

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

PRINTED: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2015
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY 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	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from February 11, 2015 through February 20, 2015. 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 121. The Stage 2 sample totaled 32 residents.</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;</p>	F 000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	
F 253 SS=B	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour with E6 (Environmental Services Director) on 2/20/15 between 10:55 AM - 11:15 AM, it was determined that the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior. Findings</p>	F 253	<p>F 253</p> <p>A. Residents remain in room 121, 120A, 222B, 230B, 101, 124, 221, 225, 202, and 117.</p> <p>B. The following deficient practices have been addressed to maintain sanitary, orderly and a comfortable interior for the residents. The ball/end missing on the end of the bathroom emergency call light cord has been replaced with a brand new one as of 2/20/15. The horizontal wall trim behind the beds in rooms 120A, 222B and 230B have been removed and the wall has been re-seamed and made aesthetically appealing and safe. The drywall has been replaced with new drywall in rooms 101, 124 221 and 225 in the noted areas on the 2567 and made aesthetically appealing and safe. The bathroom door has been painted in room 124. The toilet seat in room 117 has been replaced as of 2/20/15. Room 202 has had a complete renovation which included stripping and polishing the floor and painting the room and bathroom.</p>	4/2/15

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

Carl Seasholtz

TITLE

NHA

(X5) DATE

3/19/15

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 253	Continued From page 1 include: 1. Ball/rod missing on the end of the bathroom emergency call light cord in room 121 shared by two residents. The ball/rod makes it easier for residents with limited finger dexterity to pull/activate the emergency cord. 2. Horizontal wall trim behind beds in rooms 120A, 222B and 230B were broken. E6 stated the broken trim may be due to raising the bed while the bed is close/against the wall. E6 stated that repair would include either replacement or removal of the trim. 3. Significant drywall damage in rooms 101 (next to window), 124 (next to window- spackling applied, awaiting sanding and repainting), 221 (next to window), and 225 (below paper towel dispenser). E6 stated that the areas required spackling, sanding and repainting. 4. The interior of the bathroom door in room 124 has thinned and missing paint making the door unaesthetic. 5. Toilet seat in room 117 was extremely worn with dark discoloration due to wearing of the finish. E6 stated that the toilet seat needed to be replaced. 6. Significant dark grey floor scuffing (two areas approximately 8 inches in width that ran the entire length of the room from the doorway to the far wall) in room 202. E6 stated that the scuff marks were from a resident's walker and the floor needed to be stripped and polished. All findings were confirmed with E6 during the	F 253	C. In-servicing shall be completed on or before 4/2/15 for center staff on the request form for maintenance for issues related to damage in resident rooms. This shall be the responsibility of the Maintenance Director/ Nurse Practice Educator (NPE)/designee. The Maintenance Request Forms will be placed at each nurse's stations and collected daily by EVS/Maintenance (Exhibit A). The request will be placed on the Maintenance Log List and completed within a reasonable timeframe but no greater than one month D. Maintenance/designee will complete rounds weekly in resident rooms and common areas x 3 months. Random audits will be conducted weekly until 100% success of 3 consecutive evaluations, then 3 times a week until 100% success of 3 consecutive evaluations then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later. When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and recommendations as needed.	4/2/15

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F 253	Continued From page 2 environmental tour on 2/20/15 from 10:55 AM-11:15 AM.	F 253		
F 25B SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interviews with 6 (I#1, I#2, I#3, I#4, I#5, and I#6) out of 20 stage 1 sampled residents, who wished to remain anonymous, it was determined that the facility failed to ensure comfortable sound levels on 2 of 2 nursing units. Findings include: Stage 1 was performed from 2/11/15 to 2/13/15. Resident noise concerns included the following: 1. Unit 1- screaming at night, talking to self (unsure if staff or resident), constant singing, and CNA's talking loudly on the day and evening shifts. 2. Unit 2- noise at night, staff loud on cell phones, and resident yelling. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 2/20/15 at approximately 2 PM.	F 258	1. Residents interviewed chose to remain anonymous and will presume they remain in the facility. 2. All residents have the potential to be affected by the noise level. 3. In-servicing shall be completed on or before 4/2/15 for all staff on the importance of rest to maintain optimal health and wellness, review of facility cell phone policy and appropriate noise levels in the evening and early morning hours. This shall be the responsibility of the Director of Nursing/ Nurse Practice Educator (NPE)/designee. 4. Random audits shall be completed on all units across all three shifts weekly until 100% success of 3 consecutive evaluations, then 3 times a week until 100% success of 3 consecutive evaluations, then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later (Exhibit B). When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and recommendations as needed.	4/2/15
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		

