

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

PRINTED: 12/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/17/2014
NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 256 POSSUM PARK ROAD NEWARK, DE 19711		
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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from October 27, 2014 through November 17, 2014. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 101. The Stage 2 survey sample totaled 28 residents.</p> <p>During the annual survey immediate jeopardy was identified on 10/27/14, the first day of the survey, when it was determined that the facility had 5 bathrooms with a total of 9 residents with accordion style doors that could be locked from the inside and staff lacked the knowledge and ability to have rapid access to remove the residents in an emergency such as fire, falls, stroke and heart attack. Although the affected bathroom doors had a small keyhole, facility staff did not carry a key(s) to open the doors or know that they existed. The facility was notified of the immediate jeopardy on 10/27/14 at 4 PM.</p> <p>The immediate jeopardy (IJ) was abated on 10/27/14 at 4:20 PM after the lock mechanisms were removed from the affected bathrooms.</p> <p>Abbreviations used in this 2567 are as follows: NHA - Nursing Home Administrator; MD- Medical Director; DON - Director of Nursing; UM - Unit Manager; RN-Registered Nurse; LPN - Licensed Practical Nurse;</p>	F 000			

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

TITLE

(X6) DATE

*Kathleen H. Duca*, Executive Director 12/16/14

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 CNA - Certified Nurse's Aide; TAR - Treatment Administration Record; MAR - Medication Administration Record; POS - Physician's Order Sheet; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); MRR - Medication Regimen Review- monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; CAA - Care Area Assessment (care areas identified by MDS findings that reflect conditions, symptoms and other areas of concern that prompts care planning); mg - milligrams; Continence [continent] - control of bladder and/or bowel function; Incontinence [incontinent] - loss of control of bladder and/or bowel function; Occasionally incontinent - less than 7 episodes of urinary incontinence during the 7-day MDS assessment; Frequently incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during the 7-day MDS assessment; UTI - Urinary Tract Infection (bacteria in the urine); Post-after.	F 000		1/15/2015
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	F 157	1. R60's POA, dietary, and rehab staff were notified by the Unit Manager of the weight loss. The Physician was also notified and states the weight loss was expected and beneficial for this resident.	1/15/2015

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F 157	<p>Continued From page 2</p> <p>intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to immediately notify one (R60) out of 28 stage 2 sampled resident's family members when there was a significant change in condition with potential for requiring physician intervention. The facility failed to immediately notify R60's son/POA [Power of Attorney] when they identified on 7/21/14 that R60 lost 29 pounds (16.9%), a severe weight loss, in approximately 1 1/2 months. Findings include:</p> <p>The facility policy "Weight Management", dated</p>	F 157	<p>2. Current residents identified with severe weight loss/gain could be affected. Residents with severe weight loss will be reviewed and proper notification to dietary, rehab, POA/RP will be confirmed by the DON/Designee and noted in the residents medical record.</p> <p>3. Past practice was to have dietician communicate the weight loss to staff and POA/RP. New process will be initiated to have nurse/designee communicate weight loss per policy. The licensed staff will be in-serviced on this new process before the plan of correction due date by the DON/designee.</p> <p>The Dietician will submit weekly reports to the DON of any resident with a severe weight loss. The DON/designee will review that</p>	

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F 157	<p>Continued From page 3</p> <p>6/30/10, stated, "... Parameters for evaluating significant unplanned/undesirable weight change are... Interval... 1 month... Severe Gain/Loss &gt; (greater than) 5%... Any significant or progressive weight loss/gain is to be noted and reported to the resident's... family/responsible party and documented in the medical record. If there is an actual 5% or more weight loss/gain in one month, nursing will notify... and the resident's family..."</p> <p>Review of the facility's undated "Vital Signs And Weight Record" in which monthly weights are recorded, stated in the instructions... "... Identify weight gain or loss in the appropriate WT (weight) CHANGE column by specifying the difference (in pounds) between 'new' weight and previous weight. The DATE NOTIFIED columns need to be completed when it is necessary to notify the individuals listed (Included family)... Each entry must be signed by a nurse."</p> <p>Review of R60's weights from 1/3/14 through 6/15/14 revealed stable weights ranging from 169.4 to 172 pounds (lbs.). R60's weight on 6/15/14 was 171.3 lbs. and on 7/21/14, R60's weight declined to 142.4 lbs. which represented a severe weight loss of approximately 29 lbs. (16.9%).</p> <p>Review of R60's current Vital Signs And Weight Record lacked family notification and a nurse's signature.</p> <p>A nurse's note, dated 7/24/14, stated, "Call placed to POA... and notified that resident has had significant weight loss..."</p> <p>E10 (UM) was interviewed on 11/12/14 at 11:01 AM. After reviewing the instructions in the Vital</p>	F 157	<p>the documentation of weight loss has been communicated to appropriate departments and RP/POA weekly over the next 4 weeks or until 100% compliance is obtained.</p> <p>4. The DON will report to the QA committee monthly so the committee can make further recommendations as necessary.</p>	

