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 _____	**06/02/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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** Based on interviews and record review, it was determined that the facility failed to develop a comprehensive care plan for one (R1) out of three sampled residents reviewed for [MEDICAL TREATMENT]. Findings include: The following was reviewed in R1's record: 3/12/2020 - R1 was admitted to the facility and required [MEDICAL TREATMENT]. 5/27/2020 - Review of R1's record lacked evidence of a care plan for [MEDICAL TREATMENT]. 6/1/2020 - E2 (DON) confirmed that the facility did not have a care plan for R1's [MEDICAL TREATMENT]. Findings were reviewed with E1 (NHA), E2 and E3 (Corporate Consultant) during the Exit Conference on 6/2/2020 at 10:00 AM.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to provide [MEDICAL TREATMENT] care and services to meet the needs for two (R1 and R2) out of three sampled residents for [MEDICAL TREATMENT] review by not fully completing the facility's portion of the communication form to inform the [MEDICAL TREATMENT] center of pertinent clinical information. Findings include: Cross Refer to F880 1. Review of R1's clinical record revealed the following: 3/12/2020 - R1 was admitted to facility and required [MEDICAL TREATMENT]. 5/7/2020 2:25 PM - A progress note documented that R1 had a frequent cough and R1 was tested for COVID-19. 5/9/2020 - R1 was transported to [MEDICAL TREATMENT] and the [MEDICAL TREATMENT] Communication form lacked communication of R1's COVID-19 status. 5/12/2020 12:33 PM - A lab report indicated R1 was positive for COVID-19. 5/12/2020 - R1 was transported to [MEDICAL TREATMENT] and the [MEDICAL TREATMENT] Communication form lacked communication of R1's COVID-19 status. 5/16/2020 - R1 was transported to [MEDICAL TREATMENT] and the [MEDICAL TREATMENT] Communication form was missing. 5/27/2020 9:48 AM - An interview with the D1 ([MEDICAL TREATMENT] Staff) and D2 ([MEDICAL TREATMENT] Staff) revealed that R1 had been to [MEDICAL TREATMENT] on 5/9, 5/12 and 5/16/2020. On 5/19/2020 the transportation driver let the [MEDICAL TREATMENT] center know that R1 was COVID positive. R1's [MEDICAL TREATMENT] was canceled and rescheduled for the next day. 5/28/2020 11:48 AM - During an interview with T1 (Transportation Staff) and T2 (Transportation Staff), it was revealed that on 5/9, 5/16, and 5/19/2020, R1 was transported to [MEDICAL TREATMENT] without notification that R1 was a person under investigation for COVID-19 or that R1 became COVID-19 positive on 5/12/2020. It was on 5/19/2020 when the transportation service was picking up R1, that the transportation staff learned of R1's COVID-19 status. The transportation staff called their dispatch and the [MEDICAL TREATMENT] center to notify them of R1's positive COVID-19 status. R1 was rescheduled for the next day at the appropriate COVID [MEDICAL TREATMENT] facility. 5/28/2020 1:29 PM - During an interview, E2 (DON) confirmed that the facility did not have a process to communicate infectious diseases, including COVID-19 results with [MEDICAL TREATMENT]. 5/28/2020 1:47 PM - During an interview, E4 (LPN) revealed that she was not aware of a specific policy for communicating COVID-19 status' to the [MEDICAL TREATMENT] center. E4 further revealed if the resident was a person under investigation or positive for COVID-19, E4 would provide that information to the transport team. 5/28/2020 3:42 PM - An interview with E6 (RN) revealed that although the facility had a doctors order to call the [MEDICAL TREATMENT] center for monitoring R1's positive COVID-19 status daily, this wasn't done. 5/29/2020 10:30 AM - Review of the facility infection control policies lacked evidence to support that a process was in place to communicate infectious disease status' of residents to contracted agencies, including [MEDICAL TREATMENT] centers. 5/29/2020 - Review of the facility [MEDICAL TREATMENT] communication log lacked evidence that the [MEDICAL TREATMENT] facility was made aware of R1's COVID-19 status. There was no evidence that R1's COVID-19 positive status was communicated to [MEDICAL TREATMENT] by the facility, including when R1 was presumptive positive. 2. Review of R2's clinical record revealed the following: 2/3/2020 - R2 was admitted to the facility and received [MEDICAL TREATMENT]. 4/27/2020 - A care plan for R2 was initiated because of his potential COVID-19 status. 4/28/2020 - R2 was transported to [MEDICAL TREATMENT] and the [MEDICAL TREATMENT] Communication form lacked communication of R2's COVID-19 status. 5/28/2020 1:29 PM - During an interview, E2 (DON) confirmed that there was not a process to communicate infectious diseases, including COVID-19 results with [MEDICAL TREATMENT]. 5/28/2020 1:47 PM - During an interview, E4 (LPN) revealed that she was not aware of a specific policy for communicating COVID-19 status' to the [MEDICAL TREATMENT] center. E4 further revealed if the resident was presumptive or positive for COVID-19, E4 would provide that information to the transport team. 5/29/2020 10:30 AM - Review of the facility infection control policies lacked evidence to support that a process was in place to communicate infectious disease status' of residents to contracted agencies, including [MEDICAL TREATMENT] centers. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Consultant) during the Exit Conference on 6/2/2020 at 10:00 AM.
