

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 088040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2015
NAME OF PROVIDER OR SUPPLIER LOFLAND PARK CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 716 N. KING STREET SEAFORD, DE 19973		
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from January 6, 2015 through January 13, 2015. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 99. The survey sample totaled 35.</p> <p>Abbreviations used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set-standardized assessment form used in nursing homes; RNAC - Registered Nurse Assessment Coordinator; EMR - Electronic Medical Record; TAR-Treatment Administration Record; MAR-Medication Administration Record; Sacrum-large triangular bone at the base of the spine; Coccyx-tailbone; Gluteal fold-A prominent fold on the back of the upper thigh that marks the upper limit of the thigh from the lower limit of the buttock; PU-Pressure ulcer-sore area of skin that develops when the blood supply to it is cut off due to pressure; Stage II (2) pressure ulcer -skin forms an open sore. The area around the sore may be red and irritated; Stage III (3) - skin develops an open, sunken hole</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Theresa Dennis, GILD, NHA

Administrator

2/3/2015

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 000	Continued From page 1 called a crater. There is damage to the tissue below the skin; Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Santyl- Debriding (removing tissue) ointment; Optifoam-non adhesive dressing that protects wounds and keeps out bacteria.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272		

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F 272	<p>Continued From page 2</p> <p>Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the for two [R67, R130] out of 35 sampled residents the facility failed to ensure the comprehensive assessment was accurate. Findings Include:</p> <p>1. R57 was admitted on 8/4/14. The admission MDS dated 8/11/14 was incomplete in the area of mental status.</p> <p>Review of the Social History and Initial Assessment in the EMR documented the mental status assessment as being completed on 8/12/14. The resident was found to be independent for decision making.</p>	F 272	<p>I272</p> <p>A. R57 was discharged from facility on 11/10/14. R130 had a corrected MDS on 1/28/15 to include falls reflected during the review period.</p> <p>B. The dashboard in the electronic reporting system, PointClickCare (PCC), will be reviewed daily by all disciplines to ensure MDS is completed by the Assessment Reference Date (ARD). The RNAC/CRC (Clinical Reimbursement Coordinator) was educated by the Administrator on 2/2/15 about reviewing all information that will be relevant in completing each section of the MDS according to the look back period for each item set (see Attachment A). The above practices will be utilized to ensure accuracy of all resident information in the next MDS due for each resident.</p> <p>C. The DON/designee will lead discussion at the morning and afternoon clinical meetings about MDS assessments needing completed each day for follow up to ensure MDS completion is timely. The Nurse Practice</p>	3/13/15

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F 272	Continued From page 3 An Interview on 1/12/15 at 10:00 AM with E5 and E16, the facility's RNACs revealed that Social Services did not complete their assessment until 8/12/14 which resulted in the data not being included in the Admission MDS dated 8/11/14. 2. R130 was documented in the nurses' notes and in facility reports as having falls on 10/16 and 12/21/14. Review of the MDS dated 12/24/14 documented in the area of falls that there had been no falls since the prior assessment of 9/23/14. Review of the 12/24/14 Nursing Assessment included in the EMR documented that R130 had no falls since the previous assessment. A nurse documented that no falls have occurred since the previous assessment. An Interview on 1/12/15 at 10:07 AM with E5 and E16 revealed that the Nursing Assessment data in the EMR is populated into the MDS. If the assessment did not include the falls then the falls would not be included on the MDS.	F 272	F272 Continued C. Educator (NPE) will complete education with all nurses regarding the dashboard in PCC & completion of assessments accurately by 3/6/15 (see Attachment B). D. The DON/designee will conduct random audits (see Attachment C) of 10% of the resident population weekly until 100% compliance is achieved with MDS being completed thoroughly & accurately by the ARD over 3 consecutive evaluations. Then monthly until 100% compliance achieved over 3 consecutive evaluations. All results will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 314 SS=D	483.28(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		

