**MANOR HOUSE OF DOVER**

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<td>F 279</td>
<td>483.20(D), 483.20(K)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
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A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observations and interview, it was determined the facility failed to develop a care plan to reflect use of oxygen (O2) for 1 of 19 (Resident #83) sampled residents included in the stage 2 review.

The findings included:

- Review of the facility’s comprehensive plan of care documented, "...PURPOSE... To provide an individualized Plan of Care, for each resident, by means of a written document... The Comprehensive Plan of Care will be updated to...

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**The Care Plan of Resident # 68 was reviewed and updated by the MDS Coordinator to reflect the use of oxygen.**

2/26/14

A 100% audit of residents with physician orders for oxygen was conducted by the Director of Nursing Service and care plans reviewed by the MDS Coordinator to ascertain each resident has an appropriate careplan for Oxygen use. 2/27/14

All resident care plans will be reviewed and updated within 7 days of admission, quarterly, or upon any change in condition to ensure each resident's plan of care is reflective of the resident's current condition and treatment.

New physician orders are reviewed daily in the Clinical Start-up Meeting for new orders and care planned immediately. Those in attendance at the Clinical Start-up Meeting include the Director of Nursing Service, Assistant Director of Nursing/ Unit Manager, Restorative Nurse, Health Information Officer, and MDS/Care Plan Coordinator. 3/14/14

The Director of Nursing Service or her designee will conduct a 100% audit on all resident's with Oxygen orders on a monthly basis for the next two months. Results will be presented to and reviewed by the QAPI Committee to monitor for continued compliance at their monthly meeting. The QAPI Committee consist of the...
F 279 Continued From page 1
reflect resident's current condition at least every
90 days, or whenever significant changes
occur...

Medical record review for Resident #68
documented an admission date of 1/14/14 with
diagnoses of Chronic Obstructive Pulmonary
Disease, Hypertension, Atrial Fibrillation,
Hypertopidemia, Celiac Disease and Esophageal
Reflux. Review of a physician's order dated
2/3/14 documented, "...O2 AT 4 LITERS A
MINUTE (LPM) VIA NASAL CANNULA (NC) TO
KEEP O2 SATS [saturations] ABOVE 92%
[percent]." Review of the care plan dated
2/14/14 did not address Resident #68's use of
oxygen.

Observations in Resident #68's room on 2/24/14
at 8:19 AM, revealed Resident #68 lying in bed
receiving O2 BNC at 2.5 LPM.

Observations in Resident #68's room on 2/24/14
at 1:39 PM, revealed Resident #68 lying in bed
receiving O2 BNC at 3.5

Observations in Resident #68's room on 2/25/14
at 7:55 AM and 12:10 PM, revealed Resident #68
lying in bed receiving O2 BNC at 2 LPM.

Observations in Resident #68's room on 2/25/14
at 2:15 PM, revealed Resident #68 lying in bed
receiving O2 BNC at 1.5 LPM.

During an interview in the Minimum Data Set
(MDS) office on 2/26/14 at 1:00 PM, Nurse #4
was asked if there was a care plan for oxygen for
Resident #68. Nurse #4 stated, "No, but there
should be..."
F 280 Continued From page 2

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on policy review, review of a resident incident report, medical record review and interview, it was determined the facility failed to update a care plan for 1 of 19 (Resident #50) sampled residents included in the stage 2 review.

The findings included:

Review of the facility's comprehensive plan of care policy documented, "Each resident shall have a Comprehensive Care Plan based on the comprehensive assessment (MDS) [Minimum

F 280 The Care Plan of Resident # 50 was reviewed and updated by the MDS Coordinator to reflect the fall which occurred on 2/24/14. 2/26/14

An audit of all residents with falls in the past 90 days was conducted by the Director of Nursing Service and care plans reviewed by the MDS Coordinator to ascertain each resident had an appropriate care plan and interventions for preventing future falls.

All RNs and LPNs were re-educated on the importance of updating the plan of care immediately after any fall.

Inservice was conducted on 3/19/14 by the Director of Nursing Service. Falls and interventions are discussed in the daily Stand-up Meeting attended by the Administrator, Director of Nursing Service, Unit Manager, MDS Coordinator, Restorative Nurse, Health Information Officer, Social Services, Dietary Manager, Activities and Maintenance. 3/19/14

The Director of Nursing Service or her designee will conduct a 100% audit on all residents with falls each month for the next two months.

