STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. Building B. Wing	07/02/2024

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Shipley Living	2723 Shipley Road Wilmington, DE 19810

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46134 Based on record review and interviews, it was determined that for three (R18, R34 and R270) out of the survey sample of seventeen residents reviewed for resident rights, the facility failed to ensure that the residents had the right to a dignified existence. Findings include: 1. Review of R270's clinical record revealed: 6/19/24 - R270 was admitted to the facility with multiple diagnoses, including obstructive uropathy, and R270 had a foley catheter in place at admission. 6/25/24 - A review of R270's electronic medical record (EMR) revealed the presence of an admission care plan with interventions to care for R270's catheter, which included to place the catheter bag away from the entrance room door. The following observations were made on 6/24/24: 10:29 AM - An uncovered urinary catheter bag hanging on the right had side of the bed, visible from the entrance room door. 12:30 PM - An uncovered urinary catheter bag hanging on the right side of the bed, visible from the entrance door. The following observations were made on 6/25/24: 10:30 AM -R270 was sitting in his wheelchair with the 3/4 urine filled catheter bag hanging on the wheelchair, and which was visible from the doorway. 11:41 AM - R270 was observed sitting in his wheelchair in the doorway of his room, with an uncovered catheter bag hanging on the back of his wheelchair. Additionally, the CNA wheeled R270 to the shower room with the uncovered catheter bag dragging on the floor. 6/26/24 10:45 AM - The above 11:41 AM observations were confirmed with E3 (ADON) and E4 (Clinical Specialist). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone). 48409 2. Review of R34's medical records revealed: 5/4/24 - R34 was admitted to the facility with diagnoses including neurogenic bladder. 5/10/24 - R34's clinical records documented, Ensure that tubing and dignity bag are off the floor. 5/13/24 - R34's care plan included, Privacy bag at all times. 6/24/24 10:30 AM - R34 was observed lying in the bed, an uncovered, an undated urinary collection bag with yellow urine was observed on the floor on the left side of the bed. 6/24/24 1:30 PM - R34 was observed lying in the bed, the uncovered, an undated urinary collection bag with yellow urine continued to be on the floor on the left side of the bed. 6/25/24 10:30 AM - R34 was observed lying in the bed, an uncovered, an undated urinary collection bag with yellow urine was observed on the right side of the bed on the floor. 6/25/24 2:30 PM - R34 was observed lying in the bed, an uncovered, the undated urinary bag with yellow urine continued to be observed on the right side of the bed on the floor. 3. Review of R47's clinical records revealed: 1/6/22 - R47 was admitted to the facility with diagnoses including neurogenic bladder. 5/10/23 - R47's clinical records documented, Check tubing for kinks, and privacy bag at all times, secure catheter to reduce friction. 6/24/24 10:30 AM - R47 was observed lying in bed, an undated, uncovered urinary collection bag with yellow urine was observed touching the floor on the left side of the bed. 6/24/24 2:30 PM - R 47 was observed lying in bed, an undated, uncovered urinary collection bag with yellow urine continued to be touching the floor on the left side of the bed. 6/25/25 10:00 AM - R47 was observed lying in bed, an uncovered, undated urinary collection bag with yellow urine hanging on the right side of the bed and visible from the doorway. 6/25/24 2:30 PM - R47 was observed lying in bed, an uncovered, undated urinary collection bag with yellow urine in a wash basin was on the left side of the bed on the floor. 6/25/24 3:00 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 47621 2. Review of R4's clinical record revealed: 1/21/24 - R4 was admitted to the facility. 1/23/24 - R4 participated in his Care Plan conference and signed his Care Plan Conference Summary dated 1/23/24. 4/26/24 - R4's quarterly Minimum Data Set (MDS) assessment was completed. The facility was not able to produce any documentation of R4 participating in any other Care Plan conferences. 6/28/24 12:20 PM - During an interview, E4 (Corporate CNS) stated, The facility did not do a care plan meeting in April with [R4]. We are scheduling one ASAP. We did not update the care plan in April because we didn't have a care conference. 32545 3. R13's clinical record revealed: 5/24/24 - R13 was admitted to the facility after being hospitalized . 5/30/24 - R13's admission MDS assessment stated that she had a moderate cognitive impairment. 6/7/24 at 6:47 PM - A physician's order by E5 (NP) discontinued R13's Flomax medication with a diagnosis incorrectly listed as benign prostatic hyperplasia (BPH). There was no evidence in R13's clinical record that F1 (R13's POA) was notified of this medication change. 6/9/24 at 6:45 PM - A physician's order by E5 (NP) discontinued R13's Primidone medication with a diagnosis incorrectly listed as depression. There was no evidence in R13's clinical record that F1 was notified of this medication change. 6/28/24 at 10:35 AM - During an interview, F1 confirmed that she was R13's Power of Attorney for Care. F1 confirmed that she was not notified that E5 (NP) discontinued R13's Flomax medication prescribed for urinary retention and the Primidone medication as F1 stated it was prescribed for R13's tremors. 6/28/24 at 11:30 AM - Finding was reviewed with E2 (DON) and E3 (ADON). 7/2/24 at 2:15 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48409 Based on observation and interview, it was determined that for three (R19, R33 and R45) residents reviewed, the facility failed to ensure that the call bells were within their reach on three observed occasions. Findings include: 1. Review of R19's medical records revealed: 4/2/2016 - R19 was admitted to the facility with diagnoses including shortness of breath, asthma, and congestive heart failure. 