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F 314	<p>Continued From page 4</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and interview it was determined that the facility failed to ensure that for one (R85) out of 35 sampled residents, received the necessary treatment and services to promote healing of a PU. R85 received treatment to a PU that was not in compliance with the facility guideline. Additionally it is unclear if the initial treatment was ordered by the physician. The first documented physician assessment of R85's wound was approximately one month after admission. Findings include:</p> <p>1a. Review of R85's clinical record revealed:</p> <p>11/25/14- An initial admission assessment was completed and documented R85's skin condition as the sacrum being red and had two dark areas in between the buttocks with small yellow area in the center of the sacrum.</p> <p>11/25/14-Physician's orders and Interim plan of care directed staff to apply A&D ointment to R85's buttocks twice daily and as needed.</p> <p>11/28/14- 1:46 PM A nursing note was written that documented R85 as having a "sacrum with redness and 2 areas of deep tissue injury noted".</p> <p>11/28/14-A treatment was initiated based on the skin care protocol to cleanse the gluteal fold with wound cleanser, apply Optifoam dressing change every seven days and as needed. This treatment</p>	F 314	<p>F314</p> <p>A. An order clarification for R85 was obtained on 1/20/15 for wound care.</p> <p>B. Current residents have had a skin inspection completed by using the weekly skin assessment. Any areas identified are receiving appropriate treatment and services and are recorded on the facility's Skin Integrity and Treatment Report. The NPE completed an audit (see Attachment D) by 2/3/15 to ensure all skin integrity areas have been labeled anatomically correct per facility guidelines and all treatments have physician orders. All anatomical locations & physician orders for treatments will be within facility guidelines by 2/4/15.</p> <p>C. The NPE will complete education with all nurses by 3/6/15 to include the following: Skin Integrity Management Policy & Procedure and Practice Standards, Pressure Ulcer Guidelines, Skin & Wound Care Quick Reference/Guidelines, Anatomical Location Guide, and completion of the Skin Integrity Report (see Attachment B).</p>	3/13/15

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F 314	<p>Continued From page 5</p> <p>Is listed under the facility's "Wound and Skin Care Procedures Quick Reference/Guidelines", as recommended for full thickness Stage 3 or 4 wounds with copious (heavy) drainage. The recommended treatment for DTI's, which are unstageable wounds, would be application of sure prep (a protective clear treatment application). This guideline documented that a written physician's order was required. There was no evidence of a physician's order for the Optifoam treatment.</p> <p>Medline Industries (manufacturer of Optifoam), description and indications for use of Optifoam described the dressing as highly absorbent and appropriate for partial and full thickness wounds, DTI is not listed.</p> <p>11/26/14-The wound skin integrity report, a chart that documented the progression of the wound each week, documented the initial status of R85's wound as two small areas, present on admission, deep tissue injury, intact, with no depth and no drainage.</p> <p>November 2014 TAR for R85 documented administration of Optifoam through end of the month.</p> <p>12/3/14- The wound skin integrity report documented the wound as epithelial (inner layer of tissue) with superficial depth and minimal drainage.</p> <p>12/10/14- The wound skin integrity report, documented the wound as epithelial with slough present, no measurement of depth, and no drainage.</p>	F 314	<p>F314 Continued</p> <p>C. New admissions with skin integrity areas identified and change in condition for skin assessments will be reviewed by the DON/designee at morning clinical meetings to discuss treatments & verification of physician orders obtained.</p> <p>D. The DON/designee will complete a random audit (see Attachment D) of 10% of the population weekly to determine if Skin Integrity Reports have anatomical location identified per facility guidelines and treatment identified per physician order until 100% compliance occurs for 3 consecutive evaluations. Then audits will occur monthly until 100% compliance occurs for 3 consecutive evaluations. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>		

