STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES - PIKE CREEK	5651 LIMESTONE ROAD WILMINGTON, DE 19808

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F 0635 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide doctor's orders for the resident's immediate care at the time the resident was admitted.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility's policy and procedure, it was determined that for two (R1 and R2) out of three sampled residents, the facility failed to ensure that physician orders [REDACTED]. Findings include: The facility's policy and procedure titled Medication Reconciliation, dated 11/20/2016, stated, . medication reconciliation is a process for creating a complete and accurate list of patient's current medications at admission and with each transition of care to ensure medication safety . Process: At admission: Review medication list obtained from referral source (hospital .). Review discrepancies with admitting attending physician for disposition and reconciliation . Cross refer F760, example #1. 1. The following was reviewed in R1's clinical record: 4/9/2020 12:49 PM - The hospital's Interagency Discharge Orders stated R1's primary discharge [DIAGNOSES REDACTED]. - [MEDICATION NAME] (a blood thinner) 150 mg inject subcutaneously (sq) every 12 hours. - Cefaxolin (an antibiotic) 2 gm every 8 hours via intravenous (IV) infusion. - Insulin [MEDICATION NAME] 35 units to be injected subcutaneously at bedtime. - Insulin [MEDICATION NAME] 100 units/ml to be administered before each meal and to see details. - Insulin [MEDICATION NAME] 5 units sq before each meal. 4/9/2020 - Record review lacked evidence of R1's time of admission to the facility on [DATE]. 4/9/2020 - Review of the admission orders [REDACTED]. 4/10/2020 1:48 AM - The first Progress Note by E8 (LPN) stated that R1 was admitted to the facility, however, it did not include the time of admission and/or that the admission medication reconciliation was performed with R1's attending physician, E9 (MD). 4/10/2020 2:20 PM - A Medical Practitioner Note by E9 (MD) documented completion of an admission history and physical, post hospital visit, as well as hospital record review and medication reconciliation. 4/10/2020 - A subsequent review of the Order Summary Report documented the following new physician's orders [REDACTED]. - Flush IV line with 10 ml of NS before and after medication administration every shift for IV maintenance ordered on [DATE] at 2:31 PM. - Insulin [MEDICATION NAME] sliding scale coverage before each meal ordered on [DATE] at 2:21 PM. The facility failed to have a system in place that ensured, at the time of R1's admission, physician orders [REDACTED]. 7/14/2020 1:11 PM - During an interview with E2 (DON), E2 verbalized that although not documented in R1's Progress Note, R1 was admitted to the facility on [DATE] at 8:45 PM. E2 stated that despite the facility not having evidence of admission orders [REDACTED]. Cross refer to F684 and F760, example #2. 2. The following was reviewed in R2's clinical record: 7/2/2020 1:14 PM - The hospital's Interagency Nursing Communication Record included a list of the following medications and the time of the last dose given for each of the medications: [REDACTED]. - Insulin [MEDICATION NAME] 10 units sq daily; the last dose was given on 7/1/2020 at 7:00 PM. In addition, to resume the following medications at bedtime: - Atorvastatin (for high cholesterol and triglycerides) 80 mg. - [MEDICATION NAME] (a supplement to aid with sleeping); no dosage was documented. 7/2/2020 7:32 PM - The hospital's Discharge Summary stated R2 was discharged from the hospital at 7:32 PM and R2's primary discharge [DIAGNOSES REDACTED]. 7/2/2020 - R2 was admitted to the facility from the hospital, however, the clinical record lacked evidence of the time R2 was readmitted to the facility. 7/2/2020 - Review of R2's admission orders [REDACTED]. This order was incorrectly entered into the facility's electronic Medical Record, including the eMAR. - Insulin [MEDICATION NAME] 10 units sq daily at bedtime. - [MEDICATION NAME] 3 mg. daily at bedtime. There was a lack of admission orders [REDACTED]. 7/3/2020 1:06 AM - The first Progress Note by E5 (LPN) documented that R2 was admitted to the facility and .MD called made aware of new orders at this time . Although E5 (LPN) documented in the above Progress Note that she called the attending physician to make him/her aware of the new orders, there was lack of evidence of receiving admission orders [REDACTED]. There was a lack of evidence of medication reconciliation during this initial visit. 7/16/2020 9:00 AM - An interview with E5 (LPN) revealed that R2 was readmitted to the facility around 6:00 PM on 7/2/2020, but was uncertain of the actual time, as she was addressing an urgent situation during the evening shift (3:00 PM to 11:00 PM shift). E5 verbalized that performing admission medication reconciliation and obtaining admission orders [REDACTED]. E5 reiterated that the evening R2 was readmitted to the facility was busy and there was a shortage of staff to assist in obtaining physician orders [REDACTED]. 