

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

PRINTED: 08/19/2015
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 07/31/2015
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 annual survey was conducted at this facility from July 23, 2015 through July 31, 2015. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 126. The survey sample totaled thirty five (35).</p> <p>Abbreviations/Definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; NP - Nurse Practitioner; PA - Physician Assistant; ADLs - Activities of Daily Living, such as bathing and dressing; BMP - Basic Metabolic Panel (blood test); ER - Emergency room; F - degrees Fahrenheit; LFT - Liver Function Test (blood test); PRN - As needed; POS-Physician order sheet; MAR - Medication Administration Record; MDS - Minimum Data Set (standardized assessment used in nursing homes); Cognitive function - mental abilities;</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Bonnie Lavin *Administrator* *9-8-15*

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 Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Dialysis - cleansing of the blood by artificial means when kidneys have failed; Incontinence - loss of control of bladder and/or bowel function; Pressure ulcer -sore area of skin that develops when blood supply to it is cut off due to pressure, laying/sitting on it; Pseudobulbar affect - medical condition with sudden and uncontrollable episodes of crying or laughing; Prophylactic - medication or a treatment designed and used to prevent a disease from occurring; Rejection of care - behavior that interrupts or interferes with the delivery or receipt of care; Tolerance - to put up with; UTI-urinary tract infection-bacteria in the urine.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the	F 156	The Notice of Medicare Non-Coverage letter to R2 was unable to be located. Currently, for all residents receiving the Notice of Medicare Non-Coverage letter, copies are being secured and filed in the Business Office. The Business Office Manager re-educated the Bookkeeper responsible for obtaining and filing the Notices. This occurred on 8/3/15. She reviewed proper and accurate record keeping. The Business Office Manager/Designee	9-10-15

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F 156	<p>Continued From page 2</p> <p>resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification</p>	F 156	will complete random audits of the Notices to determine compliance with the process. Reviews will be conducted weekly until 100% success is obtained for three consecutive evaluations; then, monthly until 100% compliance for three consecutive evaluations is reached. All findings will be reported to the Quality Assurance and Improvement Committee for data evaluation and recommendations.		

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F 156	<p>Continued From page 3</p> <p>agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</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 the Notice of Medicare Non-Coverage letter to one (R2) out of three residents discharged from skilled services. Findings include:</p> <p>On 7/23/15 at 8:40 AM, E5 (Business Office Manager) provided the surveyor with two of the three requested signed Notice of Medicare Non-Coverage letters. E5 stated she could only find two letters.</p> <p>Upon review of R2's medical record on 7/29/15,</p>	F 156		

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F 156	Continued From page 4 the letter for this resident was not found. During an interview on 7/30/15 at 8:53 AM E6 (Admission Director) reviewed the computerized financial records in her computer then looked through papers in a file obtained from the business office. E6 stated "I can't find it. Sorry." At 9:38 AM E5 stated she looked everywhere for R2's letter and "can't find it". The facility failed to provide the Notice of Medicare Non-Coverage to this resident. These findings were reviewed with E2 (DON) and E3 (ADON) on 7/31/15 at 2:00 PM.	F 156			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	A self-report was submitted on 4/1/2015 for resident R114 (see attachment 225-1). Resident R114 continues to reside in the facility and there have been no further allegations. Incidents regarding residents currently residing in the facility are being reviewed by the Administrator, Director of Nursing or designee for the need to report to the Department of Long Term Care Residents Protection and to verify that these are being reported within the time frame dictated (see attachment 225-2). No changes required to policies/procedures. NPE/designee will in-service current staff on or before 9/9/15, regarding what constitutes	9-10-15	

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F 225	<p>Continued From page 5 State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and other facility documentation, it was determined that for one (R114) out of 35 sampled residents the facility failed to ensure all allegations of abuse and neglect were immediately reported to the State agency. Findings include:</p> <p>The facility policy entitled "Abuse Prohibition" last revised on 12/01/11 indicated:</p> <ul style="list-style-type: none"> -anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to their supervisor immediately; -the notified supervisor will report suspected abuse immediately (not to exceed 24 hours) to the administrator or designee and other official in 	F 225	<p>abuse, what must be reported to the Department of Long Term Care Residents Protection and the time frame for such reporting.</p> <p>Director of Nursing/Administrator/designee will review incident reports, concerns, and grievances to verify that appropriate and prompt reporting occurs. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>		

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F 225	<p>Continued From page 6 accordance with state law.</p> <p>Review of facility documents revealed the following:</p> <p>In a written statement by E8 Dementia Unit Director it was documented that on Monday 3/30/15 E8 was on the phone in her office when she heard E11 CNA talking in the hall and noticed her voice was "elevated and stern and it caught my attention. When I got off the phone I was going to talk to her but E11 was on break." E8 documented that R114 stated to her that "E11 is always mean to me (R114), she got up in my face and said shut up". According to E8's written statement she went to look for E11 but it was after 3:00 PM and "she was gone." When E8 came in Tuesday 3/31/15 E11 was not working. On Wednesday 4/1/15 E8 notified E2 DON and the State agency.</p> <p>The facility reported an allegation of emotional abuse by a CNA toward a resident with the employee being placed on administrative leave pending the investigation to the State agency on 4/1/15 at 9:30 AM.</p> <p>During an interview on 7/30/15 at 2:08 PM with E8 it was confirmed that an allegation of emotional abuse was not reported to the state agency until 4/1/15, three days after E8 became aware on 3/30/15. E8 stated the investigation "began on Monday 3/30/15 but I didn't report it to the state right away, I did report it to my supervisor E2 but I didn't report it to the state right away because I thought I had to have all the statements first."</p> <p>These findings were reviewed with E2 and E3</p>	F 225		