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 interviews, record review and other documentation as needed, it was determined that the facility failed to implement appropriate infection control practices for two (R1 and R2) out of three sampled residents reviewed for transmission based precautions as evidenced by failure to communicate residents' COVID-19 status with the contracted [MEDICAL TREATMENT] facility. Findings include: The [MEDICAL TREATMENT] contract, dated 5/24/2011, documented, 1. The nursing facility shall ensure that all appropriate medical and administrative information accompanies all [MEDICAL CONDITION] residents at the time of referral to the [MEDICAL CONDITION] [MEDICAL TREATMENT] Unit. 2. Interchange of information The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the [MEDICAL CONDITION] Residents. Review of facility infection control policies lacked a process that described how the facility would communicate the presence of infectious diseases when residents were going to a [MEDICAL TREATMENT] facility. 1. The following was reviewed in R1's record: 3/12/2020 - R1 was admitted to the facility and required [MEDICAL TREATMENT]. There was no evidence of a care plan for [MEDICAL TREATMENT] in the medical record. 5/7/2020 2:25 PM - A progress note documented, Resident noted with frequent cough, afebrile (no fever), seen by N/P (Nurse Practitioner) and new orders re/cd (received) for a COVID-19 test, abts (antibiotic) and labs, son made aware, tolerated COVID test well. 5/9/2020 - The [MEDICAL TREATMENT] Communication form documented that R1 went to [MEDICAL TREATMENT] and there was no evidence that R1's COVID-19 status was communicated on that form. 5/9/2020 - Record review revealed that R1 went to [MEDICAL TREATMENT] and the COVID-19 infectious disease status was not reported to the [MEDICAL TREATMENT] facility. 5/12/2020 - Record review revealed that R1 was transported to the [MEDICAL TREATMENT] center and received [MEDICAL TREATMENT] at his usual, non-COVID [MEDICAL TREATMENT] facility. The facility failed to notify the [MEDICAL TREATMENT] center and the transportation service of R1's COVID-19 status. 5/12/2020 12:33 PM - A lab report indicated that R1 was positive for COVID-19. 5/12/2020 - A care plan for being positive for COVID-19 was initiated. 5/14/2020 - Record review revealed a doctors order to call the [MEDICAL TREATMENT] center for monitoring of R1's COVID-19 positive status every day.

