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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

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F 000	INITIAL COMMENTS	F 000		

An unannounced annual recertification survey was conducted at this facility from February 8, 2016 through February 12, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 89. The Stage 2 survey sample size was 26.

Abbreviations/definitions used in this 2567 are as follows:
NHA - Nursing Home Administrator;
DON - Director of Nursing;
ADON - Assistant Director of Nursing;
RNAC - Registered Nurse Assessment Coordinator;
RN - Registered Nurse;
LPN - Licensed Practical Nurse;
CNA - Certified Nurse's Aide;
FMD - Facility Maintenance Director;
MAR - Medication Administration Record;
MDS- Minimum Data Set (standardized assessment forms used in nursing homes);
NSS - normal saline solution, a sterile mixture of salt and water with a salt concentration similar to tears, blood, and other body fluids;
POS - physician order sheet;
TAR- treatment administration record;
FMD - Facility Maintenance Director;
BID - twice a day;
PRN - as needed;
L - left;
c - with;
BM- bowel movement;
Always incontinent - no episodes of continent voiding (urinating);

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 3/14/16

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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Calcium (Ca) Alginate - wound dressing with calcium and sodium fibers made from seaweed;
Continence - control of bladder function;
Cubic Centimeter/ cc - a unit of capacity, volume;
Dehydration - a condition in which the body has less than normal fluid;
Dialysis - cleansing of the blood by artificial means when kidneys have failed;
Distal - situated away from the center of the body;
End-Stage Renal Disease - (ESRD) disease where the kidneys stop working;
Incontinent/Incontinence - loss of control of bladder function;
I&O/ Intake and Output - monitoring the amount of fluids a resident takes in and comparing this to the amount of fluid a resident puts out;
Ischium - bony areas on each buttock;
IV/Intravenous - within the veins OR administration of medications/fluids through a tube directly into a vein;
Lactulose - a laxative used to treat constipation;
NN - nurse's notes;
Occasionally incontinent - less than seven (7) episodes of incontinence;
Proximal - situated nearer to the center of the body;
Pressure sore/ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure;
Recapitulation (Recap) - monthly facility review of physician's orders to ensure completeness and accuracy before the orders are signed by the resident's physician;
Renal - related to the kidneys;
Santyl - ointment containing enzyme that helps remove dead tissue;
Unstageable - tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or

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F 000	Continued From page 2 brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); Voiding diary - three (3) day monitoring of a resident's voiding in an attempt to determine patterns; 24 hour chart check - process by which the 11 PM to 7 AM shift rechecks all orders written in the preceding 24 hours in order to identify potential errors.	F 000		
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 $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.	F 278	1. A. R29 continues to reside in the facility and is in stable condition. A correction to the MDS has been completed to accurately reflect the resident's current urinary incontinence status. B. R19 continues to reside in the facility and is in stable condition. A correction to the MDS has been completed to accurately reflect the resident's use of an anti-anxiety medication. 2. A. All residents who are incontinent are at risk for this practice. The DON/Designee will perform an audit of MDS for residents who are incontinent to ensure that their urinary incontinence status is accurately reflected. B. All residents who are currently receiving anti-anxiety medications are at risk for this practice. The DON/Designee will perform a MDS audit of all residents receiving anti-anxiety medications to ensure the MDS is coded correctly.	04-07-16

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F 278	Continued From page 3 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that the facility failed to accurately assess two (R19 and R29) out of 26 Stage 2 sampled residents. The facility failed to accurately assess R29 in the area of continence status and failed to accurately assess R19 in the area of medication usage. Findings include: 1. R29 was readmitted to the facility, post hospitalization, on 10/26/15. A quarterly MDS assessment, dated 10/30/15, was completed and revealed the following: Under Section H of the 10/30/15 MDS assessment, the facility coded R29 as occasionally incontinent of bladder. Review of CNA electronic data revealed that on 10/28/15 on the 11 PM to 7 AM shift, staff documented R29 was continent of bladder on one (1) occasion. Review of R29's voiding diary, which was in progress on 10/28/15, revealed there were no continent voidings. During an interview on 2/11/16 at 11:32 AM findings were reviewed with E4 (RNAC). E4 confirmed that historically R29 was always incontinent and that she (E4) should have questioned the CNA who documented the resident was continent on 10/28/15. E4 agreed that it was an error in coding since the voiding diary, in progress at the time, did not support evidence of a continent voiding. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (Corporate Nurse)	F 278	3. A. MDS Coordinator failed to accurately assess R29's continence status. The MDS coordinator will be in-serviced by DON/Designee to fully assess the resident's continence status before actually coding it to the MDS. B. MDS Coordinator failed to identify the resident's use of anti-anxiety medication. The MDS Coordinator will be in-serviced by DON/Designee on accurately identifying the use of anti-anxiety medication on the MDS. 4. A. A weekly review of completed MDS will be conducted by DON/Designee to ensure the residents' incontinence status is accurately coded until 100% compliance times 4 weeks, then a monthly audit of 10% of completed MDS until 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance. B. A weekly audit of completed MDS's will be conducted by DON/Designee to ensure accurate coding of anti-anxiety medication usage until 100% compliance times 4 weeks, then a monthly audit of 10% of completed MDS's until 100% compliance times 2 months.	