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F 225 F 253 SS=E	Continued From page 7 ADON on 7/31/15 at 2:00 PM. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for 15 (103, 105, 106, 107, 118, 119, 121, 122, 123, 124, 128, 218, 230, 301, and 309) out of 60 rooms reviewed, the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior. Findings include: The following was observed during an environmental tour on 7/30/15 at 2:30 PM: -The resident tubs in rooms 105, 118, 121, 123, 124, 128, and 218 were stained and had corroded drains. -The bathroom in room 218 was missing a faucet. -In room 106 a faucet flange was missing. -In the Central North unit shower the floor was stained, the ceiling heaters were peeling and the racks for bathing supplies were peeling and rusty. -The bathroom in room 107 had a cracked toilet seat. -The non-skid floor applications were peeling in	F 225 F 253	The tubs have been cleaned and sanitized. The faucet in room 218 has been replaced. The faucet flange in room 106 has been replaced. The Central North shower room floor is clean and the supply rack has been replaced. The ceiling heater has been replaced. The toilet seat in room 107 has been replaced. The non-skid tape in room 103 has been removed as not required at this time. The blue floor mats have been replaced. The loose/bent towel racks have been repaired/replaced. Other rooms were audited to verify compliance with tubs, fall mats, towel racks and plumbing fixtures. The Environmental Services Director has an audit tool to review the need for cleaning and equipment repair. Education was provided to the Environmental Services Director by Administrator on deficiencies noted. Audits will be performed weekly by the Environmental Services Director. The Administrator/Designee will review audits by the Environmental Services	9-10-15	

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F 253	Continued From page 8 room 103 in front of bed A. -Three thick blue floor mats found in rooms 103, 107 and 119 were ripped along the edges and in poor condition. -Five bathrooms (rooms 122, 123, 124, 230, 309 and 301) had loose and bent non-institutional towel racks. The appearance of these towel racks were similar to the grab bars and could be mistaken for the same. All findings were confirmed with E14 (Maintenance Director) during the environmental tour on 7/31/15 from 10:30 AM to 11:30 AM. These findings were reviewed with E2, DON and E3, ADON on 7/31/15 at 2:00 PM.	F 253	Director to determine compliance. Reviews will be conducted weekly at 10% of rooms until 100% success is obtained for three consecutive reviews, then 10% of rooms monthly until 100% success is obtained for three consecutive reviews. All findings will be reported to the Quality Assurance and Process Improvement committee for evaluation and recommendations.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272	A correction to the MDS dated 5/7/15 was submitted to CMS on 8/5/15 for R55. A correction to the MDS dated 7/14/15 was submitted to CMS on 8/5/15 for R252. Both residents continue to reside in the facility and are stable. Current residents with visual impairment were reviewed to verify the accuracy of MDS documentation (see attachment 272-1). No changes required to policies and procedures. NPE/designee will discuss with current licensed nursing staff on or before 9/9/15, the need to verify that care plan, nursing assessment and MDS	9-10-15	

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F 272	<p>Continued From page 9</p> <p>Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to accurately assess two (R55 and R252) out of 35 sampled residents. Findings include:</p> <p>1. For R55 the admission MDS dated 2/12/15 and the quarterly MDS dated 5/7/15 assessments stated her vision was adequate. The MDS defined adequate as " sees fine detail, such as regular print in newspapers/books". The resident had visual impairment as noted in her care plan dated 8/5/14. An interview with R55 on 7/28/15 at 12:50 PM revealed the resident was unable to read large print and stated she was blind.</p> <p>2. For R252 on the MDS dated 4/28/15 (Admission) and subsequent Medicare</p>	F 272	<p>reflect accurate data and the residents' current status, including vision.</p> <p>Director of Nursing/designee will conduct random reviews of MDS's for residents with visual impairment to verify that the MDS reflects the residents' current status. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>	

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F 272	Continued From page 10 assessments dated 5/13, 7/2, 7/6, and 7/14/15 had assessments stating her vision was adequate. The resident's care plan (dated 4/13 and 6/17/15) addressed the resident's visual impairment. R252 was not able to be interviewed due to confusion. The MDS assessments did not accurately reflect the resident's impaired vision. An interview with E8 (Dementia Unit Director) was conducted on 7/28/15 at 1:30 PM and revealed that the MDS vision assessment was incorrect for both residents. These findings were reviewed with E2, DON and E3, ADON on 7/31/15 at 2:00 PM.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278	A correction to the MDS's dated 4/23/15 and 7/22/15 were submitted to CMS on 8/5/15 for R215. R215 continues to reside in the facility and is stable. R184 no longer resides in the facility. Current residents with dental concerns were reviewed to verify that the nursing assessment, MDS and care plans reflect the residents' current status (see attachment 278-1). No changes required to policies/procedures. NPE/designee will discuss with current licensed nursing staff on or before 9/9/15, regarding the requirement that the nursing	9-10-15