517/24 - R19's significant change MDS assessment documented a BIMS score of 14 (fourteen), indicating no cognitive impairment. 6/24/24 10:15 AM - R19 was observed lying in bed. The bell was observed on the floor near the head of the bed. 6/24/24 11:30 AM - R19 was observed lying in bed. The call bell was observed on the floor near the head of the bed. 6/24/24 1:00 PM - R19 was observed lying in bed. The call bell continued to be on the floor near the head of the bed. 6/24/24 1:10 PM - The surveyor asked R19 if she used the call bell to let the staff know if she needed assistance, R19 stated, Yes, where is my call bell?. 2. Review of R33's clinical records revealed: 11/30/23 - R33 was admitted to the facility with diagnoses including acute respiratory failure, congestive heart failure and chronic pain. 6/24/24 - R33's quarterly MDS assessment documented a BIMS score of 14, indicating no cognitive impairment. 6/24/24 10:30 AM - R33 was observed sitting in the wheelchair in her room. The call bell was observed lying on the floor behind the wheelchair. 6/24/24 12:30 PM - R33 was observed sitting in the wheelchair in her room. A CNA brought R33's lunch. The call bell was observed lying on the floor behind the wheelchair. 6/24/24 1:30 PM - R33's call bell continued to be on the floor behind the wheelchair. 6/24/24 1:45 PM - The surveyor asked R33 if she used the call bell to let the staff know if she needed assistance, R33 stated, Yes. 3. Review of R45's clinical records revealed: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/23/23 - R45 was admitted to the facility with diagnoses including heart disease, depression, dementia, and muscle weakness. 6/21/24 - R45's annual MDS assessment documented a BIMS score of 00, indicating severe cognitive impairment. 6/24/24 10:35 AM - R45 was observed lying on the bed. The call bell was on the floor behind the bed. 6/24/24 11:35 AM - R45 was observed lying on the bed. The call bell was on the floor behind the bed. 6/24/24 1:35 PM - R45 observed lying on the bed. The call bell continued to be on the floor behind the bed. 6/24/24 1:50 PM - The surveyor asked R45 if she used the call bell to get the staff's assistance, R45 stated, Yes. 6/24/24 2:00 PM - Findings were confirmed with E3 (ADON). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46134 Based on record review and interview, it was determined that for one (R5) out of one resident reviewed for hospitalization , the facility failed to notify the resident and the resident's representative in writing of R5's transfer to the hospital, including the reason for the transfer. Findings include: Review of R5's clinical record revealed: 6/13/23 - R5 was admitted to the facility. 5/15/24 - R5 was transferred to the hospital because of chest pain. R5 was admitted to the hospital and was discharged back to the facility on [DATE]. 6/27/24 2:20 PM - During an interview, E3 stated that the facility's process for hospital transfer communications is to provide verbal communication to resident representatives when residents are transferred to the hospital, not written communication. R5's representative would not have received written communication related to E5's 5/15/24 transfer. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 47621 Based on record review and interviews, it was determined that for one (R44) out of seventeen reviewed for Resident Assessments, the facility failed to assess R44 no less than once every three months. Findings include: 11/14/23 - R44 was admitted to the facility. 1/3/24 - R44's admission Minimum Data Set (MDS) assessment was completed. 1/29/24 - R44 was hospitalized . 1/30/24 - R44 was readmitted to the facility. 2/6/24 - R44's admission MDS was completed. As of 6/26/24, there were no other MDS assessments completed for R44. There has been more than 141 days since the last MDS assessment. 6/27/24 1:26 PM - During an interview, E33 (MDS coordinator) confirmed that R44 was past due for a quarterly MDS assessment. E33 stated, I'm not sure why the system did not flag him. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for two (R21, R22) out of seventeen residents reviewed for Resident Assessments, the facility failed to ensure accuracy of the assessments. Findings include: 1. Review of R21's clinical record revealed: 8/10/19 - R21 was admitted to the facility with diagnoses, including but not limited to, Parkinsonism, epilepsy and hypertension. 5/3/24 - R21's quarterly Minimum Data Set (MDS) assessment was completed and failed to document in Section I Parkinson's disease as one of R21's diagnoses. 6/27/24 1:21 PM - During an interview, E33 (MDS Coordinator) confirmed that the diagnosis of Parkinson's was not in R21's MDS dated [DATE] and that it should have been included. 2. Review of R22's clinical record revealed: 4/27/21 - R22 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation, heart failure and dementia. 5/1/24 R22's annual MDS assessment was completed and documented in Section I pneumonia as one of R22's active diagnoses. The facility was unable to produce evidence that verified coding pneumonia as an active diagnosis for R22 as there was no evidence of this diagnosis in R22's chart for this quarter. 6/28/24 12:06 PM - During an interview, E4 (Clinical Specialist) stated, The pneumonia documented on the 5/1/24 MDS was a mistake. [R22] did not have pneumonia during that period of time. We are fixing the MDS and resubmitting it. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 47621 Based on record review and interview, it was determined that for one (R62) out of two reviewed for PASARR, the facility failed to secure R62's PASARR upon admission on 4/8/24. Findings include: 4/8/24 - R62 was admitted to the facility with diagnoses including Parkinson's, diabetes and bipolar disorder. 