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F 272	Continued From page 3 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; 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 272	F 272 A. Resident 148 is no longer in the facility. Resident 8 has been transferred out of the facility. Resident 37 remains in the facility and continues on current routine pain regimen. The upcoming MDS will reflect the current routine pain regimen. B. The Admission Nursing Assessment and subsequent expanded nursing assessment for residents will be completed in its entirety and the Admission MDS will accurately reflect identified problems and follow up with dental consults as needed. The MDS section for broken or loosely fitting full or partial dentures will be completed and reviewed for residents that have improper fitting dentures. Residents currently on a pain regimen will be reviewed for accuracy of MDS completion. C. In-servicing shall be completed on or before 4/2/15 for all licensed nursing staff and Clinical Reimbursement Coordinators (CRC) on accurate coding of MDS assessments. This shall be the responsibility of the Director of Nursing and/or Nurse Practice Educator. Prior to MDS submission the CRC will review the accuracy of the MDS coding. The CRC will confer with licensed nurses for accuracy of dental assessment and pain regimen.	4/2/15

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F 272	<p>Continued From page 4</p> <p>Interview It was determined that for three out of 32 (R6, R37 and R148) sampled residents the facility failed to ensure the accuracy of the comprehensive assessment. Findings include:</p> <p>1. R148 had an Admission Nursing Assessment dated 1/8/15 that identified no dental concerns.</p> <p>R148 had an Admission MDS dated 1/15/15 that indicated there were no identified dental problems.</p> <p>An interview with the resident on 2/13/15 at 3:09 PM revealed that he had multiple missing and broken teeth. He further stated that some are so sharp that he has to watch himself when he is eating to not cut himself. The resident opened his mouth and showed the surveyor the missing and broken teeth. He also stated that he called a clinic in Dover for dental care, but the waiting list was about a year long.</p> <p>During an interview on 2/16/15 at 2:22 PM, E3 (ADON) confirmed that a proper dental assessment had not been done.</p> <p>2. R6's Admission MDS dated 4/9/15 documented in the area of oral/dental status no natural teeth or tooth fragments. The section for broken or loosely fitting full or partial denture was not checked as being a problem for the resident.</p> <p>The next two quarterly assessments dated 10/9/14 and 1/9/15 indicated no dental problems. The area for broken or loosely fitting full or partial denture was not checked.</p> <p>An interview on 2/11/15 at 1:48 PM with R6 revealed that she had loose fitting upper dentures</p>	F 272	<p>D. Don/designee will complete random audits on 10% of current residents that have missing/broken teeth and/or loose fitting dentures (Exhibit C) and 10% of current residents on routine pain management for accuracy of recent MDS and/or follow up with a dental exam as needed. The audit will be completed weekly until 100% is achieved over three consecutive evaluations is reached. Then monthly x 3 until 100% is achieved over 3 consecutive evaluations. All findings will be reported to the Quality Assurance and Process Improvement Committee for data evaluation and recommendation as needed for the next 3 months.</p>	4/2/15	