7/16/2020 9:30 AM - During an interview with E2 (DON), E2 verbalized that although the facility had no evidence of admission orders [REDACTED]. Subsequent to this interview, the Surveyor reviewed the 7/3/2020 1:51 PM initial visit Progress Note by E11 and there was lack of evidence that an admission medication reconciliation was conducted. The facility failed to have a system in place that ensured, at the time of R2's admission, the facility had physician orders [REDACTED]. Findings reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/16/2020 at 11:30 AM.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** Based on record reviews and interviews, it was determined that for one (R1) out of three sampled residents, whose discharge was anticipated by the facility, the facility failed to ensure there was a discharge summary that included a recapitulation of the resident's stay, including pertinent laboratory (labs), radiology, and consultation results. Findings include: Review of R1's clinical record revealed: 6/19/2020 - A document titled, My Transition Home was completed by E8 (LPN), which included services provided by various departments, as well as a list of medications and providers involved in after discharge care. 6/19/2020 5:00 PM - A Progress Note by E7 (NP), documented a discharge progress note. The progress note lacked evidence of a recapitulation of R1's stay in the facility from 4/9/2020 to 6/19/2020. 7/16/2020 9:30 AM - An interview with E1 (NHA) revealed that the facility considered that completing the My Transition Home and the discharge progress note by E7 (NP) would meet the regulatory requirements. The Surveyor responded that the documentation lacked evidence of a recapitulation of R1's stay, including pertinent labs, radiology, and consultation results. 7/16/2020 11:30 AM - Findings were reviewed during an Exit Conference with E1 (NHA) and E2 (DON).
F 0684 **Level of harm** - Minimal harm or potential for 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** Based on record review and interview, it was determined that the facility failed to ensure that one (R2) out of three sampled residents received medication as ordered in the plan of care. Findings include: Cross refer to F635, example #2, F760, example #2, and F842, example #1. The following was reviewed in R2's clinical record: 7/2/2020 1:14 PM - The

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

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Hospital's Interagency Nursing Communication Record included [MEDICATION NAME] (a supplement to aid with sleeping) to be administered at bedtime. 7/2/2020 7:32 PM - The Hospital's Discharge Summary stated R2 was discharged from the hospital at 7:32 PM and R2's primary discharge [DIAGNOSES REDACTED]. 7/2/2020 - Review of R2's clinical record revealed that the order for [MEDICATION NAME] 3 mg daily at bedtime was in a pending status with a start date of 7/3/2020 (it was unclear why the start date would be on 7/3/2020 since the medication was to be continued after discharge from the hospital). 7/2/2020 - Review of the eMAR revealed that R2 was not administered any medications on the day of admission on 7/2/2020. 7/3/2020 1:06 AM - A Progress Note by E5 (LPN) documented that R2 was admitted to the facility and .MD called made aware of new orders at this time . 7/15/2020 1:11 PM - During an interview with E2 (DON), E2 verbalized that although it was not documented in R2's Progress Note, R2 was admitted to the facility on [DATE] after 10:00 PM. 7/15/2020 1:59 PM - The surveyor received a copy of R2's Hospital Discharge Summary which indicated that R2 was discharged from the hospital on [DATE] at 7:32 PM. 7/16/2020 9:55 AM - An interview with E5 (LPN) revealed that R2 was readmitted to the facility around 6:00 PM, but was uncertain of the actual time as she was addressing an urgent situation during the evening shift (3:00 PM to 11:00 PM shift). The facility failed to have a system in place which ensured that R2 was administered his medications as ordered upon discharge from the hospital. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/16/2020 at 11:30 AM.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of medical literature as indicated, it was determined that the facility failed to ensure that two (R1 and R2) out of three sampled residents were free from significant medication errors. R1 and R2 were admitted to the facility and were not administered significant medications. Findings include: [MEDICATION NAME]: What is [MEDICATION NAME]? .it is an anticoagulant to prevent blood clots . (https://www.drugs.com/mtm/[MEDICATION NAME].html) Insulin [MEDICATION NAME]: What is insulin [MEDICATION NAME]? . a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours . used to improve blood sugar control .sometimes used together with a long-acting or intermediate-acting insulin . (https://www.drugs.com/mtm/insulinasparat.html) Insulin [MEDICATION NAME]: . Insulin [MEDICATION NAME] is a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours used to improve blood sugar control . (https://www.drugs.com/mtm/insulinasparat.html) Cefaxolin (Referred to as [MEDICATION NAME]): What is [MEDICATION NAME]? . antibiotic . used to treat bacterial infections, including severe or life-threatening forms . (https://www.drugs.com/mtm/[MEDICATION NAME].html) Cross refer to F635, example #1. 