Results will be presented to and reviewed by the QAPI Committee consisting of the Medical Director, Administrator, Director of Nursing
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>USE COMPLETION DATE</th>
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<td>F280</td>
<td>Continued From page 3</td>
<td>Data Set] fully developed within 7 days after completion of the Comprehensive Assessment... The Comprehensive Plan of Care will be updated to reflect resident's current condition at least every 90 days, or when ever significant changes occur...&quot; Medical record review for Resident #50 documented an admission date of 8/3/11 with diagnoses of Psychosis, Atrial Fibrillation, Senile Dementia, Cataract, Rehabilitation Process, Hypertension, Hypopotension and Esophagitis. Review of the care plan dated 11/14/13, was not updated to reflect the resident's fall on 2/22/14. Review of the &quot;Resident Incident Report&quot; dated 2/24/14 documented &quot;Resident reported to this nurse that last night she rolled over in bed and fell to the floor...&quot; During an interview in the conference room on 2/26/14 at 2:00 PM Nurse #3 stated &quot;...care plan was not updated...&quot;</td>
<td>Service, Pharmacy Consultant, Restorative Nurse, Health Information Officer, Social Services, Certified Dietary Manager, Activities, and Maintenance Supervisor.</td>
<td>02/26/2014</td>
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<tr>
<td>F328</td>
<td>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</td>
<td>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</td>
<td>02/26/2014</td>
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**F 328** Continued From page 4

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observations and interviews, it was determined the facility failed to ensure oxygen (O2) was administered at the rate prescribed by the physician for 2 of 3 (Residents #41 and #68) sampled residents receiving O2 therapy included in the stage 2 review.

The findings included:

1. Review of the facility's "Oxygen Administration" policy documented, "...Place the oxygen delivery device on the resident and adjust it to achieve resident comfort...Reassesses oxygen flow meter for correct liter flow..."

2. Medical record review for Resident #41 documented an admission date of 3/18/13 with diagnoses of Hypertension, Alzheimer's Disease, Non-Alzheimer's Dementia, Psychotic Disorder, Depression and Hypothyroidism. Review of a physician's order dated 2/9/14 documented, "...Oxygen at 2L/min [liters per minute] by nasal cannula..."

Observations in Resident #41's room on 2/24/14 at 8:22 AM and 1:41 PM and on 2/25/14 at 7:44 AM, revealed Resident #41 lying in bed receiving O2 per BNC at 2.5 LPM.

Observations in Resident #41's room on 2/25/14 at 2:20 PM and 4:12 PM, revealed Resident #41 seated in a chair at the bedside receiving O2 per BNC at 2.5 LPM.

During an interview in Resident #41's room on

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**F 328**

The Oxygen flow meter was immediately adjusted for Residents # 41 and #68. These residents were immediately assessed by the RN for signs symptoms of respiratory distress with no negative findings. The Director of Nursing Services identified all residents with physician orders for oxygen and all residents were assessed by the RN for any signs or symptoms of respiratory distress with no negative findings. All Oxygen concentrators were checked by the RN to ensure liters per minute were set as prescribed by the physician. Any negative findings were immediately corrected.

All Nurses were re-educated on proper Oxygen administration on 3/19/14 by the Director of Nursing Service.
F 328 Continued From page 5
2/25/14 at 4:12 PM, Nurse #2 was asked what rate Resident #41's O2 was on. Nurse #2 stated, "Looks like about 2 and a half..." 

3. Medical record review for Resident #68 documented an admission date of 1/14/14 with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Atrial Fibrillation, Celiac Disease, Hyperlipidemia and Esophageal Reflux. Review of a physician's order dated 2/3/14 documented, "...O2 AT 4 LITERS A MINUTE VIA NASAL CANNULA TO KEEP O2 SATS [saturations] ABOVE 92% [percent]..."

Observations in Resident #68's room on 2/24/14 at 8:19 AM, revealed Resident #68 lying in bed receiving O2 per BNC at 2.5 LPM.

Observations in Resident #68's room on 2/24/14 at 1:39 PM, revealed Resident #68 lying in bed receiving O2 per BNC at 3.5.

Observations in Resident #68's room on 2/25/14 at 7:55 AM and on 2/25/14 at 12:10 PM, revealed Resident #68 lying in bed receiving O2 per BNC at 2 LPM.