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F 272	Continued From page 5 and was on a waiting list at a medical clinic, but was 1200th on the list. An interview on 2/18/15 at 2:52 PM with E2 (DON) and E3 (ADON) revealed that they did not know anything about dental issues with R6 and were not aware that she was on a waiting list for dental care. A follow-up interview shortly thereafter confirmed the resident was on a dental waiting list and was now 440th in line. An interview on 2/20/15 at 10:52 AM with E3 confirmed that the resident had complaints about loose fitting upper dentures and she does not wear her lower dentures. On 2/20/15 at 11:03 AM observation and interview revealed that R6 had upper and lower dentures, but does not wear the lowers and the uppers are loose and need to be realigned. The resident's MDS's failed to identify the problem of loose fitting dentures. 3. R37's annual MDS dated 9/17/14 indicated the presence of a pain medication regimen. Review of the quarterly MDS dated 12/18/14 documented the resident was not on a pain medication regimen. Review of the medical record revealed that between 9/17/14 and 2/20/15 the resident had been receiving two medications daily for pain. These findings were reviewed with E1 (NHA) and E2 on 2/20/15 at 2 PM.	F 272			
F 281	483.20(k)(3)(l) SERVICES PROVIDED MEET	F 281			

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F 281 SS=D	<p>Continued From page 6</p> <p>PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure that one (R52) out of 32 sampled residents was properly administered medication by a licensed nurse. Findings include:</p> <p>The facility's policy for Medication Administration states under Practice Standards; -Remain with patient until administration is complete. Do not leave medications at the patient's bedside.</p> <p>On 2/11/15 at 11:55 AM R52 was observed sitting on his bed with two white pills on his over the bed table. When asked about these medications, the resident stated they belonged to his roommate. Immediately thereafter, E9 (RN), who was passing medication in the hallway was made aware of the medication in R52's room. E9 stated that she left R52 with 3 pills in his hand to take and then went back into the room to check on the resident.</p> <p>Identification of the two pills revealed they were Keppra (seizure medication) and Magnesium (supplement) both ordered on the Medication Administration Record to be administered at 9 AM to R52.</p> <p>These findings were reviewed with E1 (NHA) and E2 (DON) on 2/20/15 at 2 PM.</p>	F 281	<p>F281</p> <ol style="list-style-type: none"> R52 no longer resides in the facility. No residents were affected by the deficient practice. No further observation of medications were noted during rounds on 3/12/2015 (Exhibit D). In servicing by Nurse Practice Educator will be completed by 4/2/2015 for licensed nursing staff on procedure for Medication Administration: Oral which includes, Stay with patient until the drug has been swallowed (Exhibit E). Don/designee will complete random rounds to validate compliance with medication Administration. Don/designee will conduct random rounds on both units on all shifts. Audits will be conducted daily until 100% success of 3 consecutive evaluations then 3 times a week until 100% success of 3 consecutive evaluations then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later. When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and recommendations as needed. 	4/2/15	

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F 309 SS=D	<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 the facility failed to provide care and services to attain or maintain the highest practicable physical, mental and psychosocial level of well-being for 1 (R171) of 32 sampled residents. The facility failed to follow the plan of care that required a Depakote (anti-seizure medication) level (amount of Depakote in the resident's blood) to be drawn on 1/30/15. Findings Include:</p> <p>1. R171 had a physician order written on 1/29/15 for a Depakote level to be done on 1/30/15 along with a CBC (Complete Blood Count) and a BMP (Basic Metabolic Panel). The psychiatrist requested that a Depakote level be done due to concerns about R171's sleepiness, being slow to respond to voice and irritability upon arousal.</p> <p>Chart review on 2/16/15 revealed that the CBC and BMP results were in the medical record, but not the Depakote level. On 2/16/15 at approximately 1 PM, E2 (DON) was asked where lab results could be located if not found in the chart. E2 stated the Depakote level was not obtained on 1/30/15 and she wrote in the lab</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> R 171 no longer resides in the facility. Depakote level drawn 2/19/2015 was within normal limits. Audit of labs scheduled for 3/11/2015 were completed to determine any other residents that may have been affected by the deficient practice (Exhibit F). In servicing by Nurse Practice Educator will be completed by 4/2/2015 for licensed nursing staff on Laboratory Tracking Form that includes monitoring of results for labs ordered. (Exhibit G). Don/designee will complete random audits to validate compliance with completion of laboratory orders. Don/designee will conduct random rounds on both units. Audits will be conducted daily until 100% success of 3 consecutive evaluations then 3 times a week until 100% success of 3 consecutive evaluations then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later. When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and recommendations as needed. 	4/2/15

