

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

PRINTED: 03/23/2016
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 03/14/2016
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 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from March 7, 2016 through March 14, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 101. The Stage 2 sample totaled twenty eight (28) residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse Aide; MDS - Minimum Data Set-standardized assessment form used in nursing homes; RNAC - Registered Nurse Assessment Coordinator; MD - Medical Doctor; ADL (Activities of Daily Living) - tasks needed for daily living i.e., dressing, hygiene, eating, toileting, bathing; BM (Bowel movement) - stool; i.e.-that is; MOM (Milk of Magnesia) - Laxative; mg (milligram) - Unit of weight; mL (Milliliter) - Unit of volume; PO - By mouth; PRN - As needed; Bisacodyl - Laxative; Constipation - Difficulty in passing stool; Flaccid - limp.	F 000			
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Theresa Dennis, PhD, NHA TITLE
Center Executive Director (X8) DATE
3/31/16

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 241 SS=D	<p>Continued From page 1 INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on dining observations and interviews, it was determined that the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for four (R35, R67, R79 and R185) out of 28 sampled residents. For R35, R67 and R79, the facility failed to ask the resident's permission before putting a clothing protector in place. For R185, the resident watched another resident being feed for 23 minutes before she was assisted with feeding. Findings include:</p> <p>1. During lunch observation in the first floor dining room on 3/11/16 from 11:55 AM to 1:15 PM, the following were observed: *At 11:55 AM, E14 (CNA) was observed placing a white terry clothing protector around R79's neck, without asking permission from this alert resident. *At 12:08 PM, E14 was observed placing a white terry clothing protector around R35's neck, without asking permission from this alert resident. *At 12:57 PM, E14 was observed placing a white terry clothing protector around R67's neck, without asking permission from this alert resident.</p> <p>These findings were reviewed with E4 (ADON) on 3/11/16 at 3:00 PM who confirmed none of these</p>	F 241	<p>F241</p> <p>A. R79, R35, and R67 were reviewed by the interdisciplinary team (IDT) on 3/25/16 and determined that all three of these residents need to be asked about their preference for a clothing protector prior to each meal. A scheduled seating has been developed to ensure R185 is not waiting to be fed while others are eating.</p> <p>B. Current residents have the potential to be affected.</p> <p>C. A root cause analysis (RCA) was completed on 3/25/16 to determine potential causes for staff not asking residents about clothing protectors prior to placing it on residents and a resident waiting to be fed while others at her table were eating and for why a resident would wait to be fed. Activities of daily living (ADL) care plans will be updated for residents regarding clothing protectors by 4/1/16. On 3/29/16 a new process was developed for</p>	4/28/16	

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F 241	Continued From page 2 3 residents had care plans that included not needing to be asked permission before placing clothing protectors. 2. During lunch observation in the first floor dining room on 3/9/16 from 11:45 AM to 1:30 PM, the following were observed: *At 1:03 PM, R185 was wheeled into the dining room and placed at a table where another resident was being fed by E13 (CNA). *At 1:05 PM, a server placed a plate of food in front of R185. *At 1:08 PM, E13 took R185's plate of food back to the kitchen because no one was available to feed this resident who was totally dependent for feeding. *At 1:10 PM, server put a closed carton of milk on table in front of R185 which went untouched. *At 1:25 PM, E13 obtained a plate of food from the kitchen and started to feed R185. R185 sat at a dining room table, watching another resident, who was being fed, for 23 minutes before she was fed her lunch. These findings were reviewed with E4 on 3/11/16 at 3:00 PM. These findings were reviewed with E1 (NHA) and E2 (DON) on 3/14/16 at 2:00 PM.	F 241	C. Contiued residents eating meals in the dining room. Effective 3/30/16 a nurse has been assigned to the dining room on first floor due to the high volume of residents needing assistance with meals. Cue cards were placed on 3/30/16 in the cabinets with the clothing protectors as a reminder to staff to ask residents (See Attachment A). Education will be completed by current staff on dignity by 4/21/16 (See Attachment B). D. The DON/Designee will complete daily audits (See Attachment C) of residents being asked for clothing protectors & residents at one table all being served at same time until 100% compliance achieved on 3 consecutive evaluations, then weekly until 100% compliance on 3 consecutive evaluations, then monthly until 100% compliance on 3 consecutive evaluations. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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	F 279		