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F 278	<p>Continued From page 11</p> <p>\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to assure the accuracy of assessments for 2 (R215 and R184) out of 35 sampled residents. Findings include:</p> <p>1. R215's admission MDS dated 1/22/15 documented no broken or loose teeth.</p> <p>Upon return from the hospital, a 3:01 PM nursing note dated 3/10/15 stated the resident's dislocated shoulder was corrected and that R215's two top front teeth were broken.</p> <p>Answers from the electronic medical record assessment entitled Nursing Assessment - Expanded automatically flow into the MDS assessment.</p> <p>The dental section of R215's expanded nursing assessment dated 4/23/15 and 7/22/15 stated no obvious broken teeth. As a result the quarterly MDS assessments dated 4/23/15 and 7/22/15 did not reflect the resident's broken teeth.</p> <p>Two quarterly MDS assessments (4/23/15 and 7/22/15) for this resident were not accurate as</p>	F 278	<p>assessment, MDS and comprehensive care plan all accurately reflect the resident's current status, including oral status.</p> <p>Director of Nursing/designee will conduct random reviews of nursing assessments, MDS, comprehensive care plans to verify that the information in all three documents is accurate and reflects the resident's current status. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>	

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F 278	Continued From page 12 they did not reflect broken teeth which were identified on 3/10/15. These findings were reviewed with E2 (DON) and E3 (ADON) on 7/31/15 at 2:00 PM. 2. Cross refer F325 example #1 The following weights were documented in R184's electronic medical record; 5/9/15 114.4 5/15/15 107.2 (a 7 pound or 6.1% weight loss from 5/9/15) 5/22/15 107.4 5/25/15 102 (a 12 pound or 10.5% weight loss from 5/9/15) The 14-day Medicare MDS dated 5/21/15 documented the current weight as 114. The MDS should have documented the 5/15/15 weight of 107.2 which would have identified a 5% or greater weight loss. An interview on 7/27/15 at 3:09 AM with E19, RD, revealed that the 5/21/15 MDS should have included the 5/15/15 weight of 107.2. These findings were reviewed with E2 and E3 on 7/31/15 at 2:00 PM.	F 278		
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. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	R95 no longer resides in the facility. Current residents with behaviors were reviewed to verify that these were care planned appropriately to reflect the resident's current status (see attachment 279-1).	9-10-15

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F 279	<p>Continued From page 13</p> <p>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 interview it was determined that for one (R95) out of 35 sampled residents the facility failed to develop a care plan for an identified need. Findings include:</p> <p>Review of R95's clinical record revealed the following:</p> <p>A quarterly MDS assessment dated 6/5/15 identified the behavior of rejection of care that occurred 1 to 3 days during the seven day assessment period. This behavior was not identified on the previous MDS assessment dated 3/06/15.</p> <p>Review of all of R95's care plans last updated 6/25/15 revealed there was no evidence that a care plan was developed to address this behavior of rejection of care.</p> <p>During an interview on 7/30/15 at 10:33 AM with</p>	F 279	<p>No changes required to policies/procedures. NPE/designee will discuss with current licensed nursing staff on or before 9/9/15, regarding the development of comprehensive care plans and the need to update the care plans when the resident status changes, including behaviors.</p> <p>Director of Nursing/designee will conduct random reviews of residents' changes in condition to verify that these changes are reflected in the residents' comprehensive care plans. . Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>		

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F 279	Continued From page 14 E3 ADON it was indicated that following a change discovered during the MDS assessment, the nurse manager was responsible for initiating a care plan in response. During an interview on 7/30/15 at 10:37 AM with E9 RN and charge nurse on R95's unit it was confirmed that a care plan was not developed to address R95's behavior of rejection of care. These findings were reviewed with E2 DON and E3 on 7/31/15 at 2:00 PM.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	R265 no longer resides in the facility. Current residents with skin breakdown were reviewed, using the skin integrity reports, to verify that the care plans reflect areas of actual skin breakdown (see attachment 280-1). No changes required to policies/procedures. NPE/designee will discuss with current licensed nursing staff on or before 9/9/15, regarding importance of accurate comprehensive care plans and revising care plans with changes in resident condition, including newly developed skin issues. Director of Nursing/designee will perform random reviews of residents with skin breakdown, using the skin integrity reports, to verify areas of skin breakdown are reflected accurately in the	9-10-15	

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F 280	Continued From page 15 by: Based on record review it was determined that for one (R265) out 35 sampled residents the facility failed to revise a care plan for a change in condition. Findings include: R265's care plan dated 6/4/15 and last revised 7/2/15 for actual skin breakdown included the pressure ulcer to the lower back that the resident had on admission. On 6/23/15 the resident was documented on the Skin Integrity Report to have developed a pressure area to the head of the penis caused by a tube draining urine from his body. The care plan was not updated to reflect this new area of skin breakdown. This finding was reviewed with E2, DON and E3, ADON on 7/31/15 at 2:00 PM.	F 280	comprehensive care plan. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.		
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 record review and interview it was determined that for one (R109) out of 35 sampled residents the facility failed to ensure an	F 309	R109 still resides in the facility and pain documentation is being reviewed for accuracy. Resident pain level is currently at acceptable level and documentation is being done appropriately, including the numeric outcome. Documentation for current residents receiving PRN (as needed) pain medication was reviewed for accuracy (see attachment 309-1). NPE/Designee will in-service current licensed nursing staff on the Pain Management Policy regarding pain	9-10-15	