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F 309	Continued From page 8 (laboratory) book for a Depakote level to be done on 2/17/15. Chart review on 2/19/15 continued to lack Depakote level results for R171. Interview with E2 on 2/19/15 at 10 AM confirmed findings. The Depakote level entry in the lab book for 2/17/15 was crossed out. E2 stated she did not know who crossed out the Depakote level or why. E2 consequently obtained an order for a Depakote level to be done STAT (as soon as possible) on 2/19/15. A copy of the STAT Depakote level was provided to the surveyor on 2/19/15 and the result was within the normal range.	F 309			
F 323 SS=D	The facility failed to obtain a Depakote level on 1/30/15 for R171. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and the environmental tour with E6 (Environmental Services Director) on 2/20/15 from 10:55 AM to 11:15 AM, it was determined that the facility failed to ensure that the resident environment remained as free from accident hazards as is possible on both units of the facility. Findings include:	F 323	F323 1. Bolts securing the toilet in rooms 221 and 230 were cut down and capped on 2/20/2015. 2. Environmental Services Director/designee completed rounds on bathroom facilities in the center to determine all toilet bolts were capped (Exhibit H). 3. Environmental Services staff were instructed on providing/maintaining an environment that remains as free of accident hazards as is possible by 4/2/2015 (Exhibit I). Environmental Services Director/designee will complete environmental rounds to monitor for potential safety/accident hazards (See attachment) 4. Environmental Director /designee will conduct random rounds once a week x 3 then monthly x 2 then quarterly. Findings of audits will be reported to the Quality assurance and Improvement Process	4/2/15	

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F 323	Continued From page 9 1. Bolts securing the toilets in rooms 221 and 230 were exposed and rusty, with each protruding approximately 3-4 inches in length above the base of the toilet, creating a hazard for the four residents sharing these bathrooms. There were no caps present on the bolts. 2. Blank outlet plates (solid cover screwed over an unused electrical outlet) by the windows in rooms 123 and 230, were cracked and broken, with partial visibility of the internal wiring. Findings were confirmed with E6 during the environmental tour.	F 323		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R52) out of 32 sampled residents the facility failed to identify a significant weight change and assess for interventions for the weight change .Findings include:	F 325		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2016
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973	
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F 325	<p>Continued From page 10</p> <p>Weights and Heights Policy -if a patient weight is less than or greater than five pounds from the previous weight, the patient will be re-weighed and the weight verified by a licensed nurse to determine accuracy -the weight exception report will be reviewed by a licensed nurse with follow-up as indicated. -significant weight change is defined as: 5% in one month, 10% in 6 months</p> <p>R52 was admitted on 2/1/15 after a broken leg. The resident also had lung cancer with metastasis (cancer had spread) to the brain. R52's weight on admission was 129.4 lbs. (pounds). He was on a regular diet.</p> <p>On 2/4/15 a care plan was initiated for resident is at nutritional risk, suboptimal oral meal intakes, increased nutrient needs secondary to stage IV (advanced) metastatic cancer with approaches that included; -offer alternate food choices if less than 50% consumed at mealtime -monitor of changes in nutritional status...changes in intake...weight loss/gain</p> <p>Nutritional Assessment dated 2/4/15 documented intake variable since admission, about 50% over 2 days, has snacks at bedside from family and reports that granddaughter to be bringing meals when desired, metastatic cancer with low BMI (body mass index), suboptimal (less than the standard) oral meal intakes...does not want to try supplements at this time.</p> <p>On 2/8/15 R52's weight was 119.8, a 9.6 lb. or 7.4% weight loss. There was no evidence that a re-weight was done for a 5 or more lb. variance.</p>	F 325	<p>F325</p> <ol style="list-style-type: none"> R52 no longer resides in the facility. Review of weight exception report will be completed by 4/2/15 to determine other residents affected and follow up completed per policy (Exhibit J). In servicing by Nurse Practice Educator will be completed by 4/2/2016 for Licensed Nursing staff on weight procedure including, follow up on weight if less than or greater than five pounds from previous weight, verification of re weight and certified nursing aides on obtaining weights and re-weights as required. The certified nursing assistants utilize the Early Warning tool and report to Nurses. The Dietician will be made aware of weight loss through the use of the Point Click Care exception notification, which triggers a weight loss from the Early Warning Tool used by the certified nursing assistants and reported to nursing which is entered into Point Click Care. Don/designee will conduct random rounds on both units. Audits will be conducted daily until 100% success of 3 consecutive evaluations then 3 times a week until 100% success of 3 consecutive evaluations then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later. When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and actions as needed. 	4/2/15