4/21/24 - R62's Minimum Data Set (MDS) assessment documented bipolar disorder as one of R62's diagnoses in Section I. 6/27/24 1:30 PM - During an interview, E2 (DON) stated, We haven't been able to locate that PASARR. We are looking. R62 came here from an AL (Assisted Living) community. 6/28/24 8:52 AM - During an interview, E2 stated, We still have not been able to find her (R62's) PASARR. I am going to request it online again and see if they will send me a duplicate. 7/2/24 2:10 PM - E2 confirmed that the facility has not located R62's PASARR document. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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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. 47621 Based on record review and interviews, it was determined that for two (R54 and R172) out of four reviewed for care plans, the facility failed to develop and implement a person-centered care plan. Findings include: 1. Review of R54's clinical record revealed: 5/16/23 - R54 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis and stroke affecting R54's right side. 5/22/24 - E36 (DO) ordered, Apply resting hand splint to righthand at the end of 3-11 shift and remove at the end of 11-7 shift. Review of R54's care plan revealed no interventions/tasks regarding R54's righthand splint. The facility was not able to produce any documentation of the righthand splint on R54's care plan. 6/28/24 8:55 AM - During an interview, E2 (DON) confirmed that R54's care plan did not include any mention of R54's righthand splint. We can add it into the care plan if that is what we need to do. 48409 2. Review of R172's clinical records revealed: 11/14/21 - R172 was admitted to the facility. 1/24/24 - R172's quarterly MDS assessment documented that the resident was completely dependent on staff for all activities of daily living including turning, repositioning, showers, and transfers. R172's BIMS score was 6, which indicated severe cognitive impairment. 7/1/24 9:20 AM - A review of R172's Kardex (electronic document for the aides to inform the staff of the residents' care needs) lacked information of how many staff members were needed to assist with turning and repositioning in bed. A review of R172's care plan also lacked documentation of how many staff members were needed for turning and repositioning in bed. 7/1/24 1:15 PM - During an interview, E5 (Unit Manager) stated, Physical Therapy determines how many staff members are needed for transfers and turning and repositioning. This information is then communicated to nursing, the order is obtained from the doctor, and the Kardex and the care plan are updated. 7/1/24 2:17 PM - During an interview, E6 (Physical Therapy Director) stated, The residents are seen on admission and evaluated for bed mobility and transfer status. This information is given to nursing for the resident's records. E6 failed to give the surveyor any documents of R172's evaluation and recommendations for bed mobility upon request. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/1/24 2:30 PM - During an interview, E14 and E19 (CNAs), stated that they look at the Kardex for information on residents' care including bed mobility and transfers. The facility failed to evaluate and develop a care plan for how many staff members were needed for R172's turning and repositioning, and that this information was documented on the Kardex status for staff to care for her safely. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46134 Based on record review and interview, it was determined that for one (R5) out of one resident reviewed for care planning, the facility interdisciplinary team failed to review and revise R5's care plan after a comprehensive assessment was completed. Findings include: Review of R5's clinical record revealed: 6/13/23 - R5 was admitted to the facility. 5/28/24 - A Minimum Data Set (MDS) comprehensive assessment was documented for R5, which included a newly assessed care area for dehydration. 6/13/24 - A care plan meeting was held with the interdisciplinary team to review R5's care needs. 6/25/24 - A review of R5's electronic medical record (Emr) care plan revealed the lack of a care plan problem for dehydration. 6/28/24 10:40 AM - During an interview, E33 (MDS Coordinator) confirmed that dehydration was a new care area identified for R5, but that R5's care plan lacked a problem for dehydration after the care plan meeting was held on 6/13/24. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46134 Based on clinical record review and interview, it was determined that for three (R5, R223 and R270) out of twenty-one residents reviewed for care planning, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by having LPNs complete the admission assessment and admission progress note. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 . Admission Assessments * - RN . *= Once a care plan is established, the LPN may do assessments . The Braden Scale is a validated tool designed to assess a patient's risk of developing pressure ulcers. National Library of Medicine, Nov. 21, 2022. 1. Review of R5's clinical record revealed: 6/13/23 - R5 was admitted to the facility. A review of the clinical record revealed the following 6/13/23 facility admission assessments conducted by E38 (LPN): Wander Risk Evaluation, Pain evaluation, Bladder and Bowel Continence evaluation, Trauma Informed Screening, Functional Abilities and Goals-Admission, Baseline Care Plan, Braden (scale for predicting pressure ulcer risk) evaluation and a Skin and Wound-Total Body Skin Assessment. The admission progress note was completed by E37 (LPN). 