Observations in Resident #68's room on 2/25/14 at 2:15 PM, revealed Resident #68 lying in bed and receiving O2 per BNC at 1.5 LPM.

During an interview in Resident #68's room on 2/25/14 at 4:00 PM, Nurse #2 was asked what rate Resident #68's O2 was on. Nurse #2 stated, "Looks like about three..."

F 371 483,35(i) FOOD PROCURE, SS=D STORE/prepare/serve - Sanitary  

F 328 The Director of Nursing Service or her designee will monitor oxygen administration on all residents on a random basis for the next 8 weeks to assure compliance. Results will be presented to and reviewed by the QAPI committee to monitor for continued compliance. The QAPI Committee meets monthly and consists of the Medical Director, Administrator, Director of Nursing Service, Pharmacy Consultant, Restorative Nurse, Health Information Officer, Social Services, Certified Dietary Manager, Activities and Maintenance Supervisor.
**F 371** Continued From page 6  
The facility must -
1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and  
2. Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on policy reviews, observations and interviews, it was determined the facility failed to ensure food was dated when stored and staff followed hand hygiene while cleaning dishes in the kitchen on 2 of 3 days (2/24/14 and 2/25/14) of the survey.

The findings included:

1. Review of the facility's "Refrigerated Storage" policy documented, "...PROCEDURE... Raw meats, poultry, and fish will be wrapped, dated and labeled... All foods will be properly wrapped and/or stored in sealed containers and dated and labeled..."  

Observations in the kitchen on 2/24/14 at 5:45 AM and 9:30 AM, revealed 2 undated, unlabeled deep pans of raw chicken covered with aluminum foil in the refrigerator.

During an interview in the kitchen on 2/24/14 at 5:45 AM, dietary staff member #1 was asked what was in the undated, unlabeled pans in the refrigerator. Dietary staff member #1 stated, "...looks like marinated chicken..." Dietary Staff #1

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| F 371 | 1. The refrigerated pan of marinating chicken was immediately labeled. 2/24/14  
Dietary Staff was re-educated on the "Importance of Dating and Labeling Refrigerated Food Items" on 2-28-14. The in-service was conducted by the Certified Dietary Manager. 2/28/14  
The Certified Dietary Manager will conduct random inspections each week for the next 8 weeks to assure all foods are properly wrapped and stored in sealed containers, dated and labeled appropriately.  
Results of the random inspections will be presented to the monthly QAPI Committee meeting to assure continued compliance. The QAPI Committee consist of the Medical Director, Administrator, Director of Nursing Service, Pharmacy Consultant, Restorative Nurse, Health Information Officer, Social Services, Certified Dietary Manager, Activities, and Maintenance Supervisor.  |
F 371 Continued From page 7

was asked if the food was dated. Dietary Staff #1 stated, "Not that I see."

During an interview in the kitchen on 2/24/14 at 9:30 AM, the Certified Dietary Manager (CDM) was asked about the undated and unlabeled pans in the refrigerator. The CDM stated, "...chicken... they put it in there yesterday. They just failed to write the date on it..."

2. Review of the facility's "Hand Washing Procedures" policy documented, "...POLICY... It is the policy of this facility to prevent the transmission of bacteria. Hands are to be frequently and thoroughly washed...
PROCEDURE... Because hands are the point of contact with bacteria, dish washing and pot washing sinks will not be used for hand washing... Proper hand washing techniques will be used to eliminate the source of some of the bacteria in a food service department... the technique for hand washing is as follows... Wet hands with warm water... Cover hands with germicidal liquid soap... Rub hands together... Rinse hands well under running water, holding them so the water flows from the wrists down the fingers..."

Review of the facility's "STANDARD FOR DRESS, CLEANLINESS AND CONDUCT" policy documented, "...Wash hands with soap and hot water before leaving the restroom, after coughing, sneezing, smoking, combing hair, and always before handling food..."