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F 314	<p>Continued From page 6</p> <p>12/17/14 - The wound skin integrity report documented the wound as epithelial with slough present, 1.5 centimeters in depth and moderate drainage.</p> <p>December 2014 TAR documented administration of Optifoam to R85 until the order was changed on 12/26/14 to Santyl. Review of the physician's progress notes indicate the first documented assessment of R85's wound by the physician was on 12/26/14.</p> <p>During an interview on 1/14/15 at 2:45 PM E7 (RN, facility wound care nurse) confirmed R85's wound as initially staged as a DTI. E7 then explained that the original treatment order was appropriate and used to protect R85's intact skin, for cushioning, to create moistness to facilitate healing and to absorb drainage if the wound opened as well. E7 was unable to recall if the Optifoam was E17's, (medical doctor), recommendation because the exact note and order was not available.</p> <p>1b.11/25/15-R85's initial admission assessment documented the anatomical location of the wound was at the center of the sacrum.</p> <p>11/28/14- The treatment order transcribed to the TAR identifies the anatomical location of the wound as the "gluteal fold".</p> <p>12/1/14- The December 2014 TAR identifies the anatomical location of the wound as the "gluteal fold" with "sacral" written as well.</p> <p>12/28/14-Revised TAR, as a result of a change in treatment identifies the anatomical position of the wound as "sacral areas".</p>	F 314		

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F 314	Continued From page 7 During an interview on 1/12/14 at 2:41PM with E7 it was confirmed that R85's wound is and has always been on the sacrum. E7 explained the reason for two anatomical descriptions (some references to gluteal fold and some references to sacrum) on clinical documentation "because its all there in the same place it's the coccyx (tailbone) sacral area where they open the gluteal fold the crease the sacral area is there". E7 further elaborated stating the "gluteal fold is what you call the area when you spread (the buttocks) then the coccyx sacral area is the whole area". E7 did not think using two anatomical descriptions of the wound would be confusing to staff and stated "I think they get the whole picture of it, it's in the sacral area, once you pull (the buttocks) but that's what the folds are." E7 used two different anatomical descriptions to document the location of a single wound on R85's clinical record. E7 also initiated a treatment incompatible with the type of wound present on R85 according to recommended guidelines. Variations of anatomical location of the wound on the clinical record and failure to implement treatment according to facility recommended regimen indicate a failure of the facility to ensure that R85 received the necessary treatment and services to promote healing. These findings were reviewed with E1, NHA and E2, DON on 1/13/16 at 3 PM	F 314		
F 329 SS=E	483.26(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

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F 329	<p>Continued From page 8</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to monitor for changes in behavior, identify specific target behaviors and failed to consistently provide non-pharmacological interventions prior to the prn (as needed) administration of Ativan (anti-anxiety medication) for 1 (R40) out of 35 stage 2 sampled residents. Findings include:</p> <p>R40 was admitted to the facility in 2014 with diagnoses including an anxiety (nervousness, fear and worrying) disorder and</p>	F 329	<p>F329</p> <p>A. R40 is being followed routinely by the psychiatric nurse practitioner (NP) from MedOptions. She was evaluated for the use of prn Ativan on 12/12/14 with the recommendation for continuing plan of care per resident preference. A follow up visit from the NP is scheduled for 2/4/15. A request for pharmacist consultation was also requested as resident is due in February for her quarterly review. The pharmacist consultant review is scheduled for 2/5/14.</p> <p>B. The Administrator completed an audit (see Attachment E) of all residents with prn psychoactive medications on 2/2/15 and all residents have behavior monitoring sheets with indications for use of prn medication and nonpharmacological interventions in place.</p> <p>C. The NPE will complete education for all nurses by 3/6/15 to include the following: Psychotherapeutic Medication Use Policy, Documentation on the Behavior Monitoring Record with focus on nonpharmacologic interventions,</p>	3/13/15