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) The medical record lacked evidence that the [MEDICAL TREATMENT] facility was contacted about monitoring or R1's COVID-19 status. 5/16/2020 - Record review revealed that R1 was transported to the [MEDICAL TREATMENT] center and received [MEDICAL TREATMENT] at his usual, non-COVID [MEDICAL TREATMENT] facility. 5/19/2020 - Record review revealed that transportation arrived at the facility to pick up R1 and learned that R1 was COVID-19 positive. R1 was not transported, and [MEDICAL TREATMENT] was rescheduled for a COVID-19 designated facility. 5/19/2020 11:18 AM - A progress note documented, Due to positive COVID 19 test, resident's [MEDICAL TREATMENT] location and chair time have changed. Resident to attend [MEDICAL TREATMENT] Tuesday, Thursday, and Saturday. 5/27/2020 9:48 AM - An interview with D1 ([MEDICAL TREATMENT] Staff) and D2 ([MEDICAL TREATMENT] Staff) revealed that R1 had been to [MEDICAL TREATMENT] on 5/9, 5/12 and 5/16/2020. On 5/19/20 the transportation driver let the [MEDICAL TREATMENT] center know that R1 was COVID positive. The [MEDICAL TREATMENT] center called the facility to follow up with the information and the resident was returned to the facility. 5/28/2020 11:48 AM -During an interview with T1 (Transportation Staff) and T2 (Transportation Staff), it was revealed that on 5/9, 5/16, and 5/19/2020, R1 was transported to [MEDICAL TREATMENT] without notification that R1 was a person under investigation for COVID-19. It was on 5/19/2020 when the transportation service was picking up R1, that the transportation staff learned of R1's COVID-19 status. The transportation staff called their dispatch and the [MEDICAL TREATMENT] center to notify them of R1's positive COVID-19 status. R1 was rescheduled for the next day at the appropriate COVID [MEDICAL TREATMENT] facility. 5/28/2020 1:29 PM - During an interview, E2 (DON) confirmed that there was not a facility process to communicate infectious diseases, including COVID-19 results to [MEDICAL TREATMENT]. 5/28/2020 1:47 PM - During an interview, E4 (LPN) revealed that she was not aware of a specific policy for communicating COVID-19 status' to the [MEDICAL TREATMENT] center. E4 further revealed if the resident was under investigation or positive for COVID-19, E4 would provide that information to the transport team. 5/28/2020 3:42 PM - Interview with E6 (RN) revealed that the facility failed to follow the doctors order to call the [MEDICAL TREATMENT] center to monitor R1's COVID-19 positive status every day. 5/29/2020 10:30 AM - Review of the facility infection control policies lacked evidence to support a facility process to communicate infectious disease status' of residents to contracted agencies, including [MEDICAL TREATMENT] centers. 5/29/2020 - Review of the [MEDICAL TREATMENT] communication log lacked evidence that the [MEDICAL TREATMENT] facility was advised of R1's COVID-19 status 2. The following was reviewed in R2's record: 2/3/2020 - R2 was admitted to the facility and received [MEDICAL TREATMENT]. 4/27/2020 - A care plan for R2 was initiated because of his potential positive COVID-19 status. 4/27/2020 - The facility record documented that R2 had a room change for the management of COVID-19 like symptoms. 4/28/2020 10:38 AM - A progress note documented, R2 remains under strict droplet precautions. 4/28/2020 4:00 PM - A progress note documented, Picked up later this shift to go to [MEDICAL TREATMENT]. 4/28/2020 - A [MEDICAL TREATMENT] Communication form was not completed for this day. 4/29/2020 - Record review revealed a COVID-19 test was conducted on R2. 4/30/2020 6:43 PM - A progress note documented, Patient seen and examined. Nursing reports patient was not dialyzed today as he was picked up and brought back as [MEDICAL TREATMENT] center rescheduled patient for AM pending COVID test results. 4/30/2020 - A [MEDICAL TREATMENT] Communication form was not completed for this day. 5/1/2020 2:25 PM - A progress note documented that a copy of the COVID-19 test result was sent to the [MEDICAL TREATMENT] center and transport was made aware of the results. 5/27/2020 10:30 AM - During an interview with D3 ([MEDICAL TREATMENT] Staff) the surveyor was informed that R2 was brought to their facility and on arrival the transportation company notified them R2 was COVID-19 positive. The [MEDICAL TREATMENT] center returned R2 to the facility and new arrangements were made for R2 to attend the appropriate [MEDICAL TREATMENT] facility that treated COVID-19 patients. 5/28/2020 1:47 PM - During an interview with E4 (LPN), it was revealed that she was not aware of a specific policy for communicating infectious disease status' to the [MEDICAL TREATMENT] center. E4 further revealed if the resident was presumptive or positive for COVID-19, E4 would provide the resident status to the transport team. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Consultant) during the Exit Conference on 6/2/2020 at 10:00 AM.