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F 325	Continued From page 11 There were no further nutritional assessments in the clinical record. R52 was discharged home on 2/13/15. An interview on 2/16/15 at 2:12 PM with E3 (ADON) revealed that she did not have any information about a weight loss for R52 and she directed me to the dietitian (RD). An interview on 2/16/15 at 2:25 PM with E9 (RD) revealed that when a resident experiences a weight loss she receives a call to see the resident at her next visit as well as an e-mail. She visits the facility twice a week. When she comes to the building she also pulls an exception report to check weight changes on the residents. She further revealed that by the time she was aware of R52's weight loss, the resident had been discharged. A follow up interview with E9 on 2/19/15 at 11:56 AM revealed that she checked her records and found that she was never notified about R52's weight loss. She provided the exception reports that had been printed and they lacked E52's name and indication of weight loss. E9 stated the facility was unclear why the resident did not appear on the report. There was no evidence that R52's weight loss was addressed before discharge from the facility. These findings were reviewed with E1 (NHA) and E2 (DON) on 2/20/15 at 2 PM.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	<p>Continued From page 12</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any 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 chart review and interview, it was determined that the facility failed to consistently monitor for the effectiveness of prn (as needed) medications for 2 (R67 and R171) out of 32 sampled residents. Findings include:</p> <p>1. R171 received prn Xanax (medication for anxiety) 7 times between 1/28/15 and 2/5/15. The back of the MAR (Medication Administration Record) where the administration of Xanax was recorded was blank. Usually the back of the</p>	F 329	<p>F329</p> <ol style="list-style-type: none"> R67 remain in the facility. R171 has been discharged to home. Current residents receiving PRN psychotropic medications were assessed by the DON/designee for the use of PRN medication and documentation of its effectiveness. (Exhibit K). The Licensed Nursing Staff will utilize the MAR and PRN effectiveness sheets (Exhibit L). In-servicing shall be completed on or before 4/2/15 for the licensed nursing staff on documentation required on the MAR as it relates to the effectiveness of PRN medications. This shall be the responsibility of the Director of Nursing/ Nurse Practice Educator (NPE)/designee. Random audits shall be completed on residents with PRN psychotropic medications on both units and documentation of effectiveness of medication (Exhibit M). Audits will be conducted on 10% of the residents with PRN psychotropic medications usage daily until 100% success of 3 consecutive evaluations then 3 times a week until 100% success of 3 consecutive evaluations then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later. When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and recommendations as needed. 	4/2/15	

