

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

PRINTED: 05/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2015
NAME OF PROVIDER OR SUPPLIER MILFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MARVEL ROAD MILFORD, DE 19963	
(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 complaint survey was conducted at this facility from May 3, 2015 through May 12, 2015. The deficiencies cited in this report are based on record reviews, staff interviews, family interviews, and review of other facility documentation as indicated. The census the first day of the survey was 123. The sample size included three (3) active and two (2) closed records.</p> <p>Abbreviations used in this report are as follows: DON - Director of Nursing; ADON - Assistant Director of Nursing; NHA- Nursing Home Administrator; NP- Nurse Practitioner; PNP- Psychiatric Nurse Practitioner; SW- Social Worker; MD- Medical Doctor; MDS- Minimum Data Set-standardized assessment form used in nursing homes; Depression-medical condition involving sad mood; Dementia-a decline in mental ability that negatively impacts daily life; Anxiety-general term for disorders that cause nervousness, worrying and apprehension; Hallucinations-sensing things that appear real but are only in the mind; Delusions-a belief that is not based on reality; Psychosis-lack of contact/touch with reality; Psychiatric-relating to mental disorders; Psychoactive medications- medications that affect the mind and behavior; Antipsychotic medications- medications used primarily to manage psychosis and mental illness; Anti-anxiety medications-medications used to treat anxiety;</p>	F 000		

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

Mark Levin

TITLE

Administrator

(X6) DATE

6-15-15

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 000	Continued From page 1 Antidepressant medications- medications used to improve mood.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157	A. R2 no longer resides in the center. B. Current residents receiving psychotherapeutic medications have been reviewed to confirm that informed consent has been obtained (see attachment 157-1). C. The Nurse Practice Educator/designee will in-service licensed nursing staff on the center's policy and procedure (see attachment 157-2 thru 157-3) regarding the use of psychotherapeutic medications, including the requirement to notify the resident and/or responsible party and obtaining informed consent (see attachment 157-4 thru 157-5). Medical Director will meet with physicians and extenders to review and discuss requirements of the policy (see attachment 157-4 thru 157-6). New orders for psychotherapeutic medications or changes in psychotherapeutic medications will be reviewed by Assistant Director of Nursing/designee to determine that communication has been made to resident/responsible party regarding the medication and informed consent obtained (see attachment 157-1) D. Director of Nursing/designee will conduct random audits of	6-10-15	

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F 157	<p>Continued From page 2</p> <p>by:</p> <p>Based on record review, family interviews, and staff interviews, it was determined that for one (1) of five (5) residents reviewed (R2), the facility failed to immediately notify R2's involved family members when significant changes to R2's medication treatment plan were made. Psychoactive medications were ordered and administered without consulting or notifying R2's family until after the medications had already been administered to R2 multiple times. The lack of family notification was a failure to comply with established facility policy / procedure which required informed consent for the use of psychotherapeutic medications. Findings include:</p> <p>According to the facility's "Psychotherapeutic Medication Use" policy / procedure, the purpose of the policy was "to support the involvement of patients and family members (for example care conference or discussion group) in the use of psychotherapeutic medications" and the process included obtaining informed consent for the use of the medications at the time they were prescribed.</p> <p>Cross-refer F329.</p> <p>R2 was admitted to the facility on 9/10/14 with a diagnosis of dementia and depression and was receiving Trazedone, an antidepressant medication at the time of admission. According to physician orders, two additional psychoactive medications were ordered for R2 by E4 (attending physician) on the following dates with no documented discussion with R2's family or notification of R2's family.</p> <p>-Zoloft (antidepressant, ordered on 9/16/14);</p> <p>-Zyprexa (antipsychotic, ordered on 9/25/14); and</p>	F 157	<p>psychotherapeutic medication orders and changes in dosage to determine that notification and informed consent has been obtained (see attachment 157-1) as follows:</p> <ol style="list-style-type: none"> 1. 10% daily until 100% success with three consecutive evaluations, then 2. 10% three time per week until 100% success with three consecutive evaluations, then 3. 10% once per week until 100% success with three consecutive evaluations, then 4. 10% per month until 100% success with two consecutive evaluations. A determination will be made at that time if the process will continue, be revised or be resolved. <p>The results/progress of the project will be reported by the Director of Nursing/Designee to the Quality Assurance and Process Improvement committee for the next three months for data evaluation and recommendations.</p>	