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F 279	<p>Continued From page 3</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for 4 (R4, R10, R193 and R213) out of 28 sampled residents the facility failed to ensure a comprehensive care plan was developed based on the assessment and identified needs. Findings include:</p> <p>1. R213 was admitted to Hospice services on 2/24/16. Review of the care plan on 3/11/16 lacked evidence that a care plan for end of life / Hospice services had been initiated.</p> <p>An interview on 3/11/16 at 11:19 AM with E4 (ADON, unit 1) confirmed that Hospice services were in place on 2/24/16. There was also no evidence that a Hospice care plan had been initiated by the facility.</p> <p>2. 10/10/15 - R193 was admitted to the facility's locked Homestead unit.</p> <p>1/17/16 - Quarterly MDS assessment showed the</p>	F 279	<p>F279</p> <p>A. R213 hospice care plan and R193 ADL care plan were initiated on 3/11/16. R4 ADL care plan was revised to reflect flaccid on left side 3/14/16. R10 impaired communication was revised on 3/15/16.</p> <p>B. A complete audit for ADL care plans was completed on 3/11/16 and current residents have an ADL care plan in place. 7 hospice residents were reviewed on 3/23/16 and care plans for hospice are in place. An audit was completed for all ADL and impaired communication care plans to determine accuracy by 4/1/16.</p> <p>C. RCAs were completed for hospice care plan not being initiated, ADL care plan not being initiated, and incorrectness of information in care plans. A Hospice communication form was developed on 3/28/16 (See Attachment D) for hospice providers to communicate when a resident has been denied or opened with hospice. All forms</p>	4/28/16	

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F 279	<p>Continued From page 4</p> <p>resident required limited assistance with personal hygiene.</p> <p>3/11/16 - Review of R193's care plan (initiated 10/10/15, revised 2/10/16) found it lacked a problem about ADLs. There was no evidence that an ADL entry had ever been initiated for this resident.</p> <p>3/11/16 interview at 9:15 AM with E10 (Homestead Manager). When asked what care plan entry would be included when a resident required limited supervision with personal hygiene, E10 stated it would be the ADL problem. E10 reviewed R193's care plan and confirmed there was no ADL entry.</p> <p>3. Random observations during the days of 3/7/16 and 3/8/16 revealed R4 is flaccid on the left side. Review of the care plan dated 02/16/16 revealed a problem stating that R4 is flaccid on the right side.</p> <p>An interview on 3/11/16 at 10:45 AM with E5 (ADON) and E12 (LPN) confirmed that R4 is flaccid on the left side. Therefore the care plan was not accurate.</p> <p>4. Random observations during the days of 3/7/16 and 3/8/16 revealed R10 is hard of hearing and does not wear a hearing aid. Review of care plans dated 10/21/15 and 01/13/16 revealed a problem of R10 being hard of hearing, and included an intervention of staff ensuring he was wearing a hearing aid.</p> <p>An interview on 3/11/16 at 10:45 AM with E5 and</p>	F 279	<p>C. Continued</p> <p>will be discussed in the next morning clinical meeting so the entire IDT is aware and care plan is initiated. All residents admitted to facility will have ADL care plan initiated, even if independent with ADLs upon admission. When nurses complete admission assessment, in addition to checking communication appliances (i.e. hearing aide), a note will be made in the comment section as to whether the appliance is with the resident. Education will be completed with current staff documenting in the electronic medical record (EMR) regarding the initiation and revision of care plans by 4/21/16 (See Attachment B).</p> <p>D. The DON/Designee will complete daily audits (See Attachment E) on 10% of the resident population for care plan accuracy for initiation and revision of the focus, goals, and interventions until 100% compliance achieved on 3</p>		