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F 278	Continued From page 4 during the exit conference on 2/12/16 at approximately 3:30 PM. 2. The 12/28/15 quarterly MDS assessment stated R19 did not receive any antianxiety medication during the seven (7) day review period (12/22/15 through 12/28/15). Review of the MAR revealed R19 received antianxiety medication (Clonazepam) daily from 12/22/15 through 12/28/15. The facility failed to accurately code R19's 12/28/15 MDS assessment in the area of Medications. During an interview on 2/11/16 at approximately 11:37 AM, E4 confirmed that antianxiety medication use failed to be coded on R19's MDS assessment, dated 12/28/15. Findings were reviewed with E1, E2, E3, and E6 during the exit conference on 2/12/16 at approximately 3:30 PM.	F 278	The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	
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,	F 280	1. R53 continues to reside in the facility and is stable. R53's care plan has been reviewed and revised to address the resident's fluid restriction. 2. Any resident who is on a fluid restriction is at risk for this practice. Care plans of residents who are on a fluid restriction will be reviewed and revised to reflect the fluid restriction and appropriate approaches. 3. The facility failed to revise R53's care plan to reflect fluid restriction with appropriate approaches.	04-07-16

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F 280	Continued From page 5 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 by: Based on record review and interview, it was determined that the facility failed to revise the care plan to reflect actual care needs for one (R53) out of 26 Stage 2 sampled residents. Findings include: The facility's policy and procedure entitled, "Process for Care Plan Development and Communication", last revised on 9/25/14, stated, "... Each facility shall follow a care planning process to ensure timely development and updating of the resident's plan of care... 8. Ongoing and quarterly review of the residents' plan of care will occur at the weekly care plan meetings. Problem statements, goals and approaches/interventions will be reviewed, discussed and updated at this time and revisions made as needed...". R53 was admitted to the facility on 11/19/15. Upon admission, R53's physician ordered the resident to be on a fluid restricted diet due to his diagnosis of ESRD with dialysis services. Review of the at risk for dehydration related to fluid restriction and decreased kidney function care plan, developed on 11/19/15 and last revised 12/4/15, revealed approaches including: Provide	F 280	Licensed nurses will be in-serviced by the Staff Developer regarding the revision of residents' care plans to include fluid restriction and appropriate interventions. 4. Weekly care plan audit of new residents with fluid restrictions and new orders that include fluid restriction will be reviewed to ensure for appropriate revisions until 100% compliance times 4 weeks, then monthly until 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	

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F 280	Continued From page 6 adequate fluids before and with meals; Encourage fluid intake each shift and during medication pass; provide additional fluids via IV or a fluid challenge as per orders/as needed. These care plan approaches were inappropriate for R53, a resident on fluid restrictions, and failed to be revised. In an interview, on 2/10/16 at 11 AM, E2 (DON) confirmed the finding.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that 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 for one (R53) out of 26 Stage 2 sampled residents. For R53, the facility failed to have evidence that fluid restriction orders were being maintained. Findings include: The facility's policy and procedure entitled, "Fluid Restriction", last revised on 6/30/10, stated, "...1.	F 309	1. R53 continues to reside in the facility and is stable and the fluid restriction was added to the POS and MAR. 2. All residents who are on a fluid restriction are at risk for this practice. DON/Designee will review all admission orders for the past 60 days to identify any fluid restriction orders and will compare to monthly POS's and MAR's to ensure appropriate documentation of the fluid restriction. 3. A. The facility failed identify the fluid restriction omission on MAR during the 24 hour chart checks. The licensed nursing staff will be in-serviced by the Staff Developer on appropriate procedure regarding the 24 hour chart checks. B. The facility failed to transcribe R53's fluid restriction order to the monthly POS. All residents who have fluid restrictions will	04-07-16