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F 157	Continued From page 3 -Remeron (antidepressant, ordered on 9/26/14). -Zyprexa (antipsychotic, dose reduction ordered on 9/26/14 due to excessive sedation of R2). Interview with E6 (son of R2) on 5/5/15 at 11 AM and Interview with E7 (daughter of R2) on 5/7/15 at 12:15 PM revealed that although both were identified in the clinical record as R2's healthcare decision makers, neither was contacted or notified by the facility about the addition of two antidepressant medications (Zoloft and Remeron) and an antipsychotic medication (Zyprexa) to R2's medication treatment plan until after the medications had already been administered to R2 and family members had noticed a change in R2's level of alertness. E6 and E7 both reported to the surveyor that they were not fully aware of all psychoactive medications being administered to R2 until a meeting was held between facility staff and family members on 10/1/14. At that time, facility staff identified all psychoactive medications R2 was already receiving and presented the "Psychoactive Medication Informed Consent" form to R2's family for signing. E2 (DON) confirmed the lack of family notification to the surveyor on 5/5/15 at 2:05 PM. These findings were reviewed with E1 (NHA), E2, and E3 (ADON) at the exit conference on 5/12/15 at 12:40 PM.	F 157			
F 279 SS=D	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.	F 279	A. Resident R2 no longer resides in the center. B. . Current residents with behaviors were reviewed to determine appropriate care plans are in place to address behavior management (see attachment 279-1).	6-10-15	

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F 279	<p>Continued From page 4</p> <p>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.</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 record review and staff interviews, it was determined that for one (1) of five (5) residents reviewed (R2), the facility failed to utilize the results of assessments to review and revise the care plan to address behavior management. Findings include:</p> <p>Cross-refer F329.</p> <p>R2 had a care plan addressing symptoms of depressed mood initiated on 9/10/14. When anxiety was identified as a possible source of the behaviors by E5 (PNP) on 9/15/14, another antidepressant medication (Zoloft) was recommended for R2 and ordered by E4 (MD) the following day (9/16/14). There was no change to the care plan to identify strategies and interventions to reduce R2's anxiety. On 9/25/14, the antipsychotic medication, Zyprexa, was</p>	F 279	<p>C. Nurse Practice Educator/designee will in-service licensed nursing staff regarding the development of comprehensive care plans that incorporate strategies for management of challenging behaviors (see attachment 279-2 and 279-3), including non-pharmacological interventions. For residents exhibiting new challenging behaviors, the nursing staff will contact the nursing manager or nurse on call to consult on the nursing plan of care.</p> <p>D. Director of Nursing/Designee will complete random audits of behavioral care plans to determine they are appropriate and individualized to include non-pharmacological interventions (see attachment 279-1):</p> <ol style="list-style-type: none"> 1. 10% daily until 100% success with three consecutive evaluations, then 2. 10% three time per week until 100% success with three consecutive evaluations, then 3. 10% once per week until 100% success with three consecutive evaluations, then 4. 10% per month until 100% success with two consecutive evaluations. A determination will be made at that time if the process will continue, be revised or be resolved. 		