2. Review of R270's clinical record revealed: 6/19/24 - R270 was admitted to the facility. A review of the clinical record revealed the following 6/19/24 facility admission assessments conducted by E39 (LPN): Elopement Evaluation, Fall Risk Evaluation, Functional Abilities and Goals-Admission, Baseline Care Plan, Braden (scale for predicting pressure ulcer risk) evaluation, Clinical Admission and the admission progress note. 6/22/24 - R223 was admitted to the facility. A review of the clinical record revealed the following 6/22/24 facility admission assessments conducted by E12 (LPN) and E39 (LPN): Dehydration Risk Evaluation, Elopement Risk Evaluation, Fall Risk Evaluation, Braden (scale for predicting pressure ulcer risk) evaluation, Functional Abilities and Goals-Admission, Baseline Care Plan, Clinical Admission. The admission progress note was written by E39. 7/1/24 - 2:35 PM - During an interview, E3 (ADON) confirmed that LPN's do admission assessments on new residents. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. Building B. Wing	07/02/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48409 Based on observation, interview, and record review, it was determined that for 1 (R45) resident out of 2 (two) reviewed for ADLs, the facility failed to ensure that R45 received appropriate care to maintain good grooming. Findings include: Review of R45's clinical records revealed: 6/23/23 - R45 was admitted to the facility with diagnoses including heart disease and muscle weakness. 7/28/23 - R45's care plan documented, .Please check my nail length, clean and trim on bath day and as necessary . 6/21/24 - R45's annual MDS assessment documented a BIMS of 00, indicating severe cognitive impairment, and was dependent on staff for bathing, grooming and hygiene. 6/24/24 10:30 AM - R45 was observed in bed, her fingernails on both hands were long and dirty. 6/24/24 12:30 PM - R45 was observed feeding herself with a fork. R45's fingernails continued to be long and dirty. 6/25/24 10:00 AM - R45 was observed with long, dirty fingernails on both hands on both hands. 6/26/24 8:30 AM - R45 was observed feeding herself with a fork, then picked up an item and put it in her mouth. Her fingernails continued to be long and dirty on both of her hands. The surveyor asked R45 if she would accept having her nails cleaned and trimmed, R45 stated, Yes. 6/26/24 2:30 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist), E32 (Corporate PT) and State of DE Ombudsman (via telephone).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 47621 Based on record review and interviews, it was determined that for one (R4) out of one reviewed for Communication-Sensory, the facility failed to ensure R4 received proper treatment to assist/ maintain hearing abilities as evidenced by not submitting a referral for a hearing consult despite R4 being severely hard of hearing. Findings include: 1/21/24 - R4 was admitted to the facility. 1/21/24 - E36 (DO) ordered in R4's electronic medical record (EMR), May have dental, podiatry, ophthalmology, audiology consult. 6/24/24 5:20 PM - During an interview, R4 stated, You have to speak in my right ear; that is the good one. I have difficulty hearing. I think it is wax buildup but I would like to have my hearing checked. 6/27/24 10:40 AM - During an interview, E26 (LPN) stated, [R4] has really bad hearing. That is why we keep his door closed because he blasts the volume on his TV and it bothers the other residents. 6/28/24 9:42 AM - During an interview, when asked about R4's hearing E35 (CNA) stated, Oh that is him. He has always been hard of hearing. That is why his TV is on the max (volume) and his door (to his room) is kept shut, because his TV is so loud. The facility was unable to produce any documentation regarding treatment or a referral for R4's hearing deficit. 6/28/24 10:41 AM - During an interview, E32 (Corporate PT) stated, We'll put him on the list for Audiology. Not sure if it is a carve out (sic) but we won't base it on his insurance. He may just need an amplifier. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46134 Based on a review of facility documents and interview, it was determined that the facility failed to complete a performance review every twelve months for one (E16) out of five nurse aides. Findings include: The facility was provided a list of five names of CNAs to provide documentation of the completion of annual performance evaluations. 7/1/24 - A review of E16's performance evaluation documentation revealed the lack of an 2024 annual performance evaluation since E16 was hired on 2/22/23. 7/1/24 12:30 PM - During an interview, E21 (HR) confirmed that E16 has not had an annual performance evaluation since E16 was hired on 2/22/23. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interviews, it was determined that for one (R54) out of six reviewed for Pharmacy Services, the facility failed to ensure that the pharmacy services provided safe and effective medication use. Findings include: Facility Medication Regimen Review (MRR) Policy Statement- the consultant pharmacist reviews the medication regimen of each resident monthly .5. The MRR involves a thorough review of the resident's medication record to prevent . d. inadequate monitoring for adverse consequences .g. incorrect medications, administration times or dosage forms . May 2019 Combination Use of Clopidogrel and Proton Pump Inhibitors Increase Major Adverse Cardiovascular Events ([NAME]) in patients with Coronary Artery Disease: A meta-Analysis- In conclusion, the result of out meta-analysis supports the notion that the combination use of clopidogrel and PPIs (such as protonix) will increase the risk of [NAME] in patients with coronary artery disease, which is in accordance with pharmacokinetic and pharmacodynamic studies. Journal of Cardiovascular Pharmacology and Therapeutics 2017, Vol 22(2), 142-152. 5/16/23 - R54 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis and stroke affecting R54's right side. 5/22/24 - E36 (DO) ordered, Clopidogrel bisulfate tablet 75 mg via G-tube one time a day for prevent blood clot. 5/22/24 _ E36 (DO) ordered, Protonix tablet delayed release 40 mg- give 40 mg via G-tube one time a day for GERD (Gastroesophageal reflux disease). The facility failed to ensure that the pharmacist assured the correct formulation of the medication protonix was utilized. A delayed released tablet should not be administered via a G-tube. 5/28/24 - E39 (Consultant Pharmacist) completed a Medication Regimen Review (MRR) and found no irregularities. 