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F 309	<p>Continued From page 16</p> <p>assessment of pain relief was conducted after the use of PRN pain medication. Eight [8] out of 18 pain medication doses administered failed to have a pain assessment after administration. Findings include:</p> <p>The facility's policy Pain Management last revised 1/2/14 documented that the resident receiving interventions for pain will be monitored for the effectiveness and side effects in providing pain relief and that staff documentation would include the effectiveness of PRN medications.</p> <p>R109's admission MDS dated 7/13/15 documented the use of a scheduled pain medication regimen, the use of PRN pain medication, non-medication interventions and current pain to the right knee that was chronic and sharp. The assessment listed the acceptable level of pain as 6 on a 0 to 10 scale.</p> <p>A care plan dated 7/13/15 for alteration in comfort had a goal of resident will achieve acceptable level of pain control for 30 days. Approaches included: -utilize pain scale, advise resident to request pain medications before pain becomes severe, medicate resident as ordered for pain, monitor for effectiveness and monitor side effects, report to physician as indicated.</p> <p>A Pain Assessment Interview dated 7/26/15 documented hurting in the last five days frequently, the pain limited day to day activities and the worst pain was a 9 on the 0 to 10 scale.</p> <p>Review of the MAR noted the resident's acceptable pain level as 6.</p>	F 309	<p>assessment both pre and post administration of as needed pain medication using either pain scale of 0 to 10 with ten being the worst pain or verbal descriptor of minimum, moderate or severe pain. Pain levels both pre and post medication will be documented on the back of the Medication Administration Record to determine effectiveness of medication. A new pain documentation MAR will be introduced to better capture the required documentation (attachment 309-2). Education will be completed by 9/9/15.</p> <p>Director of Nursing/designee will perform random reviews of residents receiving as needed pain medication to verify compliance. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>	

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F 309	Continued From page 17 Review of the MAR for the administration of the resident's PRN pain medication for July 2015 revealed 18 doses of pain medication were documented. Eight out of 18 of the doses administered failed to have a post [after] pain assessment using the same numeric scale that was used prior to administration of the medication; 7/14 - 2:00 PM, 7/16 - 2:30 AM, 7/17 - 4:00 AM, 7/19 - 9:00 AM, 7/20 - 1:45 AM and 9:00 AM, and 7/24 - 8:00 AM and 4:00 PM. An interview on 7/29/15 at 11:22 AM with E2, DON confirmed that she was aware that nurses were not always completing the post pain assessment and/or using the the same scale post pain assessment to determine pain relief. These findings were reviewed with E2 and E3, ADON on 7/31/15 at 2:00 PM.	F 309			
F 323 SS=D	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 record review, observation and interview it was determined that the facility failed to provide an assistive device to prevent injury for a resident with a history of falls by not implementing fall mat(s) for one (R159) out of 35	F 323	R159 remains in the facility and fall mats were put in place at time of noted deficiency. Resident rooms, care plans and certified nursing assistant's task bar for current residents with fall mats and alarms were audited to determine compliance (see attachment 323-1). No changes required to policies/procedures. NPE/designee will in-service current licensed nursing staff on or before 9/9/15, regarding the revision/initiation of care plans, updating the nursing assistant task bar and	9-10-15	

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F 323	<p>Continued From page 18 sampled residents.</p> <p>R159 was admitted 4/14/15 for rehabilitation after back surgery. The resident had a history of dementia caused by impaired blood flow to the brain and multiple falls.</p> <p>The care plan problem entitled risk for falls dated 4/14/15 included the following interventions: call light in reach at all times; remind to use call light when attempting to ambulate or transfer; when resident in bed place all necessary personal items within reach; monitor and assist for toileting needs.</p> <p>The care plan problem entitled decline in cognitive function from dementia (initiated 4/14/15, last reviewed 7/27/15) contained the following interventions: allow resident to make daily decisions about clothing, daily care, meal alternatives, etc.; always approach in a gentle, friendly manner; approach resident in a calm, non-threatening manner; be alert to non-verbal clues of problems; medicate as ordered.</p> <p>Nursing note dated 7/5/15 at 10:13 AM stated a description of a witnessed fall. R159 was seen getting something out of her dresser drawer, lost her balance and fell on her side. The resident was sent to the ER and was found to have a broken right hip. R159 returned to the facility on 7/13/15 after surgery for the broken hip.</p> <p>Physical Therapy Initial Evaluation dated 7/14/15 documented decreased sitting and standing tolerance, bed mobility, transfers and ambulation due to pain in the right leg. R159 needed caregiver assistance for all functional mobility. The plan was for the resident to receive physical</p>	F 323	<p>supervision of safety devices implemented for residents. Nursing assistants will be in-serviced on accurate documentation and alerting nurse if equipment is not present.</p> <p>Director of Nursing/designee will randomly review safety devices for consistent documentation in the care plan, task bar and presence in resident rooms. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>		

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F 323	<p>Continued From page 19 therapy five times a week for four weeks.</p> <p>Physician order dated 7/24/15 included bed and chair clip alarms, 1/2 side rails on the bed and fall mat.</p> <p>Care plan problem entitled risk for falls was updated 7/24/15 to include the addition of the following interventions: implement the following safety precautions - fall mat; 1/2 side rails; bed alarm and chair alarm to alert staff of resident's need to ambulate.</p> <p>On 7/24/15 the CNA documentation tasks were updated to include chair clip alarm, bed clip alarm and fall mat. The 1/2 side rails were not added at this time.</p> <p>On 7/28/15 at 9:10 AM and 7/29/15 at 9:45 AM no fall mat was observed on the floor next to the resident's bed as ordered.</p> <p>On 7/29/15 at 10:15 AM, the surveyor asked E2 (DON) for a print out of CNA documentation regarding the fall mat and reviewed the observation findings. At 10:22 AM E2 confirmed there was no fall mat in the resident's room. E2 used the telephone to make immediate arrangements for two fall mats, one for each side of the bed, and directed E18 (LPN) to update the care plan to reflect two fall mats.</p> <p>On 7/29/15 the following were added to the CNA documentation tasks: 1/2 side rails and fall mat on both sides of the bed. The care plan was also updated to include two fall mats as an intervention under the problem entitled risk for falls.</p>	F 323		