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F 329	Continued From page 13 MAR contains lines on which to write the drug's effectiveness. Review of nurses notes from this time frame revealed that the effectiveness of the prn Xanax was not recorded on 4 of the 7 occasions: 1/28 (evening shift), 1/31 (night shift), 2/3 (night shift) and 2/5 (night shift). E2 (DON) was interviewed on 2/19/15 at 10 AM and findings were reviewed. E2 confirmed the findings and expressed concern that the back of the MAR was blank. E2 stated that card stock paper should have been used which has the area for documentation on the reverse side. The facility failed to monitor the effectiveness of prn Xanax for R171. 2. R67 had a physician order, dated 5/14/14, for Restoril (sedative, for sleep) to be taken at bedtime prn for insomnia (inability to sleep). R67 received Restoril on 27 out of 31 days in December 2014, 30 out of 31 days in January 2015 and 18 out of 17 days in February 2015 (as of 2/17/15). Of the 73 doses, the facility only documented the effectiveness on the back of the MAR 2 times. Review of nurses notes from 1/1/15 to the present lacked monitoring of the effectiveness of the prn Restoril. E2 confirmed the findings on 2/20/15 at 1:40 PM during an interview. The facility failed to monitor the effectiveness of prn Restoril for R67.	F 329		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	<p>Continued From page 14</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: Based on observation and interview it was determined that the facility failed to prepare, distribute and serve food under sanitary conditions. Findings include:</p> <p>1. Inspection of the kitchen with a State Public Health Inspector on 2/18/15 from 11:15 AM to 12:30 PM revealed the following;</p> <p>-Unpasteurized eggs were noted in the cold storage area. Interview with E7 (Food Service Director) revealed that these eggs were used to prepare scrambled eggs that were being placed on a steam table or hot holding unit for service to residents. Pasteurized eggs are required to be used whenever more than one egg shell is broken and eggs are combined unless eggs are used only for a single meal and served immediately after cooking.</p> <p>-Lettuce was observed being stored in the walk-in refrigerator uncovered.</p> <p>-Toothpicks and other utensils were being stored under a hand sink. There is a risk that the sink and wastewater lines could leak.</p>	F 371	<p>F371</p> <ol style="list-style-type: none"> No residents were affected by the deficient practice. Unpasteurized and pasteurized eggs were properly stored in the cold storage area. Pasteurized eggs will be used for making single serve eggs and steam table service. <p>The lettuce was covered immediately and placed back in the walk in refrigerator.</p> <p>The toothpicks and silverware were removed from the sink immediately. The toothpicks were disposed.</p> <p>The oil in the deep fryer has been cleaned.</p> <p>During food service on the serving carts the bread will be placed in a container and a serving utensil will be used to serve bread and other meal single serve items. The syrup will be placed in containers on the steam table with ladles.</p> <p>The ice scoop will be placed in its own separate container.</p>	4/2/15

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F 371	<p>Continued From page 15</p> <p>-Oil in the deep fryer had build-up of particulate matter.</p> <p>2. Observation of lunch service on the unit one long hall on 2/11/15 starting at 12:02 PM revealed the following:</p> <p>E11 (dietary aide) was serving food, E12 (cook) was pushing the food holding unit and E13 (dietary aide) was assisting E11.</p> <p>Throughout the service E11 wore the same gloves. During the food service she contaminated her hands several times touching syrup bottles, the drawer on the food unit, the insulated cooler and her own clothing. E11 removed bread from it's bag several times to put on residents' plates with contaminated hands.</p> <p>3. Observation of the lunch service on the unit one long hall on 2/18/15 at 12:05 PM revealed the following:</p> <p>E11, E12, and E13 were in the same service positions as they were during the above mentioned 2/11/15 observation.</p> <p>E11 contaminated her gloved hands touching the insulated cooler door and other parts of the cart. She picked up rolls and grilled cheese sandwiches with her contaminated gloved hands and placed them on residents' plates.</p> <p>E13 also contaminated her hands touching the cart and packages of crackers, but continued to put grilled cheese sandwiches on plates with her gloved hands instead of using a serving utensil.</p> <p>4. During the lunch meal observation in the main</p>	F 371	<p>3. In-servicing shall be completed on or before 4/2/15 for dietary staff on the use pasteurized and unpasteurized egg use, proper storage of food for walk in refrigerator, sanitation/storage of items near sink area and schedule for cleaning the deep fryer. Proper use of gloves and serving utensils during meal service will be in-serviced to all dietary staff. This shall be the responsibility of the Food Service Director/designee.</p> <p>4. Food Service/designee will conduct random audits on use of pasteurized and unpasteurized eggs, proper storage, sanitation throughout kitchen especially sink area, cleaning of deep fryer, and infection control and proper use of serving utensils with single serve items such as bread and syrup. (Exhibit M). Audits will be conducted daily until 100% success of 3 consecutive evaluations then 3 times a week until 100% success of 3 consecutive evaluations then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later. When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and recommendations as needed.</p>	4/2/15