1. The following was reviewed in R1's clinical record: 4/9/2020 12:49 PM - The Hospital's Interagency Discharge Orders stated R1's primary discharge [DIAGNOSES REDACTED]. - [MEDICATION NAME] (a blood thinner) 150 mg inject subcutaneously every 12 hours. - Cefaxolin (an antibiotic) 2 gm every 8 hours via intravenous (IV) infusion. - Insulin [MEDICATION NAME] 35 units to be injected subcutaneously (sq) at bedtime. - Insulin [MEDICATION NAME] 100 units/ml to be administered before each meal and to see details. - Insulin [MEDICATION NAME] 5 units sq before each meal. 4/9/2020 - Record review lacked evidence of R1's time of admission to the facility on [DATE]. 4/9/2020 - Review of the admission orders [REDACTED]. - Insulin [MEDICATION NAME] 100 units/ml to be administered before each meal. - [MEDICATION NAME] 150 mg sq every 12 hours. - Insulin [MEDICATION NAME] 35 units to be injected sq at bedtime. 4/9/2020 - Review of the eMAR revealed R1 was not administered any medications on the day of admission on 4/9/2020, including, [MEDICATION NAME], Insulin [MEDICATION NAME], and Cefaxolin. 4/10/2020 2:20 PM - A Medical Practitioner Note by E9 (MD) documented completion of an admission history and physical, post hospital visit, as well as hospital record review and medication reconciliation. 4/10/2020 - A subsequent review of the Order Summary Report documented the following new physician's orders [REDACTED]. - Flush IV line with 10 ml of NS before and after medication administration every shift for IV maintenance ordered on [DATE] at 2:31 PM. - Insulin [MEDICATION NAME] sliding scale coverage before each meal ordered on [DATE] at 2:21 PM. 4/10/2020 - Review of the eMAR revealed the following: - [MEDICATION NAME] 150 mg timed for 8:00 AM was documented as not being administered; awaiting delivery from pharmacy. - R1's finger stick blood sugar was first checked on 4/10/2020 at 5:00 PM and he did not require sliding scale Insulin coverage. 5/1/2020 8:00 PM - Review of the eMAR and the corresponding Progress Note lacked evidence that the scheduled 8:00 PM [MEDICATION NAME] 150 mg was administered and that E9 (MD) was notified. 5/2/2020 8:00 AM - Review of the eMAR and the corresponding Progress Note documented that the scheduled 8:00 AM administration of [MEDICATION NAME] 150 mg was not administered as the medication was not available. The attending physician was contacted and was aware. There was lack of evidence if an order was provided by the medical practitioner, as well as when the medication arrived. 7/14/2020 1:11 PM - During an interview with E2 (DON), E2 verbalized that although not documented in R1's Progress Note, R1 was admitted to the facility on [DATE] at 8:45 PM and the late admission may have contributed to [MEDICATION NAME], Insulin [MEDICATION NAME] , and Cefaxolin not being administered. E2 confirmed the omissions of the above medications. 7/15/2020 1:00 PM - The surveyor received a handwritten statement from E6 (LPN) and E11 (NP). E6 documented that she contacted E11 (NP) and was given an order for [REDACTED]. E6 documented that she administered the smaller dose, but did not state what the smaller dosage was. In the same document, a hand written note by E11 stated that she ordered the closest dose of 140 mg be given rather than 150 mg. Subsequent to reviewing this statement, the Surveyor requested evidence of a physician's orders [REDACTED]., evidence of administration of the medication and evidence of delivery from the pharmacy of the said medication. E2 verbalized that the medication was not delivered by the pharmacy. No additional follow-up was received from the facility. The facility failed to have a system in place which ensured that R1 was free from significant medication errors. Findings were reviewed with E1 (NHA), and E2 during the Exit Conference on 7/16/2020 at 11:30 AM. Cross refer to F684 and F842, example #1. 2. The following was reviewed in R2's clinical record: 7/2/2020 1:14 PM - The Hospital's Interagency Nursing Communication Record included a list of the following medications and the time of the last dose given for each of the medications: - [MEDICATION NAME] 30 mg inject sq every 12 hours; the last dose was given was on 7/2/2020 at 8:00 AM. - Insulin [MEDICATION NAME] 10 units sq daily; the last dose was given on 7/1/2020 at 7:00 PM. 7/2/2020 7:32 PM - The Hospital's Discharge Summary stated R2 was discharged from the hospital at 7:32 PM and R2's primary discharge [DIAGNOSES REDACTED]. 7/2/2020 - R2 was admitted to the facility from the hospital, however, the clinical record lacked evidence of the time R2 was readmitted to the facility. 