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F 323	Continued From page 20 The facility failed to initiate the placement of fall mat(s) for five days to ensure the resident environment remains as free of accident hazards as possible for R159 who previously fell in the facility.	F 323		
F 325 SS=D	These findings were reviewed with E2 and E3 (ADON) on 7/31/15 at 2:00 PM. 483.25(i) 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 two (R184 and R23) out of 35 sampled residents the facility failed to identify severe weight changes. This resulted in the failure to reassess both the residents' weight loss and provide interventions as necessary. Findings include: Policy entitled Weights and Heights last revised 1/2/14 documented; -If the patient's weight is less than or greater than 5 pounds from previous weight, the patient will be	F 325	R184 no longer resides in the facility. Corrections to the MDS's dated 6/26/15, 7/1/15 and 7/15/15 were submitted to CMS on 8/25/15 and 8/26/15 to reflect R23's post dialysis weights. Current residents were reviewed for significant weight loss. Dietician, provider and family were notified of concerns. Reweights were obtained if necessary to confirm weight loss (see attachment 325-1). NPE/designee will review with current licensed nursing staff on or before 9/9/15, the process for identifying weight loss, use of post dialysis weights, timely entry of data into PCC and procedure on weights and heights (see attachment 325-2 and 325-3). Director of Nursing/designee will randomly review weight alerts, weights and vitals summary report, resident charts for appropriate identification and	9-10-15

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F 325	<p>Continued From page 21</p> <p>re-weighed and the weight verified by a licensed nurse to determine accuracy;</p> <ul style="list-style-type: none"> -The verified weight will be entered in the (name of electronic medical record) weights/vital signs module on that shift; -The weights 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 six months; -The licensed nurse will; Notify the physician/mid-level provider and dietitian in the weight change progress note. <p>1. R184 was admitted after a hospitalization for an infection, had issues with chronic fluid retention and was receiving medication therapy for cancer that was on hold while in the nursing facility. The resident took a medication that helped reduce the fluid retention.</p> <p>The admission MDS dated 5/16/15 documented that the resident was alert and oriented, on a therapeutic diet, was independent in eating once set up and weighed 114 pounds.</p> <p>A care plan dated 5/9/15 and revised 6/3/15 for fluid volume excess included the approaches; compression stockings (thick tights worn on the legs), fluid restriction, and monitor weight.</p> <p>A verbal physician's order dated 5/12/15 added a nutritional shake at 2 PM and dinner due to low protein in diet.</p> <p>A Nutritional Assessment dated 5/14/15 documented the resident weight as 114.4 pounds (5/9/15), usual body weight 110-115, intake variable, and mentioned that resident had lost about 50 pounds in the last several months due</p>	F 325	<p>notification of significant weight loss. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>		

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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 07/31/2015
NAME OF PROVIDER OR SUPPLIER MILFORD CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 MARVEL ROAD MILFORD, DE 19963		
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F 325	<p>Continued From page 22 to cancer and treatment.</p> <p>A verbal physician's order dated 5/16/15 changed the resident's diet from small portions to regular portions and confirmed a house nutritional shake twice a day.</p> <p>A care plan evaluation was conducted on 5/20/15 that included review of the aforementioned orders and documented the resident was refusing the shakes but the family was bringing in a similar nutritional shake. There was no mention of weight loss in this evaluation.</p> <p>The 14-day Medicare MDS dated 5/21/15 documented the same findings as the previous assessment, including incorrectly documenting the current weight as 114 pounds.</p> <p>The following weights were documented in the electronic medical record; 5/9/15 114.4 5/15/15 107.2 (7.2 pound or 6.2% severe weight loss from 5/9/15) 5/22/15 107.4 5/25/15 102 (12.4 pound or 10.8% severe weight loss from 5/9/15)</p> <p>The resident was discharged home on 5/26/15.</p> <p>An interview on 7/27/15 at 2:55 PM with E3, ADON, revealed that the electronic medical record did not show an alert for a greater than 5% weight loss in 30 days when R184's weight dropped to 107. She stated that if the weight was put in the computer late after the MDS was</p>	F 325		