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F 309	Continued From page 7 An order will be obtained from the resident's attending physician indicating fluid amounts allowed daily...3. Nursing and Dietary collaboratively determine the amount of fluid restriction to be used by nursing for medication administration. The remaining amount of fluid will be served during the daily meals and snack...7. Nursing will initiate/document I&O measurements documented on the I&O sheet every 8 hours and calculate 24 hour totals...". The facility's policy and procedure entitled, "Medication and Treatment Order Guidelines", dated 3/4/04, stated, "...Purpose - To ensure that the licensed nurse receives/accurately transcribes a physician's order...5. The physician order is transcribed (written) onto the medication or treatment administration record (MAR/TAR)...". R53 was admitted to the facility on 11/19/15. Upon admission, R53's physician ordered the resident to be on a 1500 cc fluid restriction due to his diagnosis of ESRD with dialysis services. R53's fluid restriction allotments for nursing was broken down by shift as follows: - 60 cc's on 11 PM to 7 AM shift; - 150 cc's on 7 AM to 3 PM shift; - 150 cc on 3 PM to 11 PM shift; for a total of 360 cc/fluid provided by nursing. The remaining 1140 cc's of fluid were provided to R53 by dietary services during meals. R53's need for dialysis care plan and the at risk for dehydration related to fluid restriction and decreased kidney function care plan, both developed on 11/19/15, included the approach of the 1500 cc fluid restriction. Additionally, the alteration in nutrition care plan, developed on 11/22/15 included the approach to encourage diet	F 309	have their monthly POS's reviewed by the unit managers to ensure documentation is on the POS's. The licensed nursing staff will be in-serviced by the staff developer on monthly POS review to identify fluid restriction. 4. A. The DON/Designee will audit all new admissions to identify any fluid restrictions orders and compare the identified orders to the MAR to ensure accurate transcription weekly until 100% compliance times 4 weeks, then 10% of all new admissions monthly until 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance. B. The DON/Designee will audit all residents with fluid restriction orders monthly on POS/MAR to ensure appropriate documentation. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	

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F 309	Continued From page 8 compliance of 1500 cc fluid restriction with 1140 cc per dietary services and 360 cc provided per nursing services. Review of R53's clinical record from admission revealed that fluid restrictions provided by dietary services were being maintained. However, there was no evidence of fluid restrictions provided by nursing services as being maintained. For R53, the facility failed to: - Identify the 360 cc fluid restriction (nursing) by shift was not on the 11/2015 MAR during a 24 hour chart check; - Transcribe the admission fluid restriction order at the time recaps were done onto the December 2015 POS and the MAR; - Failed to have the 1500 cc fluid restriction order on the January 2016 POS and MAR; - Failed to have the 1500 cc fluid restriction order on the February 2016 POS and MAR until it was brought to the facility's attention by the surveyor. On 2/10/16 at 11:45 AM, during an interview, E2 (DON) confirmed the findings.	F 309		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	1. R29 continues to reside at the facility and is stable. The resident's wound has been evaluated by the wound team and appropriate treatment has been ordered and applied. 2. Any resident receiving treatment for wounds is at risk for this practice. The DON/Designee will review all wound orders and TAR's to ensure transcription accuracy.	04-07-16