6/18/24 - E39 (Consultant Pharmacist) completed a Medication Regimen Review (MRR) and found no irregularities. 6/25/24 - Review of R54's Medication Administration Record (MAR) for June 2024 revealed protonix 40mg was scheduled to be given at 7:30 AM and clopidogrel 75 mg was scheduled to be given at 8AM. The facility failed to ensure that the pharmacist defined a schedule for administering medications (protonix and clopidogrel) that prevented potential significant medication interactions. 6/25/24 - Review of R54's June 2024 order set revealed a pharmacy warning notation next to the protonix and clopidogrel orders that stated, Coadministration of pantoprazole and clopidogrel may increase the risk of major adverse cardiovascular events. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/26/24 8:05 AM - E26 (LPN) administered protonix and clopidogrel to R54 via her G-tube. 7/2/24 11:00 AM - E4 (Clinical specialist) confirmed that the scheduled timings of the protonix and clopidogrel needed to be changed to allow more time between these medications administrations. E4 also stated, [R54] should be on a different formulation of protonix (rather than a delayed release tablet) since the medication was being crushed and administered via a G-tube. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 47621 F838 Facility Assessment- Based on record review and interview, it was determined that the facility failed accurately update the Facility Assessment Tool, which was created May 2024, with the correct name of the Infection Preventionist. Findings include: 6/26/24 11:45 AM - Review of the Facility Assessment, which was dated May 2024, revealed on page 5 Infection Preventionist: [E3] (ADON). 6/27/24 1:56 PM - During an interview, E4 (Clinical Specialist) stated, That's not right. [E2] (DON) is the facility Infection Preventionist. [E3] cannot be the Infection preventionist; she is not certified. 7/1/24 10:46 AM - During an interview, E4(Clinical specialist) stated, Infection control is a group effort while we try to fill the role. We had someone and then at the last minute, they turned down the role. [E2] (DON), [E3] (ADON) and [E33] (RN/MDS Coordinator) work on it together. The facility provided proof of E33's training and certification for the role of Infection Preventionist. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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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** 47621 Based on record review and interviews, it was determined that for one (R22) out of four residents reviewed for Advanced Directives, the facility failed maintain accurately documented medical records regarding R22's code status. Findings include: [DATE] - R22 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation, heart failure and dementia. [DATE] - E36 (DO) completed a Delaware Medical Orders for Scope of Treatment (DMOST) with F2 (R22's son/POA), which stated that R22 was to have CPR/ attempt resuscitation. [DATE] - E36 (DO) ordered, CPR- FULL code status in R22 's EMR. [DATE] - E36 (DO) documented in R22's EMR a progress note that stated, .History-Code Status List: Full scope of treatment .Advanced Care Planning details: Pt and family agreed to discuss advance directive. Patient and family would like to remain DO NOT RESUSCITATE (DNR) with no artificial nutrition or hydration through conduit. Within the same note, there is documentation of both a full code status and a DNR status for R22. [DATE] - E36 (DO) documented in R22's EMR a progress note that stated, .History-Code Status List: Full code .Advanced Care Planning details: Pt and family agreed to discuss advance directive. Patient and family would like to remain DO NOT RESUSCITATE (DNR) with no artificial nutrition or hydration through conduit. Within the same note, there is documentation of both a full code status and a DNR status for R22. [DATE] - R22's annual MDS documented a Basic Inventory of Mental Status (BIMS) score of 15, which reflected normal cognition. [DATE] 3:45 PM - During an interview, R22 stated that he wanted CPR and everything done. [DATE] 11:11 AM - During an interview, when shown the conflicting documentation in E36's [DATE] and [DATE] progress notes, E4 (Clinical specialist) stated, Yeah, we need to get that straightened out. [E36]'s note states that R22 is a full code but then later in the notes it is documented that the patient and the family would like to remain a DNR. That is confusing. But the order in the EMR and the DMOST match. Both state that R22 is a full code. Findings were reviewed during the exit conference on [DATE] at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record reviews and interviews, it was determined that for seven (R13, R22, R33, R34, R47, R54, R270) out of seventeen residents reviewed for Infection Control, it was determined that the facility failed to establish and maintain an infection prevention and control program that included Enhanced Barrier Precautions (EBP). Additionally, it was determined that for 3 (three) R34, R47, R270 residents reviewed for urinary catheter care the facility failed to ensure a safe and sanitary process regarding urinary collection bags. Findings include: Facility Enhanced Barrier Precautions (EBP) Policy Statement- Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .Policy Interpretation and Implemenetation 2. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gowns are applied before performing the high-contact resident care activity (as opposed to before entering the room) .3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube .); .10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required . May 4, 2024 1.Review of R13's clinical record revealed: 5/24/24 - R13 was admitted to the facility into room [ROOM NUMBER]b. 6/19/24 - R13's hospital records documented prior MDROs infections and a diagnosis of extended spectrum beta-lactamase (ESBL) urinary tract infection (UTI). R13's medical history indicated that EBPs would be required. There was no evidence of EBP signage or personal protective equipment (PPE) outside R13's room. 2. Review of R22's clinical record revealed: 4/27/21 - R22 was admitted to the facility into room [ROOM NUMBER]a. 6/26/24 9:10 AM- Observation of the wound team rounding and providing care to R22's left heel resolving wound without any gown. Gloves were worn. R22's medical diagnosis list in his electronic medical record (EMR) documented ICD 10 code Z16.12 Extended spectrum beta lactamase (ESBL) resistance of his left heel wound. R22's medical record also documented a history of methicillin-resistant Staphylococcus aureus (MRSA) infection. Both of these infections qualified as MDROs and therefore, R22 required EBP. 3. Review of R33's clinical record revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/30/23 - R33 was admitted to the facility into room [ROOM NUMBER]b. 12/28/23 - R33's medical record documented a urine culture with Escherichia (E) coli ESBL infection. 4/28/24 - R33's medical record documented a second urine culture with E.coli ESBL. Review of R33's hospital records revealed a MRSA positive culture while hospitalized in November 2023. Both of these infections (E.coli ESBL UTI and MRSA) qualified as MDROs and therefore, R33 required EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R33's room. 4. Review of R34's clinical record revealed: 5/4/23 - R34 was admitted to the facility into room [ROOM NUMBER]b. 5/10/24 - R34's medical record documented a urine culture with Klebsiella pneumoniae ESBL. 5/10/24 - E36 (DO) ordered in R34's EMR, Document indwelling foley catheter output Q (every) shift related to urinary retention. Both the infection (Klebsiella pneumoniae ESBL UTI), which was a MDRO, and the indwelling foley catheter (medical device) were indications for EBP; therefore, R34 required EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R34's room. 5. Review of R47's clinical record revealed: 2/12/23 - R47 was admitted to the facility into room [ROOM NUMBER]a. 3/7/24 - E36 (DO) ordered in R47's EMR, Check foley catheter Q shift for clogging. 5/29/24 - R47's medical record documented a urine culture with Vancomycin resistant enterococcus faecalis (VRE) and MRSA. Both of the infections (VRE and MRSA UTIs), which was a MDRO, and the indwelling foley catheter (medical device) were indications for EBP; therefore, R47 required EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R47's room. 6. Review of R54's clinical record revealed: 5/16/23 - R54 was admitted to the facility into room [ROOM NUMBER]b. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/16/23 - E36 (DO) ordered in E54's EMR, Check placement of tube (G-tube) and residual every shift . 6/27/24 8:05 AM - Observation of E26 (LPN) administering R54's medications via her G-tube without utilizing EBP. E26 did have gloves on. The presence of the G-tube (feeding tube) was an indication for R54 to be on EBP. There was no evidence of EBP signage or personal protective equipment (PPE) outside R54's room. 7. Review of R270's clinical record revealed: 6/19/24 - R270 was admitted to the facility into room [ROOM NUMBER]b from another facility. R270's transfer paperwork listed a diagnosis of history of ESBL infection. 6/16/24 - E36 (DO) ordered in R270's EMR, Empty foley catheter bag every shift. The presence of the indwelling foley catheter (medical device) and history of ESBL infection were both indications for R270 to be on EBP. 6/27/24 2:37 PM - During an interview, E43 stated that she does not wear any protective clothing or coverings other than gloves when emptying the foley catheter bag for R 270. 6/27/24 2:56 PM - During an interview, E26 (LPN) stated, We do use yellow gowns at times. If the resident is on precautions, the facility puts a sign up. I don't get a lot of residents on precautions because this is the long-term care wing of the facility. 7/1/24 10:52 AM - Observation of rooms 508b, 512b, 514b, 615b, 707a, and 712b revealed no signage stating the residents in those rooms were on EBPs. 7/2/24 10:35 AM - A poll of all five surveyors revealed that at no point during the previous six days of the survey had any surveyor observed any staff providing direct patient care to any residents while utilizing EBP (wearing a yellow gown and gloves). 7/2/24 11:04 AM - During an interview, E4 (Clinical Specialist) stated, We are doing EBP. We list it on [the EMR] next to the resident's name. E4 pulled up a resident on the EMR to show the surveyor the EBP order. E4 stated, Oh my God, it's not there and there is no order (pointing to the EMR). We are doing it our other two facilities. 48409 8. Review of R34's clinical records revealed: 5/4/24 - R34 was admitted to the facility with diagnoses including adult failure to thrive, seizure, and neurogenic bladder. 5/10/24 - R34's clinical records included, Ensure that tubing and dignity bag are off the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/13/24 - R34's care plan included, Privacy bag at all times. 6/24/24 10:30 AM - R34 was observed lying in the bed, an uncovered, undated urinary collection bag with yellow urine was observed on the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom. 6/24/24 1:30 PM - R34 was observed lying in the bed, the uncovered, undated urinary collection bag with yellow urine continued to be on the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom. 6/25/24 - 10:30 AM R34 was observed lying in the bed, an uncovered, undated urinary collection bag with yellow urine was observed on the right side of the bed on the floor. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom. 6/25/24 - 2:30 PM: R34 was observed lying in the bed, an uncovered, the undated urinary bag with yellow urine continued to be observed on the right side of the bed on the floor. An undated/unlabeled urinary collection container was observed on the toilet seat of the shared bathroom. 6/25/24 3:00 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist) stated. 9. Review of R47's clinical records revealed: 1/6/22 - R47 was admitted to the facility with diagnoses including urinary tract infections, neurogenic bladder, hypertension, and seizure disorder. 5/10/23 - R47's clinical records documented, Check tubing for kinks, and privacy bag at all times, secure catheter to reduce friction. 6/24/24 10:30 AM - R47 was observed lying in bed, an undated, uncovered urinary collection bag with yellow urine was observed touching the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom. 6/24/24 2:30 PM - R 47 was observed lying in bed, the undated, uncovered urinary collection bag with yellow urine continued to be touching the floor on the left side of the bed. An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom 6/25/25 10:00 AM - R47 was observed lying in bed, an uncovered, undated urinary collection bag with yellow urine hanging on the right side of the bed and visible from the doorway. An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom 6/25/24 2:30 PM - R47 was observed lying in bed, an uncovered, undated urinary collection bag with yellow urine in a wash basin was on the left side of the bed on the floor.An undated/unlabeled urinary collection container was observed on the grab bar of the bathroom 6/25/24 3:00 PM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of R270's clinical records revealed: 6/19/24 - R270 was admitted to the facility with multiple diagnoses, including obstructive uropathy, and R270 had a foley utinary catheter in place at admission. The following observations were made on 6/25/24 of R270's foley urinary catheter drainage bag: 10:30 AM - The foley urinary catheter drainage bag was on the facility floor. 11:30 AM - The foley urinary catheter drainage bag was on the facility floor. 11:41 AM - R270 was observed to be wheeled by a CNA the facility shower room with an uncovered foley urinary catheter bag dragging on the floor. 6/25/24 11:41AM - Findings were confirmed with E3 (ADON) and E4 (Clinical Specialist). Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON) E3 (ADON), E4 (Clinical Specialist) and State of DE Ombudsman (via telephone).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shipley Living	2723 Shipley Road Wilmington, DE 19810

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47621 Based on record review and interviews, it was determined that the facility failed to have a designated infection preventionist with specialized training in infection prevention and control. Findings include: May 2024 - Review of the Facility Assessment, which was dated May 2024, revealed on page 5, the Infection Preventionist was the ADON (E3). 6/27/24 1:28 PM - During an interview, E33 (RN/MDS Coordinator) stated, I am not the Infection Preventionist. It is [E3] (ADON). 6/27/24 1:56 PM - During an interview, E4 (Clinical Specialist) stated, That's not right. [E2] (DON) is the facility Infection Preventionist. [E3] cannot be the Infection preventionist; she is not certified. 7/1/24 10:46 AM - During an interview, E4 (Clinical Specialist) stated, Infection control is a group effort while we try to fill the role. We had someone and then at the last minute, they turned down the role. [E2] (DON), [E3] (ADON) and [E33] (RN/MDS Coordinator) work on it together. 7/1/24 12:26 PM - The facility has not been able to provide a copy of E2's Infection preventionist training certificate as it was sent to her previous place of employment's email and she is unable to retrieve it. The facility did not provide a copy of E33's Infection Preventionist training certificate. 7/2/24 11:09 AM - During an interview, E4 (Clinical Specialist) stated, [E2] (DON) is still trying to get a copy of her certification from [previous place of employment]. But we changed the name of the Infection preventionist on the Facility Assessment to [E33] (RN/MDS Coordinator), who is certified. 7/2/24 11:49 AM- The facility provided a copy of the Facility Assessment Tool page 5 which now stated E33 (RN/MDS Coordinator) was the facility Infection Preventionist. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for nine (R4, R13, R18, R19, R33, R45, R51, R60 and R223) out of seventeen residents reviewed for vaccines, the facility failed to document in each resident's medical record the administration of the pneumococcal and/or influenza vaccines. Additionally, it was determined that for one (R22) out of seventeen residents reviewed for immunizations, the facility failed to offer R22 an updated pneumococcal vaccine. Findings include: Vaccinations of Residents Policy Statement- All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated .All new residents shall be assessed for current vaccination status upon admission .If the resident receives a vaccine, at least the following information shall be documented in the resident's medical record: a. site of administration; b. date of administration; c. lot number of the vaccine (located on the vial); d. expiration date (located on the vial); and e. name of person administering the vaccine . October 2019 Pneumococcal Vaccine Policy Statement- All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections .2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission .6. For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record . October 2019 Influenza Vaccine Policy Statement- All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza . 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents .5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record .6. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record .10 Residents .may obtain their influenza vaccines from their personal physicians. Documentation of previous vaccination should be provided to the facility . October 2019 1. Review of R4's clinical record revealed: 1/21/24 - R4 was admitted to the facility. 2/20/24 - R4 received the PCV20 (pneumococcal 20-valent conjugant) vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R4's electronic medical record (EMR) revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of the influenza vaccine that R4 received at the hospital on 1/14/24, which was documented in DELVAX. 2. Review of R13's clinical record revealed: 5/24/24 - R13 was admitted to the facility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/20/24 - R13 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R13's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023/24 influenza vaccine or the declination of that vaccine provided by the facility. 3. Review of R18's clinical record revealed: 6/1/22 - R18 was admitted to the facility. 2/20/24 - R18 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R18's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. 4. Review of R19's clinical record revealed: 4/2/16 - R19 was admitted to the facility. 2/20/24 - R19 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R19's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023/24 influenza vaccine or the declination of that vaccine provided by the facility. 5. Review of R33's clinical record revealed: 11/30/23 - R33 was admitted to the facility. 2/20/24 - R33 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R33's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. 6. Review of R45's clinical record revealed: 6/23/23- R45 was admitted to the facility. 2/20/24 - R45 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R45's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. 7. Review of R51'sclinical record revealed: 12/22/22 - R51 was admitted to the facility. 2/20/24 - R51 received the PCV20 vaccine, which was documented in the DELVAX website. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/27/24 8:00 PM - Review of R51's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023/24 influenza vaccine or the declination of that vaccine provided by the facility. 8. Review of R60's clinical record revealed: 11/1/23 - R60 was admitted to the facility. 2/20/24 - R60 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R51's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. 9. Review of R223's clinical record revealed: 6/22/24- R223 was readmitted to the facility. 2/20/24 - R223 received the PCV20 vaccine, which was documented in the DELVAX website. 6/27/24 8:00 PM - Review of R223's EMR revealed the PCV20 pneumococcal vaccine that was administered on 2/20/24 was not documented. There also was no documentation of a 2023 influenza vaccine or the declination of that vaccine provided by the facility. 6/28/24 8:49 AM - During an interview, E4 (Clinical Specialist) stated, We had a pharmacy clinical in February. They came in and vaccinated the residents. They entered the vaccines in DELVAX. So if we put the vaccine dates in PCC under the immunization tab, we will be in compliance, right? The facility failed to document in the EMR's the dates of pneumococcal vaccines for nine residents and the dates or declinations of influenza vaccines for five residents. 10. Review of R22's clinical record revealed: Centers for Disease Control and Prevention (CDC) Guidelines for Pneumococcal Vaccine Timing for Adults, [AGE] years, in order for an adult older than [AGE] years to be up-to-date/complete with the pneumococcal vaccination, a Prevnar20 (PCV20) vaccine should be administered 1 year after that adult received PCV13. CDC, April 2022 Facility Pneumococcal Vaccine Policy- .upon admission .will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated .For residents who receive the vaccines .will be documented in the resident's medical record . Administration of the pneumococcal vaccine or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. October 2019 4/27/21 - R22 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation, heart failure and dementia. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/27/24 -Review of R22's immunizations in the EMR revealed no documentation of a pneumococcal vaccine. DELVAX, Delaware's online immunization documentation system, documented that R22 received a Prevnar13 (13-valent pneumococcal conjugate) vaccine on 8/27/2015. The facility was unable to produce documentation of a recent pneumococcal vaccination, a medical contraindication, or a declination declaration for R22. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist) and two State of DE Ombudsmen (via telephone).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46134 Based on review of facility documentation and interview, it was determined that the facility failed to provide required in-service training (12 hours per year) for five out of five CNAs reviewed. Additionally, the facility failed to provide evidence of resident abuse prevention training for the five CNAs reviewed. Findings include: The facility was provided a list of five names of CNAs to provide documentation of the required 12 hours per year of CNA in-service training. 7/1/24 - A review of facility documentation submitted for staff training lacked evidence that E16, E17, E18, E19 and E20 met the 12 hours of annual in-service training required, including resident abuse prevention training. 7/2/24 10:00 AM - During an interview E2 (DON) stated that the facility was unable to provide documentation of the total number of required training hours, including resident abuse prevention training, for E16, E17, E18, E19 and E20. The facility failed to provide 12 hours of required annual in-service training's for five out of five staff CNA's. Findings were reviewed during the exit conference on 7/2/24 at 2:15 PM with E1 (NHA), E2 (DON), E3 (ADON), E4 (Clinical Specialist), and State of DE Ombudsmen (via telephone).