7/2/2020 - Review of R2's admission orders [REDACTED]. It was unclear why the start date was 7/3/2020 as these medications were listed on the hospital's discharge list of medications to be continued.: - [MEDICATION NAME] 30 mg/0.3 ml inject 3 mg/ml sq every 12 hours for COVID-19. This order was incorrectly entered into the facility's electronic Medical Record, including the eMAR. - Insulin [MEDICATION NAME] 10 units sq daily at bedtime. 7/2/2020 - Review of the eMAR revealed R2 was not administered any medications on the day of admission on 7/2/2020, including [MEDICATION NAME] and Insulin [MEDICATION NAME]. 7/3/2020 1:06 AM - A Progress Note by E5 (LPN) documented that R2 was admitted to the facility and .MD called made aware of new orders at this time . 7/15/2020 1:11 PM - During an interview with E2 (DON), E2 verbalized that although it was not documented in R2's Progress Note, R2 was admitted to the facility on [DATE] after 10:00 PM and the late admission may have contributed to [MEDICATION NAME] and Insulin [MEDICATION NAME] not being administered. E2 confirmed the omissions of the above medications. 7/15/2020 1:59 PM - The Surveyor received a copy of R2's Hospital Discharge Summary which indicated that R2 was discharged from the hospital on [DATE] at 7:32 PM. 7/16/2020 9:55 AM - An interview with E5 (LPN) revealed that R2 was readmitted to the facility around 6:00 PM, but E5 was uncertain of the actual time, as she was addressing an urgent situation during the evening shift (3:00 PM to 11:00 PM shift). The facility failed to have a system in place that ensured R2 was free from significant medication errors. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/16/2020 at 11:30 AM.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on record reviews and interviews, it was determined that for two (R1 and R2) out of seven sampled residents, the facility failed to ensure, in accordance with accepted professional standards and practices, that the medical records were accurately documented. Findings include: Cross refer to F635, example #2, F684, and F760, example #2. 1. The following was reviewed in R2's clinical record: 7/2/2020 - Review of R2's facility admission orders [REDACTED]. There was a lack of evidence of an accurate and complete order, as the facility incorrectly documented 3 mg to be administered instead of the correct dosage of 30 mg. 7/3/2020 8:00 AM through 7/14/2020 8:00 AM - Review of the eMAR revealed that the licensed nurses

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) documented they administered a total of 13 doses of this medication as written above. 7/14/2020 - A subsequent review of a physician's orders [REDACTED]. 2. Review of R1's clinical record revealed: 6/19/2020 5:00 PM - A Progress Note by E7 (NP) included a title of a Physician. 7/16/2020 11:30 AM - During the Exit Conference, E2 (DON) confirmed that E7 was a NP and not a Physician, thus, confirming inaccuracy in the clinical record. Findings were also reviewed with E1 (NHA) at this time.
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** Based on observation, interview, and review of facility documentation as indicated, it was determined that the facility failed to thoroughly screen visitors in accordance the Center for Disease Control and Prevention's recommendation for screening of visitors. Findings include: The review of the CDC's Infection Control Guidance dated 7/15/2020 stated .Screen everyone (patients, HCP, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 infection and ensure they are [MEDICATION NAME] source control. Actively take their temperature and document absence of symptoms consistent with COVID-19 . (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control recommendation/html) 7/7/2020 12:45 PM - Upon entrance to the facility, the Surveyor was greeted by the receptionist, E4, who took the Surveyor's temperature, however, no further screening was conducted. The Surveyor was never asked specific questions, as required. 7/7/2020 1:30 PM - The Surveyor asked E4 (Receptionist) whether she needed to sign in as a visitor? E4 responded yes and proceeded to have the Surveyor sign in on the Visitor Log. The log included a location for temperature and response to the question of No S/S (signs and symptoms- dry cough/shortness of breath). There was no additional COVID-19 visitor screening conducted. The Visitor Log contained seven additional visitors prior to the Surveyor signing in and there was lack of evidence of thorough visitor COVID-19 screening for these seven visitors. 7/7/2020 1:35 PM - During an interview, E1 (NHA) was advised of the lack of COVID-19 screening of visitors and E1 stated that she would follow-up. 7/8/2020 10:00 AM - During an interview with E2 (DON), E2 stated there was a new COVID-19 screening process for visitors implemented by the corporate level on 6/26/2020, however, the process was not implemented until 7/8/2020. Finding was reviewed with E1 (NHA) and E2 (DON) during an Exit Conference on 7/16/2020 at 11:30 AM.