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F 371	Continued From page 16 DR (dining room) on 2/11/15, E14 (dietary aide) was observed using a scoop to obtain ice from a clear bin from approximately 11:30 AM - 11:45 AM. There were 22 residents in the DR during this time and approximately 4-5 more residents came later. After scooping ice into each residents glass E14 would toss the scoop back into the ice bin (which had touched her bare hand) thus contaminating the ice.	F 371		
F 431 SS=D	Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 2/20/15 at approximately 2 PM. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F431 1. The expired medications were discarded at the time of the survey. 2. Medication carts and medication rooms were audited to determine and discard any other expired medications. 3. In servicing shall be completed on or before 4/2/15 for Licensed Nursing and AWSAM (Assistance with self Administration of Medication) staff on labeling and storage of medications including, periodic medication cart/room audits for expired medications. A monitoring system will be put in place and will occur every three months for all medication carts/rooms by the 11P to 7A nurse or as designated by the DON/designee. This shall be the responsibility of the Director of Nursing and/or Nurse practice Educator.	4/2/15

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F 431	Continued From page 17 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that two expired medications were removed from the medication cart. Findings include: Observation on 2/20/15 at 10:51 AM of the Unit one short hall medication cart revealed the following medications were expired: - (1) One blister pack of Tylenol 325 milligrams (mg), a medication for mild pain or fever, with an expiration date of 9/30/14. -(1) One blister pack of Tylenol 325 mg, with an expiration date of 10/31/13. An interview on 2/20/15 at 10:55 with E10 (LPN) confirmed the medications were expired. Findings were reviewed with E1 (NHA) and E2 (DON) on 2/20/15 at 2 PM.	F 431	4. ----- The Director of Nursing/designee shall do random audits of medication carts/rooms. Monthly x 3 months. The problem will be considered resolved if the last audit is 100% in compliance with the regulation. Findings will be reported to the Quality Assurance and Process Improvement Committee for data evaluation and recommendations as needed x 3 months.	4/2/15
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		4/2/15

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F 441	<p>Continued From page 18</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>F441</p> <ol style="list-style-type: none"> The infection control monthly line listings lacked necessary data. The used pair of gloves were removed from the room. E 10 was informed by the surveyor of the incorrect hand washing technique. Current residents had the potential to be affected by the deficient practices. In servicing shall be completed on or before 4/2/15 for current employees on Infection Control Policy and Process that are designed to prevent the development and transmission of disease /infection. The in servicing will include hand washing, appropriate disposal of used gloves. This shall be the responsibility of the Director of Nursing and/or Nurse practice Educator. The Infection Control Nurse will be instructed on maintaining thorough line listings in order to track and trend the monthly data. This shall be the responsibility of the Clinical Educator/designee. 	4/2/15	

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F 441	<p>Continued From page 19</p> <p>Based on observation, review of facility documents, and interview it was determined that the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection. Findings include:</p> <p>1. The Infection Control Monthly Line Listings (compilation of facility infection data used for analysis of infection trends) were reviewed from August 2014 through January 2015. The following issues were identified:</p> <p>September 2014.- lacked precaution types/ how acquired/symptoms-dagnosis/site/results; October 2014- lacked precaution types/how acquired/onset dates; January 2015- lacked precaution types/how acquired/results/onset date.</p> <p>Findings were confirmed with E15 (Nurse Practice Educator) during an interview on 2/20/15 at 9:55 AM. E15 stated that she began doing the Infection Control Monthly Line Listings in November 2014.</p> <p>2. On 2/12/15 at 10:55 AM R139 was sitting in a chair in her room in front of her oxygen concentrator. A used pair of dirty gloves (one inside of the other) was observed on the floor in front of R139's oxygen concentrator.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 2/20/15 at approximately 2 PM.</p> <p>3. On 2/19/15 at 11:44 AM E10 (LPN) was observed performing handwashing before and</p>	F 441	<p>4. Random rounds on all shifts will be conducted by the Director of Nursing/designee to observe compliance with hand washing, and cleanliness of resident rooms (Exhibit O). Rounds will be conducted daily until 100% compliance is achieved, then weekly until 100% compliance is achieved, then monthly x 3 months. Director of Nursing/designee will provide oversight of the infection control line listing and the following tracking/trending monthly x 3 months(Exhibit P). The problem will be considered resolved if the last audit is 100% in compliance with the regulation. Findings will be reported to the Quality Assurance and Process Improvement Committee for data evaluation and recommendation as needed x 3 months.</p>	4/2/15