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F 279	Continued From page 5 E9 (Social Services) confirmed that R10 has never had a hearing aid. Therefore the care plan was not accurate.	F 279	D. Continued		
F 309 SS=E	<p>These findings were reviewed with E1 (NHA) and E2 (DON) on 3/14/16 at 2:00 PM.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R213) out of 28 sampled residents the facility failed to implement the protocol for constipation according to the plan of care. Findings include:</p> <p>The facility's Prevention for Constipation/Bowel Protocol included the following instructions:</p> <p>Review of bowel elimination pattern using alerts found under the PCC [Point and Click Care] Clinical Dashboard (electronic medical record) page every shift. Initiate the following PRN measures when resident triggers on dashboard at shift 9 or 10 of no BM.</p> <p>Step 1: Administer MOM 30 mLs po or Bisacodyl</p>	F 309	<p>consecutive evaluations, then weekly until 100% compliance on 3 consecutive evaluations, then monthly until 100% compliance on 3 consecutive evaluations. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p> <p>F309</p> <p>A. R213 was started on routine medication on 2/16/16 and no further issues with constipation have occurred.</p> <p>B. Current residents have the potential to be affected.</p> <p>C. A RCA was completed on 3/25/16. Documentation of the bowel protocol steps will be done on the bowel protocol medication</p>	4/28/16	

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F 309	<p>Continued From page 6</p> <p>5 mg tab po; Step 2: If still no BM noted the following shift, administer Bisacodyl suppository one per rectum; Step 3: If still no BM noted the following shift administer tap water enema or fleets enema one per rectum.</p> <p>The following was reviewed in R213's clinical record:</p> <p>1/4/16 - Care plan for constipation included the following approaches: -administer medications as ordered and observe for effectiveness and side effects and report to MD as indicated -monitor and record bowel movements -encourage resident to consume all fluids during meals -assess for signs and symptoms of constipation i.e., nausea, vomiting, headache, abdominal distension and cramping.</p> <p>1/7/16 6:50 PM - Nurse's note stated that step 1 of bowel protocol was given at 5 PM results pending. 1/8/16 6:28 PM - Nurse's note stated that step 1 of bowel protocol was initiated, results pending.</p> <p>The facility failed to implement step 2 on the night shift after initiating the protocol on 1/7/16, instead waited 24 hours to re-start the protocol. The resident had a BM on 1/9/16.</p> <p>1/30/16 6:23 PM - Nurse's note stated step 1 of bowel protocol given with results pending. The bowel protocol documented that step 1 was given at 3:45 PM with no results. 1/31/16 11:52 AM - Nurse's note stated that step 2 of the bowel protocol was given with results</p>	F 309	<p>C. Continued</p> <p>administration record (MAR) and the bowel protocol guidelines and physician order sheet were revised (See Attachment F). When the bowel protocol has been initiated for a resident, the nurse will flag the MAR until the resident has had a bowel movement. In the event documentation is indicated in the EMR, the documentation should include details of the abdominal assessment. Education will be completed for current nurses regarding the bowel protocol procedures by 4/21/16.</p> <p>D. The DON/Designee will complete daily audits (See Attachment G) of 100% of residents on the bowel protocol until 100% compliance achieved on 3 consecutive evaluations. Then weekly until 100% compliance on 3 consecutive evaluations, then monthly until 100% compliance on 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 309	Continued From page 7 pending. The bowel protocol documented step two at 11:40 AM with good results. The facility waited two shifts to initiate step 2 of the protocol. 2/5/16 10:59 AM - Nurse's note stated that step one of the bowel protocol, results pending. The bowel protocol documented that step 1 was administered at 10:00 AM. 2/6/16 6:30 AM - Nurse's note stated that step two of the bowel protocol was given with large results. The facility failed to implement step 2 on evening shift after initiating the protocol on 2/5/16. 2/13/16 10:20 AM - Nurse's note stated that step 1 of bowel protocol was given this am with results pending. The bowel protocol documented administration at 8:00 AM. There was no further bowel protocol implemented. The resident had a BM documented on 2/14/16 at 12:32 PM. 2/16/16 - A physician's order for a daily medication for constipation was obtained. During an interview on 3/9/16 at 10:24 AM with E11 (LPN) the above was reviewed. E11 stated that if there was anymore information on the implementation of the bowel protocol she would look for it. No further information was obtained. These findings were reviewed with E1 (NHA) and E2 (DON) on 3/14/16 at 2:00 PM.	F 309		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463	F463 A. Room 107B call light was replaced on 3/7/16. Room 124 bathroom call bell cord was changed on 3/23/16. B. On 3/7/16 an audit was completed for every room and all call bells are functioning properly. Audits were completed for all bathroom call lights. As a result of audits, bathroom call light cords were shortened or lengthened as needed, and all call light cords hang freely.	