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F 314	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure that a resident who has a pressure sore receives the necessary treatment and services to promote healing according to physician's orders. The facility failed to provide R29's pressure sore treatment as ordered for a total of seven (7) days. Findings include: R29 was readmitted to the facility on 10/26/15, post hospitalization, with an unstageable pressure sore on the left ischium. A physician's order, dated 1/12/16, stated "Cleanse L ischium c NSS, apply Santyl, pack c calcium alginate, cover c foam BID and PRN." Review of the TAR revealed the 1/12/16 physician's order was erroneously transcribed as "Cleanse L ischium wound c NSS, pat dry, pack c calcium alginate cover c foam BID and PRN." The facility failed to include the Santyl in the wound order on the TAR. As a result, the facility failed to complete the pressure ulcer treatment as ordered from 1/12/16 through 1/18/16, a total of seven (7) days. Additionally, a 24 hour chart check did not identify the transcription error. Findings were confirmed by E2 (DON) and E3 (ADON) during an interview on 2/12/16 at approximately 11:00 AM.	F 314	3. The facility failed to transcribe a wound order correctly. All wound orders will be reviewed for accurate transcription by the unit manager. Licensed nursing staff will be in-serviced by the staff developer on the transcription of wound orders. 4. The DON/Designee will audit all new treatment orders weekly until 100% compliance times 4 weeks, then monthly until 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 10 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the environment was free from accident hazards in five rooms (209, 218, 222, 223, and 227) out of 35 rooms surveyed. Findings include: Observations made on 2/8/16 during Stage 1 review, and during the environmental tour on 2/10/16, between 10:00 AM and 10:30 AM, revealed the following: 1. Room 209 - The bathroom had exposed, rusted toilet bolts; 2. Room 218 - Outlets near the ceiling contained overhead extension cords and wires that were running across the room and were not adequately fastened, causing the wires/cords to be low hanging. This presented an accident hazard. 3. Room 222 - Outlets near the ceiling contained overhead extension cords and wires that were running across the room and were not adequately fastened, causing the wires/cords to be low hanging. This presented an accident hazard. 4. Room 223	F 323	1. A. Room 209 exposed rusted toilet bolts have been cleaned and covered. B. Room 218, 222, 223 extension cords were fastened and secured. C. Room 227 elevated toilet seat has been replaced. 2. A. All rooms have the potential to be at risk for this practice. All rooms have been inspected for exposed and rusted toilet bolts. All rooms identified with exposed and rusted toilet bolts have been cleaned and covered. B. All rooms have the potential to be at risk for this practice. All rooms have been inspected and any identified loose extension cords have been fastened and secured. C. All rooms with elevated toilet seats are at risk for this practice. All elevated toilet seats have been inspected and all identified with uneven supporting legs have been replaced. 3. A. The facility failed to identify exposed and rusted toilet bolts. Inspection of toilet bolts will be added to the monthly inspection checklist. The Administrator will in-service the Environmental Director on adding the inspection of toilet bolts to the monthly inspection checklist.	04-07-16

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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 323	Continued From page 11 - Outlets near the ceiling contained overhead extension cords and wires that were running across the room and were not adequately fastened, causing the wires/cords to be low hanging. This presented an accident hazard. 5. Room 227 - The elevated toilet seat had uneven supporting legs. All findings were reviewed and confirmed with E12 (FMD) on 2/10/16 at 10:30 AM during the Stage 2 environmental tour. All findings were reviewed with E1 (NHA) and E2 (DON) on 2/12/16 at approximately 3:30 PM.	F 323	B. The facility failed to identify the loose extension cords as a hazard. Loose extension cords will be added to the monthly inspection checklist. The NHA will in-service the Environmental Director on adding the inspection of loose extension cords to the monthly inspection checklist C. The facility failed to identify uneven supporting legs of an elevated toilet seat. The inspection of elevated toilet seats will be added to the monthly inspection checklist. The NHA will in-service the Environmental Director on adding the inspection of the elevated toilet seats on the monthly inspection checklist. 4.	
F 329 SS=D	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	F 329	A. The Administrator/Designee will audit 10% of all rooms weekly for exposed rusted toilet bolts until 100% compliance times 4 weeks, then monthly until 100% compliance times 2 months. The NHA/ Designee will report to the QAPI committee for further recommendations to achieve sustained compliance. B. The Administrator/Designee will audit 10% of all rooms weekly for loose extension cords until 100% compliance time 4 weeks, then monthly until 100% compliance times 2 months. The NHA/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 12 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure each resident's drug regimen was free from unnecessary drugs including without adequate indications for its use for one (R53) out of 26 Stage 2 sampled residents. For R53, a dialysis resident who should not be given MOM, had MOM administered without an order on 11/26/15. Findings include: The facility's policy and procedure entitled, "LTC [Long Term Care] Facilities Receiving Pharmacy Products and Services from Pharmacy", last revised on 1/1/12, stated, "... Facility should not administer medications or biologicals except upon the order of a Physician/Prescriber...". On 11/19/15,the physician ordered the following renal bowel protocol for R53: "Lactulose give 30 ml every 3 days as needed for constipation...". R53's potential for constipation care plan developed on 11/19/15 and last revised on 1/13/16, included the following approaches: monitor bowel status and follow bowel protocol; Administer bowel medications per physician's order - "Lactulose...". Review of the "Resident Bowel and Bladder by	F 329	C. The NHA/Designee will audit 10% of all rooms weekly for uneven elevated toilet seats until 100% compliance times 4 weeks, then monthly times 2 months. The NHA/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance. (End of F323) F 329 1. R53 continues to reside in the facility and is stable. Resident's orders have been reviewed by physician. 2. All residents who have been ordered lactulose for constipation are at risk for this practice. The DON/designee will audit all resident who have the order for lactulose to ensure that it is given as needed and not MOM. 3. The nurse assigned to the resident failed to give the prescribed medication as ordered. All residents receiving lactulose instead of MOM will have the orders reviewed by the unit manager to ensure accurate information. Licensed nursing staff will be inserviced on the review of PRN orders and appropriate medication administration techniques. 4. The DON/Designee will do a weekly audit on residents receiving lactulose instead of MOM to ensure accurate administration of prescribed medication until 100% compliance times 4 weeks, then monthly	04-07-16

