaminated gloves, went to open the top right cabinet near the window, went back to R4 and removed soiled linens and placed them into the bathroom hamper. E22 removed the contaminated gloves, applied new gloves without first sanitizing his/her hands and assisted in turning R4. While turning R4, E20 removed the draw sheet from under the resident and threw it on the floor. The draw sheet was soiled with feces. After completion of repositioning R4, E20 picked up the draw sheet from the floor and placed it into the bathroom hamper. E22 while wearing the contaminated gloves touched the bed controls at the foot of the bed, the TV control panel and R4's call bell apparatus. 10. 8/29/19 at 1:35 PM - E29 (housekeeper) was observed cleaning room [ROOM NUMBER], a non isolation room. E29 cleaned and mopped the room, placed the mop in the water/cleaner bucket, changed gloves, did not sanitize hands, applied new gloves and went into room [ROOM NUMBER], a non isolation room, to clean and mop. 9/3/19 at 10:05 AM - During an interview, E29 (Housekeeper) explained how he/she proceeds with cleaning resident's rooms. E29 stated that the Red Rooms the rooms with red isolation bags or isolation signage are left for last and the non isolation rooms are cleaned first. E29 stated that if an isolation room is very dirty, he/she will start with the isolation rooms and leave the non isolation until the end. E29 stated that the water and cleaning solution in the mop bucket is changed approximately every four (4) rooms in non isolation rooms depending on how dirty they are. E29 stated that for isolation rooms, the water and cleaning solution is changed every two (2) rooms. E29 stated the mop heads are changed every four to five (4-5) non isolation rooms and and every two (2) isolation rooms. E29 stated he/she wears gloves to clean every room and that at times will double glove. E29 stated he/she looks at the folder in the isolation cart to see what PPE to wear. E29 stated that he/she uses hand sanitizer to clean hands after each isolation room and most times will sanitize hands after cleaning the non isolation rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/4/19 at approximately 2:15 PM - During an interview, C1 (Regional Housekeeping Director) was requested to review the procedures for the cleaning of isolation and non isolation rooms. C1 stated that non isolation rooms are cleaned first, isolation rooms are cleaned last. C1 stated that for isolation rooms, proper PPE is used and hands are washed for 3 minutes before applying gloves. C1 stated that hand sanitizers are not used prior to applying gloves. C1 stated that the sequence of room cleaning consists of emptying the trash, cleaning surfaces, dusting floors and then mopping floors. C1 stated that for non isolation rooms the water and detergent are changed at least every three (3) rooms and the mop head, dependent on how dirty it is, is changed every 6-9 rooms. C1 stated that for isolation rooms the water. detegent and mop are to be chnaged after every room is cleaned. C1 stated cleaning items such as mops and cleaning rags used in isolation rooms are to be placed into the dissolving plastic bags for delivery to the laundry. 32545 11. 8/20/19 at 12:03 PM - Observation revealed a visitor wearing an isolation gown and gloves entering R95's room. R95 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. At 12:13 PM, the visitor was observed opening the bathroom door with gloves on, then leaving the bathroom with one glove still on their right hand. The visitor walked to the door as if to leave the room, turned around, removed the glove and opened the bathroom door again and disposed of the glove. There was no sound of running water to indicate the visitor was handwashing. The visitor then exited the room. 12. 8/20/19 at 12:25 PM - Observation revealed E41 (CNA) removing an isolation gown and gloves and placing them in the trashcan in R84's room. E41 did not wash or sanitize his/her hands. R84 was on contact precautions for CRE in wounds, had a tracheostomy and was ventilator dependent. After leaving R84's room, E41 went to the nurses station, got a cup with ice, returned to R84's room, applied an isolation gown, but did not tie it properly, did not apply gloves and went into the room and delivered the ice. E41 then walked to R84's door, disposed of the gown, sanitized his/her hands and left the room. 13. 