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F 329	<p>Continued From page 9</p> <p>depression (mental disorder with feelings of sadness).</p> <p>Review of R40's January 2015 physician order sheets revealed an order, dated 5/19/14, for Ativan 1 milligram by mouth 3 times a day prn anxiety.</p> <p>Review of R40's MARs for October, November and December 2014 revealed that R40 received prn Ativan approximately 19-28 times per month during this time period.</p> <p>Behavior Monitoring Records for October through December 2014 listed the target behavior "Restlessness with anxious concerns." Restlessness with anxious concerns was identified as a target behavior approximately 3- 9 times per month during this time period. The back of the MARs stated that Ativan was given for anxiety. Additionally, the facility only listed non-pharmacological interventions on the behavior sheets 3-9 times per month, although Ativan was given 19-28 times per month. The outcome of the non- pharmacological interventions used were not consistently recorded.</p> <p>E2 (DON) was interviewed on 1/13/15 at 8:10 AM. E2 confirmed that specific target behaviors (behaviors exhibited) for prn Ativan were usually not documented for October through December 2014. E2 stated that nurses might be writing anxiety on the back of the MAR as the reason Ativan was given because it's what the physician wrote the order for.</p> <p>The facility failed to consistently provide corresponding indications for the use of prn</p>	F 329	<p>F329 Continued</p> <p>C. and Medication Administration documentation for prn medications indicating target behavior and effect (see Attachment B).</p> <p>D. DON/designee will complete weekly audits (see Attachment B) for all residents on psychoactive prn medications for identified target behaviors and nonpharmacological interventions until 100% compliance achieved on 3 consecutive evaluations. Then monthly audits until 100% compliance achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	

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F 329	Continued From page 10	F 329	F364	3/13/15
F 364 SS=E	Ativan other than for "anxiety"; they failed to identify specific target behaviors and they infrequently used non-pharmacological interventions prior to administering Ativan. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide foods that were palatable for temperature. Findings include: 1. During a lunch observation on 1/9/15 around 12:20 PM test trays were observed; Dining room plate #2 -pizza 117.4F (Fahrenheit) and cool to taste -green beans 92F and cold to taste 2. During a lunch observation on 1/13/15 around 12:30 PM test trays were observed; Dining room plate #1 -pepperoni pizza 110F and cool to taste These findings were reviewed on 1/13/15 1:45 PM with E1, NHA and E11, Food Service Director.	F 364	A. The FSD met with 3 dietary aides and a cook on 1/13/15 to discuss the policy for food temperatures. B. Residents towards the end of meal service in the first and second floor dining rooms had the potential to be affected. C. The FSD completed education with all dietary employees by 1/29/15 regarding food temperatures and procedures to follow for ensuring proper temperatures prior to meal service (see Attachment F). The Food Service Director (FSD) and Chef Manager identified certain food items with difficulty holding temperatures and changed the process for two deliveries to the kitchenettes for those items. A Root Cause Analysis was conducted on 2/2/15 to determine various other potential causes for food temperature issues. Maintenance checked the steam tables on 2/3/15 in the first and second floor kitchenettes to ensure heating element working properly. Steam tables will be placed on high at least an hour before meal service and lasers will be utilized to test water temperature to ensure it is high enough to maintain proper food	
F 371	483.35(l) FOOD PROCURE,	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2015
NAME OF PROVIDER OR SUPPLIER LOFLAND PARK CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 E. KING STREET SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371 SS=E	<p>Continued From page 11</p> <p>STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to distribute and serve food under sanitary conditions. Findings include:</p> <p>1a. During a lunch observation in the 2nd floor kitchenette on 1/8/15, E12 (Dietary Aide) was observed plating food from approximately 12:10 PM to 12:30 PM. E12 wore a black cap that covered only the top of her head; her shoulder length hair was not pulled back or covered.</p> <p>While plating food for the dining room, E12 was observed multiple times touching non-food contact surfaces (plates, serving utensils, etc.) and then reaching into a bag repeatedly for rolls to make sandwiches despite her gloves being contaminated.</p> <p>When E12 changed her disposable gloves, she failed to perform handwashing or any type of sanitizing between glove changes.</p> <p>b. During the lunch observation on 1/8/15 from</p>	F 371	<p>F364 Continued</p> <p>C. temperature. Additional education will be completed with dietary staff with process for steam tables by 2/17/15 (see Attachment G).</p> <p>D. The FSD/designee will complete daily audits (see Attachment H) of food temperatures until 100% compliance achieved on 3 consecutive evaluations. Then weekly until 100% compliance on 3 consecutive evaluations, then monthly until 100% compliance achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/13/2015
NAME OF PROVIDER OR SUPPLIER LOFLAND PARK CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 E. KING STREET SEAFORD, DE 19973	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 12</p> <p>approximately 12:40 PM to 12:45 PM, E13 (Dietary Aide) plated food for the halls (residents eating in their rooms) and there were multiple observations of her touching non-food contact surfaces (thus, contaminating her gloves) and then touching food (reaching into a bag for rolls).</p> <p>2a. During a second lunch observation in the 2nd floor kitchenette on 1/13/15, E12 (Dietary Aide) was observed plating food from approximately 12:10 PM to 12:20 PM. While plating food for the dining room, E12 was observed picking up pizza and other food items multiple times with contaminated gloves that had already touched non-food contact surfaces such as the refrigerator handle, plates, etc.</p> <p>b. During the lunch observation on 1/13/15 from approximately 12:15 to 12:25 PM, E14 (Dietary Aide) was observed making sandwiches. While assembling sandwiches, E14 was observed repeatedly touching the bread bag while reaching in to remove slices of bread, getting stacks of plates and using a knife to cut sandwiches before placing them onto plates. E14 wore the same pair of gloves to assemble sandwiches that had already touched non-food contact surfaces and were contaminated. Findings were reviewed with E1 (NMA) and E2 (DON) during the exit conference on 1/13/15 at approximately 3:50 PM.</p> <p>3. During the lunch service observation in the first floor kitchenette on 1/13/15 between 12:00 and 12:45 PM the following was observed;</p> <p>Dietary Aide E15, was observed taking the temperatures of the foods on the steam table wearing gloves. When she put the temperature</p>	F 371	<p>F371</p> <p>A. The FSD met with 3 dietary aides and a cook on 1/13/15 to discuss the policy for handwashing, hairnets usage, and cross contamination.</p> <p>B. Residents being served on the first and second floors for lunch had the potential to be affected.</p> <p>C. The FSD completed education by 1/29/15 with all dietary employees regarding the following: proper procedure for wearing hair net, proper handwashing, cross contamination from nonfood surfaces to food surfaces, and gloves & food handling (see Attachments I, J, & K). Beginning 1/26/15, Administrative staff assisting with the dining room observation initiated providing assistance and direction to dietary staff for ensuring proper sanitation during meal service. All staff will receive education regarding food sanitation by 3/6/15 (see Attachment L).</p> <p>D. The FSD/designee will complete daily audits (see Attachment M) of food sanitation until 100% compliance achieved on 3 consecutive evaluations. Then weekly until 100% compliance on 3 consecutive</p>	3/13/15