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F 325	<p>Continued From page 23</p> <p>completed the MDS would have used the previous weight, in this case the 114 pounds. E3 stated the RD should be notified of a 5% loss or more. There was no evidence that the RD was made aware of the weight change since the computer failed to alert staff to the loss.</p> <p>An interview on 7/27/15 at 3:09 PM with E19, RD, revealed that she did not become aware of R184's weight loss until it dropped to 102 at which time she requested a reweigh. The resident was discharged before the reweigh could be done. E19 also confirmed that the computer did not create an alert for the greater than 5% weight loss when the resident's weight dropped to 107. She was never made aware of this weight loss. E19 explained that the 5/21/15 MDS may have populated the original 114 weight instead of the 107 because the 107 may have been put in the computer late. The system should be that the RD be notified via email by nursing of a weight loss and it should also be on the exception report if the computer alerts the change. E19 added that the resident told her she could not eat enough to keep up with her weight, that she didn't like the health shakes and that her family was bringing in a nutritional shake to supplement her diet. E19 shared that E2, DON was also aware of the computers failure to trigger alerts for weight loss.</p> <p>Both the facility staff and the electronic medical record alerting system failed to identify a severe weight loss. This resulted in the lack of an opportunity to fully assess the resident and add interventions as indicated.</p> <p>These findings were reviewed with E2 and E3 on 7/31/15 at 2:00 PM.</p>	F 325			

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F 325	<p>Continued From page 24</p> <p>2. R23's admission MDS dated 6/26/15 and 14-day MDS dated 7/1/15 documented a weight of 202 pounds. The resident was receiving dialysis services.</p> <p>A 6/19/15 Admission Nursing Assessment documented the resident's weight as 179.4 pounds however E2 electronically crossed through this entry on the vital signs list indicating that it was an error.</p> <p>The RD Assessment dated 6/25/15 documented that the resident's weight was 201.7 pounds with a usual body weight of approximately 200 pounds. The RD noted that the diet did not meet protein goals and a daily nutritional shake was added.</p> <p>A care plan dated 6/25/15 and last revised 7/8/15 for nutritional risk included the approach of diet as ordered and on 7/7/15 added a daily nutritional supplement.</p> <p>A 30-day MDS dated 7/15/15 documented a weight of 182 pounds and indicated there had been a loss of 5% and that the resident was not on a prescribed weight loss program. There was no evidence that this weight loss was identified or assessed by facility staff.</p> <p>The following weights were documented in the electronic medical record for June and July 2015: 6/23 - 179.3 line through note 7/7 by E2 with word correction 6/26 - 201.7 7/3 - 196.9 7/3 - 196.6</p>	F 325		

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F 325	<p>Continued From page 25</p> <p>7/10 - 182 (19.7 pound or 9.7% severe loss from 6/26/15) 7/14 - 179.3 7/16 - 179.2 7/23 - 174.7 7/25 - 176.2 (25.5 pound or 12.6% severe loss from 6/26/15)</p> <p>An interview on 7/29/15 at 3:14 PM with E2: about weight changes revealed she was not sure why she canceled the 6/23/15 weight, it may have been because it was not a post-dialysis dry weight or that the RD requested she cancel it. It was noted that E2's view of the electronic record showed an alert for the significant weight changes. However there was no evidence that the facility addressed the weight changes.</p> <p>In a follow-up interview at about 4 PM the same day, E2 provided a new weight summary printed from the electronic record and stated that she obtained post dialysis dry weights and entered them into the medical record. She stated that this showed that there was not really a weight loss. E2 had removed the 6/26 and 7/3 weights from the medical record and added a 6/30 weight of 179 and restored the 6/23 weight of 179.3.</p> <p>An interview on 7/31/15 at 9:49 AM with E19 revealed that an email was sent to the unit manager on 7/15/15 requesting a re-weigh. E19 confirmed that she did not write a note or do a follow-up assessment. E19 stated that the resident's usual body weight was 175 and the only weight loss he had was related to dialysis.</p> <p>The facility failed to ensure the monitoring system properly alerted staff of a documented weight loss and the facility failed to reassess the situation</p>	F 325			

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F 325	Continued From page 26 until after the surveyor brought it to their attention. R23 was documented as having a severe weight loss that was not reassessed by the facility.	F 325			
F 329 SS=E	These findings were reviewed with E2 and E3 on 7/31/15 at 2:00 PM. 483.25(l) 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 329	R157 continues to reside in the facility. Documentation of PRN (as needed) psychotropic medications is being monitored for effectiveness. Current residents receiving as needed psychotropic medications were reviewed to determine compliance with documentation (see attachment 329-1). No changes required to policies/procedures. NPE/Designee will in-service current licensed nursing staff on F329 regarding unnecessary medications and on the correct process for documenting use of an as needed psychotropic medication which includes attempting a non-pharmacological intervention and documentation of the specific behavioral symptom on the Behavioral Medication Form. The Medication Administration Record will reflect both the reason for the medication being given and the effectiveness. Education will be completed by 9/9/15.	9-10-15	

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F 329	Continued From page 27 determined that the facility failed to ensure that one resident (R157) out of 35 sampled residents was properly monitored, on five occasions, for the effectiveness and/or reason of a medication used for behavioral symptoms. Findings include: The MAR document requires that the reason for administration and the results from the administration of the PRN medication should be recorded on the back of the MAR. Review of R157s MAR revealed: R157 was administered a prn anti-anxiety/nervousness medication on 7/13/15 and the reason and effectiveness/results were not documented. R157 was administered a dose of a prn medication for anxiety/nervousness on 7/10, 7/16, 7/20 and 7/29/15 and the effectiveness/results were not documented. An interview with E8 (Dementia Director) was conducted on 7/31/15 at 9:00AM to review these findings. These findings were reviewed and confirmed with E2 (DON) and E3 (ADON) at 2:00 PM on 7/31/15.	F 329	Director of Nursing/designee will perform random reviews to verify accurate and complete documentation when administering as needed psychotropics. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The mobile cart is no longer blocking the hand sink in the dishwashing room. The temperatures for all pantry refrigerators have been checked and are registering 40F or below. Corrected temperature logs indicating acceptable temperature range 40F or below	9-10-15	