8/20/19 at 2:12 PM - Observation revealed a cleaning cart positioned outside of R7's and R50's room. R7 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. R50 was on droplet precautions for CRE in respiratory secretions, had a tracheostomy and was ventilator dependent. E29 (Housekeeper) was observed stepping out of the room into the hallway while still wearing an isolation gown, gloves and mask to retrieve something from the cleaning cart. E29 then went back into the room. 14. 8/20/19 at 2:53 PM - Observation revealed a visitor entering R95's room with no isolation gown on but wearing gloves. R95 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	15. 8/28/19 at 9:03 AM - Observation of E42 (CNA) revealed him/her applying an isolation gown, but not securing it at the neck, and not applying gloves. E42 entered R84's room, wrote the staff assignment on R84's white board while talking with the resident. E42 then went into the bathroom and running water could be heard for less than 15 seconds (surveyor counted 1-1000 to 6-1000). E42 did not sanitize his/her hands. R84 was on contact precautions for CRE in wounds, had a tracheostomy and was ventilator dependent. 16. 8/28/19 at approximately 10:00 AM - After completion of morning care, E41 (CNA), E42 (CNA), E43 (CNA), and E44 (CNA) were observed placing R84's soiled linen into four (4) regular clear plastic bags, instead of the dissolvable laundry bags that are to be used for isolation rooms. R84 was on contact precautions for CRE in wounds, had a tracheostomy and was ventilator dependent. At 10:10 AM, E44 removed his/her PPE, did not hand wash or sanitize his/her hands and proceeded to exit the room carrying two (2) of the clear plastic bags containing soiled linen. 38827 17. 8/23/19 at 1:47 PM - E31 (housekeeper) was observed going from isolation room [ROOM NUMBER] to isolation room [ROOM NUMBER] without changing his/her gown. 18. 8/26/19 at 1:51 PM - E31 (housekeeper) was observed wearing PPE and cleaning R95's room. R95 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. When E31 finished cleaning the room, he/she came out of the room into the hall, took off the isolation gown and gloves, then walked back into the bathroom in R95's room, threw away the isolation gown and gloves, and without washing or sanitizing his/her hands went 10 feet down the hallway to the janitor's closet which required a push code to enter. 19. 8/26/19 at 2:09 PM - E31 (housekeeper) was observed wearing PPE and walking in and out of R7 and R50's room to get items from the housekeeping cart in the hall. R7 was on contact precautions for CRE in the urine, had a tracheostomy and was ventilator dependent. R50 was on droplet precautions for CRE in respiratory secretions, had a tracheostomy and was ventilator dependent. 8/29/19 at 2:29 PM - During an interview, E33 (housekeeping director) stated laundry from isolation rooms is placed into melt away bags in the isolation room before coming to the laundry room. In the dirty laundry room the melt away bags are placed directly into the washer. E33 stated the melt away bags have a red top so that laundry staff can distinguish them from non-isolation laundry. 20. 9/4/19 at 1:52 PM - E29 (housekeeper) was observed exiting R51's room and placing the mop head into a standard clear trash bag with other rags and mop heads on the housekeeping cart. E29 stated when he/she was done cleaning he/she would bring the bag of soiled rags and mop heads to the laundry. R51 was on contact precautions for CRE in wounds, had a tracheostomy and was ventilator dependent. The housekeepers failed to properly follow the facility Contaminated Isolation Room Cleaning guidelines: Damp Mop - remove mop head and double bag so there is no cross contamination. Take off all isolation clothes and properly dispose of as you exit the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Take all double bagged linens and mops to the dirty linen room and let the laundry employees know you have just completed an isolation room cleaning. Wash hands and arms using the proper hand washing technique. The facility failed to ensure that it's infection control program was implemented in regards to isolation and cohorting (a group of people who share a characteristic, in this case the same microorganism) of residents with transmittable organisms, staff and visitor use of personal protective equipment (PPE), sanitizing of hands and medical equipment, and housekeeping and laundry practices. 9/4/19 approximately 7:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.