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F 279	Continued From page 5 ordered for R2 for yelling behavior. The care plan failed to have evidence of review and revision between 9/10/14 and 9/25/14 showing what strategies and interventions the staff was utilizing to address R2's yelling behavior prior to an antipsychotic medication being ordered for this behavior. These findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 5/12/15 at 12:40 PM.	F 279			
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined that for one (1) of five (5) residents reviewed (R1) the facility failed to ensure that the post-discharge plan of care for R1 addressed required lab testing that was due the day after discharge. Findings include: R1 was discharged from the facility on 5/26/14 with home health services. A review of the clinical record revealed that R1 was receiving the blood thinning medication, Coumadin, while in the facility. Based on blood test results dated 5/22/14 (four days before discharge), R1's Coumadin dose was held (not given on 5/22/14); lowered	F 284	A. Resident R1 no longer resides at the center. B. Last 10 discharges from May are being reviewed to assure that post discharge follow ups and/or required testing is included in the discharge transition plan (see attachment 284-1). C. Nurse Practice educator/designee will in-service licensed nursing staff on guidelines for the discharge transition plan process, including required lab monitoring after discharge (see attachment 284-2 thru 284-7). D. Director of Nursing/designee will complete random audits of discharge transition plans to determine that necessary information is included to facilitate a successful transition from one level of care to another (see attachment 284-1) as follows:	6-10-15	

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F 284	Continued From page 6 5/23 through 5/26/14; and a repeat blood test was ordered for 5/27/14. On 5/23/14, however, a physician's order to discharge R1 to her home with home health care rehabilitation services was written. A review of the post-discharge plan of care developed by the facility and sent home with R1 on 5/26/14 revealed that the blood test related to Coumadin dosing due on 5/27/14 was omitted from the plan. This was confirmed by E2 (DON) on 5/12/15 at 12:20 PM. These findings were reviewed with E1 (NHA), E2, and E3 (ADON) at the exit conference on 5/12/15 at 12:40 PM.	F 284	1. 10% daily until 100% success with three consecutive evaluations, then 2. 10% three time per week until 100% success with three consecutive evaluations, then 3. 10% once per week until 100% success with three consecutive evaluations, then 4. 10% per month until 100% success with two consecutive evaluations. A determination will be made at that time if the process will continue, be revised or be resolved. The results/progress of the project will be reported by the Director of Nursing/Designee to the Quality Assurance and Process Improvement committee for the next three months for data evaluation and recommendations.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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.	F 329	A. R2 no longer resides in the center. B. Current residents on antipsychotic medications were reviewed to determine that the necessity and diagnosis for use of the medications was documented in the clinical record, the behavior monitor form was in place and non-pharmacological interventions were documented when	6-15-15	

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F 329	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, family interviews, and staff interviews, it was determined that for one (1) of five (5) residents reviewed (R2), the facility failed to ensure that an antipsychotic medication was not given to R2 in the absence of a specific condition diagnosed and documented in the clinical record. R2 was admitted to the facility with no antipsychotic medication ordered. Fifteen days after admission, an antipsychotic medication was ordered for R2 despite a lack of documentation in the clinical record of the purpose, necessity, and diagnosis requiring the use of an antipsychotic medication. In addition, the facility failed to comply with their own established policy / procedure to prevent the unnecessary use of antipsychotic medication. The facility failed to consistently monitor, failed to document the indication for usage of the antipsychotic and failed to document utilization of non-pharmacological interventions prior to medication administration. Findings include: According to the facility's "Behaviors: Management of Challenging" policy / procedure in effect during R2's stay in the facility, the staff was required to utilize a "Behavior Monitoring and Interventions Flow Record" for residents who exhibited challenging behaviors including verbal or disruptive behaviors. The purpose of this policy / procedure was included "to minimize the use of psychotherapeutic medications, including antipsychotics".	F 329	target behaviors occurred (see attachment 329-1). C. Nurse Practice Educator/designee will In-service licensed nursing staff on the facility's management of challenging behaviors policy and procedure, on the use of the behavior monitoring and interventions flow record for residents who exhibit challenging behaviors including verbal or disruptive behaviors (see attachment 329-2 thru 329-6). Nursing Director will meet with medical director, physicians and extenders to review and discuss requirements of the policy (see attachment 329-2 thru 329-7). When nursing staff observes a resident exhibiting a new challenging behavior, they will contact the nurse manager or nurse on call. The nurse manager will determine if staff has evaluated the resident for any potential triggers, ie: pain, toileting and other potential stimuli that may affect the resident. Staff will attempt diversional activities while a comprehensive plan of care is developed. The nurse will be asked to initiate the Behavior Monitoring Flow Sheet to track the behavior as well as initiating a behavior care plan. Physician services and family will be informed of the new behavior. The interdisciplinary team will meet to discuss the behaviors and identify other non-pharmacological	