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F 371	Continued From page 28 This REQUIREMENT Is not met as evidenced by: Based on observation and interview it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: 1. During the kitchen inspection on 7/28/15 at 8:35 AM there was a mobile cart blocking the handwashing sink in the dishwashing area. 2. Two out of the three pantries on resident units had unacceptable temperatures in the refrigerator. The refrigerator must be maintained at 41F or below. Observations on 7/28/15 between 1:00 PM - 1:15 PM revealed the following: - East unit temperature log documented on 7/16/15, 7/18/15, 7/27/15 temperature readings of 42F. - Homestead unit temperature log documented on 7/7/15 and 7/8/15 temperature readings of 42F. Review of the logs revealed guidelines that the acceptable temperature range was 41F to 44F which was incorrect. These findings were reviewed on 7/28/15 at 2:45 PM with E20, FSD, 2:55 PM with E9, East unit manager and 3:04 PM with E8, Homestead unit manager.	F 371	are being used. The Food Service Director will in-service current Dietary staff on or before 9/9/15, regarding the proper use and storage of mobile carts in the dishwashing room. The Food Service Director/Designee will randomly monitor the dishwashing room and hand sink for unobstructed access. The Nurse Practice Educator will in-service current Licensed Nursing staff on or before 9/9/15, regarding proper temperatures for the pantry refrigerators and completing the daily log. The Nurse Practice Educator/Designee will complete random audits of the temperature logs to assure maintenance of acceptable temperatures and proper recording on log. Reviews will be conducted weekly until 100% success is obtained for three consecutive evaluations then, monthly until 100% compliance for three consecutive evaluations is reached. All findings will be reported to the Quality Assurance and Improvement Committee for data evaluation and recommendations.		

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F 431 F 431 SS=E	Continued From page 29 483.60(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. 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:	F 431 F 431	Expired medications were discarded at the time of the survey. Medication carts and medication rooms were audited to identify other expired medications or loose pills (see attachment 431-1). No changes required to policies/procedures. NPE/designee will in-service current licensed nursing staff regarding the requirements for storage of drugs and biologicals. Director of Nursing/designee will perform random reviews of medication carts and medication rooms to verify the appropriate processes are being followed. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.	9-10-15

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F 431	<p>Continued From page 30</p> <p>Based on observation and interview it was determined that the facility failed to ensure three out of five medication carts were free of expired and/or unlabeled medications. Findings include:</p> <p>1. On 7/23/15 at 2:45 PM the medication cart was reviewed on the Homestead Unit; - Lantus Insulin [medication for high blood sugar] was labeled as being opened on 5/29/15. According to the manufacturer, an opened bottle of Lantus can be stored at room temperature for no more than 28 days and must be discarded after that, making this bottle expired on 6/26/15. Review of the MAR indicated that R6 was given Lantus at 8:00 AM from this bottle by E16 (RN). the medication was discarded. This was confirmed by interview with E16 at the same time.</p> <p>2. On 7/23/15 at 10:00 AM the South medication cart was reviewed on the East Unit; - An antacid was found to have expired on 4/2015. Interview with E12 (LPN) at the same time revealed that the resident was no longer taking this medication.; - Four sealed pills of a UTI prophylactic medication were loose in the cart with no resident name. This was confirmed by interview with E16 at the same time. E12 confirmed these findings and disposed of the medications.</p> <p>3. On 7/23/15 at 11:00 AM Cart 4 medication cart was reviewed on the Central Unit; - An antacid was found to have expired on 4/2015. Interview with E17 (LPN) at the same time revealed that the resident was no longer taking this medication; - A medication for dizziness was found to have expired on 5/31/15. Interview with E17 at the</p>	F 431			

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F 431	Continued From page 31 same time revealed that the resident was not given this medication; - A medication for nausea was found to be expired on 6/2015. Interview with E17 at the same time revealed that the resident was not given this medication; - A medicated mouthwash expired on 6/2015. Interview with E17 at the same time revealed that the resident did not receive this medication. E17 confirmed these findings and disposed of the medications. These findings were reviewed with E2 (DON) and E3 (ADON) on 7/31/15 at 2:00 PM.	F 431			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to provide accurate clinical records for three (R159, R144 and R265) out of	F 514	Individual resident notes entered in medical record by physicians and extenders were corrected for R265, R159, and R144. Notes have been added to each resident's chart in Point Click Care with clarification regarding the stated issues. As of 8-24, provider notes are being reviewed to determine compliance on current residents for accuracy. Physician and physician extenders have been instructed that notes will not be copied blindly or contain unclear documentation, clinical notes starting 8-24-15 will contain historical information vs. current assessment and the plan will be clearly labeled in each physician note. NPE/designee will review with current	9-10-15	