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F 463	<p>Continued From page 8</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure all parts of the call bell system were functioning. Call bells weren't functioning in 2 (rooms 107 and 124) out of 33 rooms surveyed. Findings include:</p> <ol style="list-style-type: none"> 1. An observation made on 03/07/16 at 10:51 AM revealed that the call bell in room 107 would not activate when the button was pushed. The call bell was repaired the same day. 2. An observation made on 03/07/16 at 11:19 AM revealed that the room 124 bathroom call bell cord was wrapped around the grab bar, preventing the call bell from functioning when activated from below the grab bar. <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 3/14/16 at 2:00 PM.</p>	F 463	<p>F463 Continued</p> <p>C. A RCA was completed on 3/25/16 regarding call light not functioning and call bell cord wrapped around bathroom grab bar. Education will be completed for housekeeping checking call bells during visit to rooms for daily cleaning. Education will be completed for current staff regarding process for work orders for call bell issues. All education will be completed by 4/21/16.</p> <p>D. The Administrator/Designee will complete daily audits (See Attachment H) of 10% of resident call bells until 100% compliance achieved on 3 consecutive evaluations. Then weekly until 100% compliance on 3 consecutive evaluations, then monthly until 100% compliance on 3 consecutive evaluations. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	4/28/16	

Always Remember to ASK all Residents...
“Would you like a clothing protector today?”



Always Remember to ASK all Residents...
“Would you like a clothing protector today?”



State Survey Plan Of Correction 2016

Lofland Park Center
April 2016



F241 Dignity

- ◆ **Dining:** Staff should promote independence and dignity in dining including the avoidance of:
 - ◆ Wearing gloves while serving beverages and food to residents.
 - ◆ Day-to-day use of plastic cutlery and paper/plastic dishware.
 - ◆ Staff standing over residents while assisting them to eat.
 - ◆ Staff interacting/conversing only with each other rather than with residents, while assisting residents.
 - ◆ Disrespect: showing respect to residents by addressing the resident with a name of the resident's choice, avoiding use of labels for residents such as "feeders," not excluding residents from conversations or discussing residents in community settings in which others can overhear private information.



F241 Dignity & Respect of Individuality

➤ The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.



Dining:

- Use of Clothing Protectors instead of napkins. (except by resident choice). Do not refer to Clothing Protectors as "Bibs".
- Staff must ask resident if he/she would prefer the use of a clothing protector during meals. It is not acceptable for staff to place a clothing protector on a resident without first asking permission.
- For all residents that are not able to express preference for clothing protector, responsible party will be contacted for permission and Activities of Daily Living (ADL) care plan will be updated to include acceptable use of clothing protectors for those residents.

F241 Dignity

- ◆ **Grooming:** Residents should be groomed as they wish to be groomed maintaining the resident's personal preferences regarding hair length/style, facial hair for men, removal of facial hair for women, and clothing style.
- ◆ **Clothing:** Encourage and assist residents to wear their own clothing rather than hospital-type gowns.



- Residents that require feeding assistance should not be taken into the dining area until a staff member is available to assist the resident with the meal.
- It is not acceptable for a resident to be placed in the dining room with other residents eating. Food should not be placed in front of the resident until a staff member can assist resident with meal.
- **New dining room format 1st floor:** The staff member is to bring the resident to be assisted with feeding one at a time. For example, if you finish assisting one member, as you are bringing them out of the dining room, you may bring the next resident into the dining room. The short hall nurse will be responsible for checking the dining room status and offer assistance for each meal. If there are no issues or assistance needed, then the nurse may return back to their other duties.

Reminder Cue cards have now been placed in the cabinets with the clothing protectors as a reminder to staff to ask resident.

Always Remember to ASK all Residents...
"Would you like a clothing protector today?"



F279 Develop Comprehensive Care Plans



- The 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.

F241 Dignity

- ◆ Respecting residents' space, not changing radio or TV station to suit staff, knocking, keeping belongings where resident likes them.



POLICY
A comprehensive, individualized care plan will be developed by the interdisciplinary team for each patient. The care plan will include measurable objectives to meet patient needs and goals as identified by the assessment process.

PURPOSE
To provide necessary care and services to attract, maintain the patient's highest achievable physical, mental, and psychosocial wellbeing.