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F 441	Continued From page 20 after obtaining a fingerstick blood glucose level on R232. Both times, E10 turned off the faucet with her freshly washed bare hands, thus contaminating her hands. The surveyor informed the nurse that she should not turn the water off with her bare hands since the faucets are considered contaminated. The nurse verbalized understanding.	F 441			
F 483 SS=D	483.70(f) 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. This REQUIREMENT is not met as evidenced by: Based on observations and the environmental tour of the facility with E6 (Environmental Services Director), it was determined that the facility failed to ensure that the bathroom emergency call system was functional for two (R30 and R75) of 32 sampled residents. Findings include: 1. During a room check on 2/11/15 at 2:14 PM, when the emergency pull cord in the bathroom of R75 was activated, the light in the hallway failed to illuminate. During the environmental tour on 2/20/15 at 10:59 AM the light in the hallway failed to illuminate when the bathroom emergency call system was activated. E6 stated that the light bulb needed to be	F 483			

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

PRINTED: 03/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2015
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY 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)	(X6) COMPLETION DATE	
F 483	<p>Continued From page 21 changed.</p> <p>2. During a room check on 2/11/15 at 2:14 PM, when the emergency pull cord in the bathroom of R30 was activated, the light in the hallway failed to illuminate.</p> <p>During the environmental tour on 2/20/15 at 10:59 AM the light in the hallway failed to illuminate when the bathroom emergency call system was activated.</p> <p>R30 and R75 share the same bathroom.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 2/20/15 at approximately 2 PM.</p>	F 463 F463	<ol style="list-style-type: none"> 1. R75 emergency pull cord in the bathroom has been fixed and the light in the hallway now illuminates. 2. No residents were affected by the deficient practice. No further observation of emergency pull cord deficient practices have been noted as evidenced by all bathroom call bell systems have been tested for proper function. 3. In-servicing shall be completed on or before 4/2/15 for center staff on the request form for maintenance for issues related to damage in resident rooms. This shall be the responsibility of the Maintenance Director/ Nurse Practice Educator (NPE)/designee. 4. Maintenance/designee will conduct random rounds on both units (Exhibit R). Audits will be conducted daily until 100% success of 3 consecutive evaluations then 3 times a week until 100% success of 3 consecutive evaluations then once a week until 100% of 3 consecutive evaluations, then will measure 1 more time a month later. When 100% success is achieved, the problem will have been successfully addressed. Findings of audits will be reported to the Quality assurance and Improvement Process Committee for data evaluation and recommendations as needed. 	4/2/15	



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 677-8661

STATE SURVEY REPORT

NAME OF FACILITY: **Seaford Center Nursing Home**

DATE SURVEY COMPLETED: **February 20, 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 February 11, 2015 through February 20, 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 121. The survey sample totaled 32.</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>Cross Reference Federal Tags: 253, 258, 272, 281 309, 323, 325, 329, 371, 431, 441, and 463.</p> <p>Date of Compliance: 4/2/2015</p>	<p>4/2/15</p>

Provider's Signature Carol Leashycki Title NHA Date 3/19/15



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DHSS - DLTCRP
3 Mill Road, Suite 308
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STATE SURVEY REPORT

Page 2 of 2

NAME OF FACILITY: Seaford Center Nursing Home

DATE SURVEY COMPLETED: February 20, 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 February 20, 2015 : F 253, F258, F272, F281, F309, F323, F325, F329, F371, F431, F441 and F463.</p>		4/2/15

Provider's Signature

Title

NHA

Date

3/19/15