Observation in the kitchen on 2/25/14 at 9:00 AM, dietary staff member #1 changed gloves and used hand sanitizer between washing dirty dishes and removing clean dishes from the ware

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2. A separate hand wash sink in the dish room has been ordered with installation to be completed immediately upon arrival. While the manufacturer of the alcohol based hand sanitizer indicates their product complies with all FDA regulations, the use of hand sanitizer will be discontinued in the dietary area. Dietary employees will use the handwashing sink in the prep area until new sink can be installed in the dishwashing area. 4/1/14
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| F 371         | Continued From page 8  
|               | washer. Dietary staff member #1 did not wash hands with soap and water. |
|               | During an interview in the CDM's office on 2/26/14 at 9:45 AM, the CDM was asked what is the policy regarding hand washing, and is the use of hand sanitizer instead of soap and water permitted. CDM stated, "We don't in here. I think nothing takes the place of soap and water." |

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<tr>
<td>F 371</td>
<td>Privacy curtains have been installed in Rooms 18 and 29 assuring full visual privacy for residents by the Maintenance Supervisor. 3/13/14</td>
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<td>A 100% audit of all rooms assuring privacy curtains gave full visual privacy was conducted by the Maintenance Supervisor and Housekeeping Supervisor on 2/28/14 2/28/14</td>
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<td>Each room will be checked for fully functional curtains that provide full visual privacy by the Housekeeping Supervisor on a monthly basis.</td>
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<td>Results of the monthly inspections will be presented to the QAPI Committee at its monthly meeting. The QAPI Committee consists of the Medical Director, Administrator, Director of Nursing Service, Pharmacy Consultant, Restorative Nurse, Health Information Officer, Social Services, Certified Dietary Manager, Activities and Maintenance Supervisor.</td>
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This REQUIREMENT is not met as evidenced by:

Based on policy review, observations and interviews, it was determined the facility failed to maintain full visual privacy for 2 of 37 (Rooms 18 and 29) resident rooms.

The findings included:

1. Review of the facility's "Rights of Nursing Facility Residents" policy documented, "...To privacy during visits and telephone calls and while attending to personal needs, unless providing privacy would infringe on the rights of others..."

2. Observations in room 18 on 2/24/14 at 7:30
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<tr>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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| F 460: Continued From page 9 AM and 2:11 PM and on 2/25 at 9:00 AM, 11:30 AM and 4:10 PM, revealed the privacy curtain did not provide full visual privacy. During an interview in room 18 on 2/25/14 at 4:10 PM, Nurse #2 was asked if the privacy curtain provided full visual privacy for the resident. After pulling the curtain, Nurse #2 stated, "No it don't..." 3. Observations in room 29 on 2/24/14 at 8:05 AM, on 2/25/14 at 7:48 AM and on 2/26/14 at 10:00 AM, revealed there was no privacy curtain. During an interview in room 29 on 2/26/14 at 10:00 AM, Nurse #4 was asked if she saw a privacy curtain for the resident. Nurse #4 stated, "No." F 468: 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure handrails were securely fixed to walls on 2 of 2 (North hall and South hall) halls of the facility that residents reside on. The findings included: 1. Review of the facility's "Rights of Nursing Facility Residents" policy documented, "...By law, every nursing facility resident has the right... To live in safe, decent and clean conditions..." | F 468: All handrails identified as being loose were immediately tightened by the Maintenance Supervisor on 2/26/14. 2/26/14 Handrail inspection is part of the monthly preventative maintenance program conducted by the Maintenance Supervisor. In addition, the Administrator will conduct random inspections on a monthly basis to assure the safety and effectiveness of the handrails with work orders issued when needed. Results will be presented to the QAPI Committee at its monthly meeting for review and recommendations. The QAPI Committee consists of the Medical Director, Administrator, Director of Nursing Service, Pharmacy Consultant, Restorative Nurse, Health
2. Observations on the north hall on 2/16/14 at 7:30 AM, revealed the following handrails were loose:
   a. Handrail between room 40 and room 1.
   b. Handrail at room 3.
   c. Handrail between rooms 4 and 5.
   d. Handrails at room 10.
   e. Handrail between rooms 16 and 17.
   f. Handrail between rooms 21 and 22.
   g. Handrail between room 23 and housekeeping supplies room.
   h. Handrail between soiled utility room and central nurses station.

3. Observations on the south hall on 2/26/14 at 2:00 PM, revealed the following handrails were loose:
   a. Handrail at room 25.
   b. Handrail at room 31.
   c. Handrail at room 33.

During an interview on the south hall on 2/26/14 at 2:00 PM, the Maintenance Supervisor verified the handrails were loose.