PRACTICE STANDARDS
An initial care plan is developed within 24 hours of admission.
The comprehensive care plan is:

- Developed within seven days of completion of the comprehensive assessment.
- Based on Nursing Assessment, subsequent assessments, Care Area Assessment (CAA), and other observations.
- Coordinated by appropriate staff, and
- Reviewed and revised a minimum of quarterly and as needed to reflect response to care and changing needs and goals.

 The PointClickCare (PCC) care plan library is used to develop the patient's care plan.

- The care plan must be customized to each individual patient's needs.
- If there is not a care plan available to meet a patient's need, Center staff may develop one using the custom care plan in PCC.

 Patients and/or health care decision makers are invited to participate in care plan meetings.

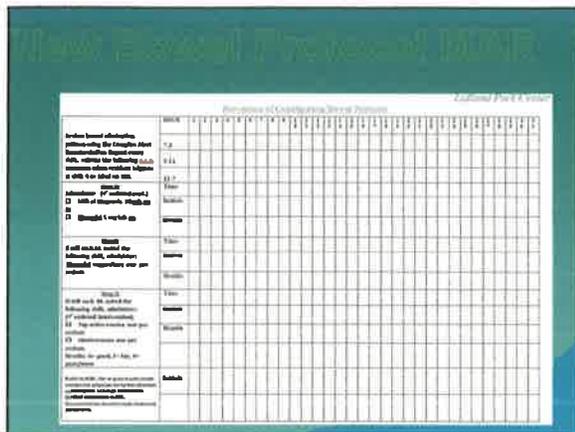
Quality of Life



Focus is on treating the resident with dignity and creating a homelike atmosphere where the resident has control over their life.

F279 Develop Comprehensive Care Plans

- Care plan should be initiated/updated for **all** residents receiving end of life/Hospice services.
- Care plan should be initiated/updated for **all** residents to include ADL function, even if independent with ADLs upon admission.
- Care Plan focus, goals and interventions should be reviewed and updated as needed for accuracy.



- Any staff member that discovers that a resident call light is not functioning properly, bathroom cord is too long in length and/or frayed, etc. needs to complete a work order using the TELS work order system online. www.tels.net
 - * * Staff can refer to the step by step instructions provided in the COMPUTER HOW-TO GUIDE at each nursing station.
- Bathroom call bell cord should not be wrapped around grab bar, preventing the call bell from functioning when activated from below the grab bar.

- ### F463 – Resident Call System – Rooms/Toilet/Bath
- ◆ The nurses' station must be equipped to receive resident calls through a communication system from resident rooms, and toilet and bathing facilities.

Nsg101 Call Lights

POLICY
All Genesis HealthCare patients will have a call light or alternative communication device within their reach at all times when unattended. Staff will respond to call lights and communication devices promptly.

PURPOSE
 To ensure safety and communication between staff and patients.





LOFLAND PARK
HOSPICE COMMUNICATION

Which hospice:

Date of visit:

Residents name:

Outcome of intake:

ACCEPTED

DENIED

If accepted when will services begin?

Comments: _____



Lofland Park Center

TITLE: Bowel Protocol	
CATEGORY: Guideline	Page: 1 of 2

Purpose: To provide a framework and guidelines for the implementation of the Bowel Protocol in order to minimize and treat episodes of constipation for an at risk population.

Patient/Resident Outcome: Treat and minimize episodes of significant constipation.

Staff Outcome: Staff will be knowledgeable of the Bowel Protocol.

Personnel: R.N., L.P.N., C.N.A.

Guidelines:

1. Constipation can be defined as: “a condition in which there is difficulty in emptying the bowels, usually associated with hardened feces.”
2. The Bowel protocol orders consists of a set of “as needed” measures to be implemented in the event that the resident/patient has had no bowel movement in a 9-10 shift time frame.
3. This order set will be requested and completed for every resident and patient of the facility. The physician may choose to prescribe an alternate approach to the treatment of constipation as he or she deems appropriate.
4. The Bowel Protocol form (attached) will be completed and individualized for each resident/patient and will be included in the admission/readmission packet for completion.
5. Routine daily laxatives may be ordered as per physician order. This protocol strictly includes as needed medication measures.
6. The assessment of the patient/resident for abdominal distension, presence and character of bowel sounds as well as palpation of the abdomen for tenderness are important elements when assessing the resident/patient.
7. C.N.A.s and/or nurses document bowel movements in Point Click Care (PCC) computer application under the Point of Care (POC) charting for each resident/patient during each shift.
8. The Nurses will review the Complex Alert Documentation Report each shift. They will confirm the validity of the B.M. alert to the best of their knowledge. The Nurse will initiate the protocol M.A.R. for each resident confirming their review of the report.
9. Once the alert is confirmed, the nurse will implement step 1 of the Bowel Protocol and administer either MOM or a bisacodyl tab as per protocol order.
10. During the next shift, the nurse will confer with the C.N.A and review PCC to ascertain if the resident has had a bowel movement following the administration of MOM or bisacodyl po tabs.
11. If there was still no B.M., the nurse will implement step 2 of the protocol by administering a bisacodyl suppository per rectum.
12. During the shift, the nurse will confer with the C.N.A. and review PCC to ascertain if the resident has had a bowel movement following the administration of the suppository.

13. If there is still no B.M., the nurse will implement step 3 of the protocol and administer either a tap water enema or fleets enema as ordered in the protocol.
14. Results of the enema are to be described as good, fair or poor/none and documented as such on the Bowel Protocol MAR.
15. If the 3 steps of the protocol are carried out and there is not a desirable result, the nurse is to complete a Change of Condition – Medical within PCC and notify the physician accordingly for further direction. Documentation should include abdominal assessment. The physician may be notified the next morning during awake hours unless the resident/patient condition warrants immediate notification.
16. The alert for the resident is not to be cleared until such time that it is confirmed that the resident has had a bowel movement.

Attachments:

- Prevention of Constipation/Bowel Protocol order set N1204 (3/2016) – file under physician order heading of paper chart
- Prevention of Constipation/Bowel Protocol M.A.R. – maintain in M.A.R. binder current month and file completed month in M.A. R. section of the paper chart.

Patient Label



Lofland Park Center Physician Orders

NKA

ORDERS: Another brand of generically equivalent product identical in dosage form and content of active ingredient may be administered unless otherwise indicated

Allergies, Sensitivities, Contraindications	REACTION Circle Response(s)	Allergies, Sensitivities, Contraindications	REACTION Circle Response(s)
Latex Allergy? YES or NO If yes, circle response →	Airway constriction Rash Hives OTHER: _____		Airway constriction Rash Hives OTHER: _____
	Airway constriction Rash Hives OTHER: _____		Airway constriction Rash Hives OTHER: _____
	Airway constriction Rash Hives OTHER: _____		Airway constriction Rash Hives OTHER: _____
	Airway constriction Rash Hives OTHER: _____		Airway constriction Rash Hives OTHER: _____

Date & Time	Nurse Initial	Reviewed Initial	(If Medication order) Medication Name	Dose	Route	Frequency/ Time Interval	Reason/ Indication for use	Read Back (RB)
PREVENTION OF CONSTIPATION / BOWEL PROTOCOL								
Refer to admission orders for routine medications ordered.								
Nutrition consult								
Encourage physical activity and assist as needed.								
Medication Orders								
			1. If no bowel movement in 9 or 10 shifts give: <input type="checkbox"/> Milk of Magnesia 30 ml PO or <input type="checkbox"/> Bisacodyl 5 mg PO					
			2. If still no bowel movement noted the following shift after Bisacodyl PO or MOM, give: Bisacodyl Suppository PR x 1					
			3. If still no bowel movement noted the following shift after Bisacodyl suppository, give: <input type="checkbox"/> Tap water enema PR <input type="checkbox"/> Fleets enema PR x 1					
			If no results from enema, contact physician for further orders.					
			Physician Signature:					<input type="checkbox"/> RB

A check mark in the "RB" box indicates telephone/verbal orders were read back and verified



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Lofland Park Center

DATE SURVEY COMPLETED: March 14, 2016

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>An unannounced annual survey was conducted at this facility from March 7, 2016 through March 14, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 101. The Stage 2 sample totaled twenty eight (28) residents.</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> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 14, 2016 F241, F279, F309, and F463</p>	<p>Cross reference to the CMS-2567(02-99) survey:</p> <p>F241, F279, F309, F463</p>	<p>04/28/16</p>

Provider's Signature *Thomas Dennis, FDD, MHA* Title Center Executive Director Date 3/31/16