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F 329	Continued From page 8 According to the facility's "Psychotherapeutic Medication Use" policy / procedure, when a psychotherapeutic medication was ordered for a resident, a comprehensive assessment of the resident would be conducted and the necessity of the psychotherapeutic medication for a specific condition would be documented in the clinical record. The purpose of this policy / procedure included to ensure that residents "are prescribed psychotherapeutic drugs for appropriate indications". Cross-refer F157 and F279. R2 was admitted to the facility from the hospital on 9/10/14 with no antipsychotic medication ordered. The care plan for R2 developed at admission on 9/10/14 Included the problem "Resident is at risk for complications related to the use of psychotropic drugs: Trazadone (antidepressant medication). Interventions to address this problem included the instruction to complete behavior monitoring flow sheets, however, no behavior monitoring flow sheets were completed for September, 2014. On 9/11/14, a care plan for "distressed mood symptoms of depression as evidenced by crying, yelling out" was initiated. The intervention "encourage participation in diversional activities" was included. A psychiatric diagnostic consultation dated 9/15/14 indicated that facility staff reported that R2 "yells out frequently. Patient (R2) heard by me (E5, PNP) spontaneously yelling out and it	F 329	Interventions that may be effective. Non-pharmacological interventions will be documented in the CNA documentation and on Behavior Monitoring Flow Sheet. If non-pharmacological interventions are unsuccessful and no medical condition is diagnosed, physician services will determine the next step of treatment. Physician services will document an appropriate diagnosis as well as the purpose for any new antipsychotic drug. Physician services will discuss new orders for antipsychotic medications with families to obtain informed consent. Residents receiving antipsychotic medications will be reviewed monthly for appropriateness of continued use. D. Director of Nursing/designee will conduct random review on antipsychotic medications and behavior monitoring and interventions flow record to determine compliance with policy as follows (see attachment 329-1): 1. 10% daily until 100% success with three consecutive evaluations, then 2. 10% three time per week until 100% success with three consecutive evaluations, then 3. 10% once per week until 100% success with three consecutive evaluations, then	

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F 329	<p>Continued From page 9</p> <p>appears secondary to anxiety". A recommendation for the antidepressant medication Zoloft was written by E5. This medication was then ordered by E4 (MD) on 9/16/14.</p> <p>A mental health consultation dated 9/16/14 indicated that R2 had dementia and was not a risk to herself or others. According to this evaluation, the staff reported that R2 had been "yelling but has settled down a bit".</p> <p>MDS assessments for R2 dated 9/17/14 and 9/22/14 revealed that R2 had no hallucinations or delusions and no behaviors that could be harmful to R2 or others.</p> <p>Care plan meeting notes handwritten by E8 (SW) dated 9/22/14 were reviewed and included the notation "yells out", however, this behavior was not identified as a significant problem. Interview with E8 on 5/11/14 at 1:10 PM confirmed that she was present at the 9/22/14 care plan meeting and wrote the notes based on the discussion about R2's condition among the interdisciplinary team members present. E8 recalled that R2 would stop calling out or making non-verbal sounds when spoken to (R2 would verbalize an answer to a question) and the behavior decreased when R2 was actively engaged in some type of activity or interaction.</p> <p>On 9/25/14, an entry was made in the communication book (a notebook used to ask the physician questions) by a facility nurse asking if an anti-anxiety or pain medication could be ordered for R2 whose noises disturbed other residents and perhaps were related to some unknown source of pain that the nursing staff</p>	F 329	4. 10% per month until 100% success with two consecutive evaluations. A determination will be made at that time if the process will continue, be revised or be resolved.		