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NAME OF PROVIDER OR SUPPLIER LOFLAND PARK CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 716 E. KING STREET SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 13 log book away she removed her gloves and washed her hands for about 3 seconds, not the recommended 20 seconds. E15 donned new gloves and began to put soup in bowls. E15 twice went to a cupboard to retrieve more bowls, contaminating her hands. E15 then proceeded to use her gloved hand to touch pizza slices while putting the pizza on a plate. E15 touched at least 11 slices of pizza with her contaminated gloves. These findings were reviewed on 1/13/15 at 1:45 PM with E1 and E11, Food Service Director.	F 371	F371 Continued D. evaluations, then monthly until 100% compliance achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Lofland Park Center

DATE SURVEY COMPLETED: January 13, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from January 6, 2015 through January 13, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 99. The survey sample totaled 35.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p>		

Provider's Signature *Yvonne D. ...* Title *Administrator* Date *2/3/2015*



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

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3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

Page 2 of 2

NAME OF FACILITY: Lofland Park Center

DATE SURVEY COMPLETED: January 13, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>This requirement is not met as evidenced by: Cross refer to CMS 2567-L, survey date completed January 13, 2015 F272, F314, F329, F364, and F371.</p>	<p>Cross reference to the CMS-2567(02-99) survey: F272, F314, F329, F364 and F371</p>	<p>03/13/15</p>

Provider's Signature *Shirley Adams, MD, MBA* Title Administrator Date 2/3/2015