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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085040		C 04/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFLAND PARK CENTER	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 complaint survey was conducted at this facility from March 27, 2014 through April 4, 2014. The deficiencies cited in this report are based on record reviews, staff and resident interviews, and review of other documentation as indicated. The facility census the first day of the survey was 100. The sample size included six (6) residents.	F 000		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to ensure that three (R3, R6 and R2) out of six sampled residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care. On multiple occasions the facility failed to administer prescribed medications in a timely manner when the residents were newly admitted or readmitted to the facility. Findings include: The Policy titled Pharmacy Services documented	F 309	F309 A. Resident R3 and R6 no longer reside in the facility. Resident R2 is currently receiving all medications as ordered by the physician. B. An audit was conducted on all new admissions/readmissions from 4/15/14 through 4/28/14 and all patients are receiving medications as prescribed by physician. All nurses were educated on policies, procedures, and protocol for medication reconciliation and obtaining medications for new admissions/re-admissions (Attachment A). C. On 3/13/14, the Administrator and Nursing Leadership identified a process issue with obtaining medications from the pharmacy. The pharmacy liaison was contacted for	5/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tawnya Dennis, BSN, NHA — TITLE: Administrator — (X6) DATE: 4/30/14

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 309	Continued From page 1 that the facility will communicate new medication orders to the pharmacy in accordance with pharmacy guidelines ... and that the purpose was to assure a standardized process for the communication of medication orders to the pharmacy. The process documented that information provided to the pharmacy regarding a new admission is sent using a completed Physician Order Sheet. The document titled Delivery Cut-off Times documented that if medication orders are faxed to the pharmacy before 8:00 AM the medication will arrive mid-afternoon the same day. If the medication orders are faxed after 8:00 AM and before 7:00 PM the medications will be delivered on the night delivery (approximately 11:00 PM) that same night. 1.R3 was admitted to the facility with diagnosis that included high blood pressure and high cholesterol. The following documentation was contained in the clinical record; 3/12/14 - Physician Order Sheet and Interim Plan of Care documented at 4:35 PM physician orders for: -Atorvastatin 80 mg (milligrams) at bedtime for high cholesterol -Hydralazine 50 mg three times per day for high blood pressure	F 309	follow up on the pharmacy process for calling the facility for clarification on new admissions. The Nurse Practice Educator posted a memo at each nurses station and sent an email to all nurses regarding the process for obtaining medications for new admissions/re-admissions (Attachment B). The Quality Asssurance team met on 4/2/14 to further discuss the medication reconciliation process and obtaining new medications for admissions/re-admissions. A new protocol was developed on 4/2/14 (Attachment C) with focus added on obtaining and administering medications for new admission/readmission. Education was completed for all nurses on thenew protocol as well as the following: Policy for Taking Medication and Treatment Orders, Physician Order Sheet and Interim Plan of Care, Policy on New Orders for Non-Controlled Medications, Policy for Management of Controlled Medications, Omnicare Delivery Cut Off Times, Policy on Medication Shortages/Drugs Not Available, Lofland Park Omnicall Supply List, Policy on Receipt of Interim/Stat/ Emergency Deliveries (Attachment D).	

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F 309	Continued From page 2 3/2014 - Medication Administration Record (MAR) lacked evidence that the Atorvastatin and Hydralazine were administered by the facility as ordered on 3/12/14. 3/13/14 - Clinical Incident Report documented that the medications did not arrive from the pharmacy and that R3 did not receive the scheduled medications of Hydralazine 50 mg at 4:00 PM and again at 11:00PM. R3 also did not receive the 9:00 PM dose of Atrovastatin 40 mg (incorrect dose documented). The facility documented that the pharmacy revealed that page 2 of the medication orders were not faxed to the pharmacy. The facility failed to obtain and administer medications as ordered by the physician upon admission to the facility. On 4/1/14 at approximately 11:15 AM during an interview with E3, Staff Educator who confirmed R3 did not receive the medications ordered by the physician, upon admission. E3 stated that the pharmacy had faxed back a request for R3's medication allergy status and could not fill the prescriptions until the information was received. The fax was not seen immediately by facility staff and the allergy information for R3 was faxed back to the pharmacy at 10:30 PM. The pharmacy was already closed for the evening.	F 309	D. The DON/designee will audit (Attachment E) 100% of the new admissions/re-admissions for a minimum of 30 days. If 100% compliance is achieved at the end of 30 days, then 10% of admissions will be reviewed weekly until 100% success over 3 weeks is achieved. Then 10% of admissions will be reviewed monthly until 100% success achieved over 3 consecutive months. If 100% is not achieved at the end of 30 days, the audit will continue until 3 consecutive audits at 100% compliance is achieved. Then the audits will continue weekly & monthly as stated above. The results of the audits will be reviewed in the monthly Quality Assurance meetings.	