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F 329	Continued From page 13 Shift Chart" Report revealed R53 had a medium BM on the evening shift of 11/24/15. R53's NN on 11/26/15 at 10:40 PM, stated, "Resident on BM list. MOM given results pending." The facility failed to follow the renal bowel protocol for R53 as ordered. MOM, administered on 11/26/15, was contraindicated for this resident and was not ordered by R53's physician. On 02/11/2016 at 12:15 PM, in an interview, E2 (DON) and E7 (RN UM) both confirmed the findings.	F 329	until 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	1. R49 continues to reside in the facility and is stable. There is no sign/symptoms of infection. 2. All residents with wounds are at risk for this practice. Hand washing guidelines for dressing changes have been made available in all TAR's. 3. The nurse performing the treatment for R49 failed to wash her hands between dressing changes. Hand washing guidelines are placed in TAR's and licensed staff will have a competency completed. The Staff Developer will in-service all licensed nursing staff on hand washing requirements when performing dressing changes. 4. The DON/Designee will randomly audit 10% of licensed nursing staff weekly until 100% compliance times 4 weeks,then monthly until 100% compliance times 2 months.	04-07-16

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F 441	Continued From page 14 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined that the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection for 1 (R49) out of 26 Stage 2 sampled residents. During wound care on 2/12/16, the facility failed to ensure that staff followed facility policy and accepted professional practice for hand washing and changing gloves after each resident contact for which hand washing was indicated. Findings include: The facility policy entitled, "Handwashing", last revised 10/15/14, stated, "Purpose - Proper hand washing technique must be used at all times when indicated. Hand washing is the most important component for managing the spread of infection...Handwashing is performed:...Before applying and after removal of medical/surgical or	F 441	The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	

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F 441	Continued From page 15 utility gloves." Wound care was observed on R49's mid upper back proximal wound on 2/12/16 at 11:40 AM. E5 (RN) changed gloves after cleaning the wound, then applied new gloves without washing her hands in between glove change. Wound care was observed on R49's mid upper back distal wound on 2/12/16 at 11:44 AM. E5 changed gloves after cleaning the wound, then applied new gloves without washing her hands in between glove change. In both instances, E5 failed to wash her hands prior to regloving, thereby allowing an opportunity for the transmission of an infection. Findings were reviewed on 2/12/16 at 11:54 AM with E5 and E3 (ADON), who was present during the wound observation. E3 stated that E5 did not have to change gloves in between. Surveyor stated, since E5 did change gloves in between, then E5 should have performed hand washing as per facility policy. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E6 (Corporate Nurse) during the exit conference on 2/12/16 at approximately 3:30 PM.	F 441		

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: Millcroft Nursing Home

DATE SURVEY COMPLETED: February 12, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual recertification survey was conducted at this facility from February 8, 2016 through February 12, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 89. The Stage 2 survey sample size was 26.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 12, 2016 F278, F280, F309, F314, F323, F329, and F441.	Cross Refer to the CMS 2567-L survey completed February 12, 2016 F278, F280, F309, F314, F323, F329, and F441.	

Provider's Signature Adrenne M [signature] Title NHA Date 3/14/16