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NAME OF PROVIDER OR SUPPLIER MILFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MARVEL ROAD MILFORD, DE 19963		
(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 329	<p>Continued From page 10</p> <p>had unsuccessfully attempted to identify through communication with R2. There was no evidence found in the clinical record of a systematic approach to responding to R2's yelling out behavior or evaluating what interventions were effective.</p> <p>Later on 9/25/14, a physician's order for the antipsychotic medication (zyprexa) was written for R2 to treat "resistant depression" (a mood disorder not responding to treatment). The next day, 9/26/14, E5 documented in a psychiatric progress note that she (E5) was unable to conduct a psychiatric exam of R2 because R2 was "somnolent" (sleepy and lethargic). Despite the lack of a psychiatric exam, E5 wrote that R2 had "psychosis" and recommended to decrease the Zyprexa dose from 2.5 mg twice a day to 1.25 mg twice a day. A review of medical and psychiatric evaluations and progress notes in the clinical record for R2 failed to identify why R2 was determined to have "psychosis" on 9/26/14.</p> <p>MDS assessments dated 9/29/14 and 10/8/14 again revealed no hallucinations or delusions or behavior that could harm R2 or others although R2 was being administered the antipsychotic medication, Zyprexa, twice a day. A total of eleven (11) doses of Zyprexa were administered to R2 between 9/25/14 and the discontinuation of the medication at the request of family members on 10/10/14.</p> <p>Staff interviews revealed inconsistencies about why R2 was given the antipsychotic medication, Zyprexa: -During an interview with the surveyor on 5/5/15 at 2:05 PM, E2 (DON) stated that R2 needed Zyprexa for yelling which was having a negative</p>	F 329			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2015
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NAME OF PROVIDER OR SUPPLIER MILFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MARVEL ROAD MILFORD, DE 19963
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(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 329	<p>Continued From page 11</p> <p>Impact on other residents;</p> <p>-During an interview with the surveyor on 5/5/14 at 3:25 PM, E4 stated that R2 needed Zyprexa to calm her down because of combative behaviors that could harm herself or others. The clinical record lacked evidence of this; and</p> <p>-During an interview with the surveyor on 5/5/15 at 5:25 PM, E10 (RN) stated that she was working when the Zyprexa was ordered for R2 and she received the verbal order from E4. E10 explained to the surveyor that R2 was not combative but had a habit of yelling out with nonverbal sounds that bothered other residents.</p> <p>In summary, the clinical record lacked evidence of:</p> <ul style="list-style-type: none"> -behavior monitoring required by facility policy / procedure and R2's care plan for September, 2014 prior to use of an antipsychotic medication; -consistently implemented diversional strategies and activities as required by R2's care plan prior to use of an antipsychotic medication; -a specific condition diagnosed and documented in the clinical record at the time an antipsychotic medication was ordered for R2 on 9/25/14 and -a lack of communication with and informed consent from the family for the administration of an antipsychotic medication to R2. <p>These findings were reviewed with E1 (NHA), E2, and E3 (ADON) at the exit conference on 5/12/15 at 12:40 PM.</p>	F 329		



**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: Milford Center

DATE SURVEY COMPLETED: May 12, 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 complaint survey was conducted at this facility from May 3, 2015 through May 12, 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 123. The sample size included three (3) active and two (2) closed records.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p>		

Provider's Signature *Bruce Selvin* Title Administrator Date 6-15-15



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 12, 2015 F157, F279, F284, and F329	Cross Refer to the CMS 2567-L survey completed May 12, 2015 F157, F279, F284 and F329.	6-15-15

Provider's Signature *Paul Quinn* Title Administrator Date 6-15-15