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F 514	<p>Continued From page 32</p> <p>35 sampled residents. Findings include:</p> <p>1. R159 was admitted 4/14/15 for rehabilitation after back surgery. The resident has a history of dementia due to impaired blood flow to the brain.</p> <p>Progress note dated 6/4/15 by E7 (NP) stated the plan for the R159's dementia included the blood tests BMP and LFT to be performed in the morning. Physician order dated 6/4/15 included these two blood tests for the morning of 6/5/15.</p> <p>Progress notes dated 6/10/15 and 6/22/15 by E7 again stated the plan for the resident's dementia included the blood tests BMP and LFT to be performed in the morning. The wording in the progress note was exactly the same as the previous note. There was no physician order for these blood tests.</p> <p>Progress note dated 7/14/15 by E4 (MD) stated the plan for the resident's dementia included the blood tests BMP and LFT to be performed in the morning. The wording in the progress note was exactly the same as the previous note written by the NP. There was no physician order for these blood tests.</p> <p>Review of the Laboratory Log Book on 7/30/15 at 8:10 AM found that R159 should have a BMP every 3 months with the next one due date of 10/10/15.</p> <p>There were inaccurate progress notes in R159's record since the NP and MD included blood tests on three occasions that were not ordered.</p> <p>These findings were reviewed with E2 (DON) and E3 (ADON) on 7/31/15 at 2:00 PM when E2</p>	F 514	<p>Certified Nursing Assistants on or before 9/9/15, the importance of accurate documentation in the medical record and the need to report any discrepancies to the licensed nurse.</p> <p>Director of Nursing/designee to conduct random review of medical staff clinical notes and Certified Nursing Assistants documentation for compliance with accuracy. Reviews will be conducted weekly at 10% of residents until 100% success is obtained for 3 consecutive reviews; then 10% of residents monthly until 100% compliance is obtained for 3 consecutive reviews. All findings will be reported to the Quality Assurance and Improvement Process Committee for evaluation and recommendations.</p>		

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F 514	<p>Continued From page 33</p> <p>stated "I know how that happened". At 2:33 PM, E2 stated that the previous progress note flowed into the computer for review.</p> <p>Cross Refer F323</p> <p>2. Physician order dated 7/24/15 for R159 included fall mat. On 7/24/15 the CNA documentation tasks were updated to include the fall mat.</p> <p>On 7/28/15 at 9:10 AM and 7/29/15 at 9:45 AM no fall mat was observed on the floor next to the resident's bed as ordered.</p> <p>On 7/29/15 at 10:15 AM, the surveyor asked E2 for a printout of CNA documentation regarding the fall mat and reviewed the observation findings above. When handing the surveyor the printed CNA documentation from the electronic medical record, E2 stated "It looks like I have some CNAs to talk to". The document showed the CNAs recorded 14 out of 15 shifts (from 7/24/15 day shift through 7/28/15 night shift) as having a fall mat in place, when in fact the fall mat was not initiated until 7/29/15. At 10:22 AM E2 confirmed there was no fall mat in the resident's room.</p> <p>These findings were reviewed with E2 and E3 on 7/31/15 at 2:00 PM.</p> <p>3. R144 was admitted on 4/11/12 after having bleeding in the brain due to a fall at home. The resident had a history of pseudobulbar affect.</p> <p>Progress note dated 1/13/15 by E15 (PA) stated "I go to see [resident first name], she is pulling herself in her wheelchair by grabbing on rails. She will answer questions occasionally but for the most part [resident first name] lives in her own</p>	F 514			

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

PRINTED: 08/19/2015
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 07/31/2015
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 514	<p>Continued From page 34</p> <p>little world, she will often strike out at other residents and staff for imaginary injustices. She can usually be redirected but not always. Staff has mixed reviews regarding the effectiveness of the [name of medication for pseudobulbar affect]. There have been recent attempts at gradual reductions in her [name of medication] which have failed miserably, there will be no further attempts at reductions. Plan for pseudobulbar affect included to continue with [name of medication] daily."</p> <p>Physician order dated 1/14/15 discontinued the medication for the pseudobulbar affect due to no benefit seen.</p> <p>Progress note dated 2/12/15 by E15 stated the exact same paragraph as the previous note including "Staff has mixed reviews regarding the effectiveness of the [name of medication for pseudobulbar affect].Plan for pseudobulbar affect included to continue with [name of medication] daily."</p> <p>There was an inaccurate progress note in R144's record since the PA wrote this resident was receiving a medication that was discontinued the prior month.</p> <p>These findings were reviewed with E2 and E3 on 7/31/15 at 2:00 PM when E2 stated "I know how that happened". At 2:33 PM, E2 stated that the previous progress note flowed into the computer for review.</p> <p>4. Review of R265's clinical record revealed the following;</p>	F 514		

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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 07/31/2015
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 514	Continued From page 35 On 6/5/15 at 7:26 PM a new physician's order to insert a tube to drain the urine from the resident's bladder due to the resident's inability to empty his bladder. Review of the Physician/NP/PA Narrative for 6/10, 6/12 and 6/17/15 documented: uses depends (disposable underwear); Urinary incontinence - bladder scans as needed to scan for retention; -at greater risk for skin breakdown; and -continue with depends. Although the resident had a tube draining urine into a bag the medical staff continued to document that the resident was incontinent and using depends. These findings were reviewed with E2 and E3 on 7/31/15 at 2:00PM.	F 514		



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: July 31, 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 July 23, 2015 through July 31, 2015. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 126. The survey sample totaled thirty five (35)</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 31, 2015 F156, F225, F253 F272, F278, F279, F280, F309 F323 F325, F329, F371, F431, and F514.</p>	<p>Cross refer to the CMS 2567-L survey completed July 31, 2015 F156, F225, F253, F272, F278, F279, F280, F309, F323, F325, F329, F371, F431 and F514.</p>	<p>9-10-15</p>

Provider's Signature Bruce Levin Title Administrator Date 8-27-15