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F 309	Continued From page 3 On 4/1/14 at approximately 11:30 AM during an interview with E1, Administrator who stated it is the expectation that the pharmacy will call the facility (not fax) one time (if before 7:00 PM) if additional information is needed before prescriptions will be filled. On 4/1/14 at approximately 4:00 PM during an interview with E5, Pharmacist, who confirmed that the process when communicating with the facility does include that the pharmacy will contact the facility via telephone if additional information is necessary. E5 confirmed that the pharmacy did not attempt to call the facility to obtain allergy information for R3 and only sent a fax requesting the allergy information. The facility failed to ensure that R3 was administered physician ordered medications in a timely manner. Findings were confirmed with E1, Administrator and E2, Director of Nursing on 4/4/13 at approximately 10:00 AM. 2. R6 was admitted to the facility with diagnosis that included congestive heart failure (heart is not pumping adequately). The following documentation was contained in the clinical record; 2/21/14 - Physician Order Sheet and Interim Plan	F 309		

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F 309	Continued From page 4 of Care documented at 6:10 PM a physician's order for: -Lasix 80 mg, administered twice a day for congestive heart failure and to rid the body of excess fluid. 2/2014 - Medication Administration Record (MAR) lacked evidence that Lasix was administered by the facility as ordered on 2/21/14. Review of the facility's medication supply list (list of medications facility keeps on hand) revealed that Lasix was available and readily accessible to nursing staff. The facility failed to administer the Lasix as ordered even though the medication was readily available in the Omnicel (area where medication is stored at the facility). It was unclear as to the reason the medication was not administered as ordered by the physician. 3/31/14 - Interview at approximately 2:00 PM with E4, Unit Manager, confirmed that R6 did not receive the dose of Lasix on 2/21/14 as ordered upon admission to the facility. Findings were confirmed with E1, Administrator and E2, Director of Nursing on 4/4/13 at approximately 10:00 AM.	F 309		

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F 309	Continued From page 5 3.R2 was readmitted to the facility after a hospital stay with diagnosis that included septic shock (infection in blood) and low blood pressure. The following documentation was contained in the clinical record; 11/14/13 - Physician Order Sheet and Interim Plan of Care documented at 6:50 PM physician's orders for: -Lantus 10 units to be administered at bedtime for diabetes (Body's inability to produce enough insulin and causes elevated sugar in the blood). -Gabapentin 300mg to be administered three times a day for pain -Midodrine 5 mg to be administered three times a day for low blood pressure -Pravastatin 40 mg at bedtime for high cholesterol 11/2013 - Medication Administration Record lacked evidence that these medications Lantus, Gabapentin, Midodrine Pravastatin were administered as ordered upon readmission on 11/21/13. The facility failed to ensure that medications (i.e., Lantus, Gabapentin, Midodrine and Pravastatin) were administered as ordered when the resident was readmitted to the facility on 11/21/13.	F 309		

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F 309	Continued From page 6 4/1/14 - During an interview with E3, Staff Educator, at approximately 11:00 AM who confirmed medications were not administered on 11/21/13 as ordered upon readmission. The facility consistently failed to administer medications in a timely manner when the resident was newly admitted or readmitted to the facility. The facility failed to ensure that ordered medications were obtained from the Omnicel (on-site facility supply) or from the pharmacy. It was unclear as to the reason the medications were not administered as ordered by the physician. Findings were confirmed with E1, Administrator and E2, Director of Nursing on 4/4/13 at approximately 10:00 AM.	F 309		

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: April 4, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from March 27, 2014 through April 4, 2014. The deficiencies cited in this report are based on record reviews, staff and resident interviews, and review of other documentation as indicated. The facility census the first day of the survey was 100. The sample size included six (6) residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1.0	**Scope**	
3201.1.2	**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**	

Provider's Signature [signature] Title Administrator Date 4/30/14

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	reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey date April 4, 2014, F309.	Cross reference to the CMS 2567-L survey: F309 with expeceted date of completion May 19, 2014.

Provider's Signature [illegible] BSN, NHA Title Administrator Date 4/30/14