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F 157	Continued From page 4 Signs And Weight Record regarding family notification for R60, E10 stated, "we don't really do that." E10 stated R60's POA should have been notified "within 24 hours" of when her weight loss which was identified on 7/21/14 and she confirmed that R60's POA was not notified until 7/24/14.  E2 (DON) was interviewed on 11/12/14 at 12:33 PM. E2 stated that R60's POA should have been notified "right away."  The facility failed to immediately notify R60's POA when they identified on 7/21/14 that R60 had a severe weight loss. R60's son/POA was notified on 7/24/14, 3 days later.	F 157		
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; Cognltive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continance;	F 272	1. R107's current MDS reflects an accurate and current assessment of the resident relating to Incontinence. 2. The MDS staff will run a caretracker report of continence status for all current residents from the last ARD date for each resident with a 7 day look back. The DON/ Designee will analyze the report against the matching MDS for coding accuracy. Inaccuracies identified will have a MDS correction submitted. 3. New-Practice: The MDS staff will submit weekly a list of resident assessments to the DON for review. The DON/Designee will review the continence status weekly for four weeks or until 100% is obtained then monthly.	1/15/2015

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F 272	Continued From page 5 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to complete an accurate comprehensive assessment for one (R107) out of 28 Stage 2 sampled residents in the area of bladder function. Findings include:  R107 was admitted to the facility on 6/12/14.  The admssion MDS assessment, dated 6/19/14, stated R107 was always continent of urine during the seven (7) day review period. Review of the electronic Bowel and Bladder Detail Report, completed by CNAs, from 6/13/14 through 6/19/14, revealed R107 had episodes of urinary incontinence on 6/16/14 and 6/19/14. The facility failed to accurately complete the 6/19/14 admission MDS assessment when R107 had episodes of urinary incontinence during the seven	F 272	4. The DON/Designee will report findings to the QA committee monthly for further recommendations.	

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F 272	Continued From page 6 (7) day review period. The MDS should have been coded as occasionally incontinent.  Findings were acknowledged by E2 (DON) during an interview on 11/6/14 at approximately 3:20 PM.	F 272		
F 280 SS=E	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 by: Based on record reviews and interviews, it was determined that for four (R4, R30, R101 and R136) out of 28 Stage 2 sampled residents the facility failed to review and revise care plans. Findings include:	F 280	1. R136 no longer resides in the community. R4, R30, and R101 care plans have been reviewed and revised by the DON/Designee to reflect the appropriate care and services to meet the needs of the resident. 2. A Care Plan audit will be completed on current residents who are incontinent, on a restorative nursing program, and who are at risk for falls to identify and other discrepancies that need to be addressed. 3. New-Practice- The IDT will meet daily to review the 24 hour report, Verbal Orders, Incident and Accidents, and new admission charts, to identify that Care Plans were developed or revised as necessary for those specific to incontinence, restorative nursing, and fall risk. 4. The DON/Designee will report findings to the QA committee monthly for further recommendations.	1/15/2015

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F 280	Continued From page 7  1. Cross refer to F315, example 2.  R4 was care planned for occasional incontinence, initiated on 6/30/14 and last revised on 7/24/14, with interventions that included: "... Brief or incontinence pad for protection & provide incontinent (sic) care each round & prn (as needed) ... Complete bowel and/or bladder assessment per protocol." R4's care plan goal stated, "Resident's incontinence will be managed to reduce the risk of skin breakdown through target date 9-14, 10-14".  Review of R4's incontinence care plan goal and interventions remained the same since admission on 6/30/14. The facility failed to review and revise the urinary incontinence care plan for R4 after the 9/26/14 quarterly MDS revealed a decline in bladder function from occasionally to frequently incontinent.  Findings were reviewed with E2 (DON) on 11/12/14 at 11:50 AM.  2. Cross refer to F315, example 3.  R30's incontinence care plan, dated 7/25/14, included the following interventions: "... Brief or incontinence pad for protection & provide incont. (incontinence) care each round & prn ... complete bowel and/or bladder assessment per protocol ...". In addition, R30's care plan goal stated, "Resident's incontinence will be managed to reduce the risk of skin breakdown through target date 10-14".  Review of R30's incontinence care plan noted that she was readmitted on 9/25/14 and 10/14/14,	F 280		

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F 280	<p>Continued From page 8</p> <p>however, R30's goal and interventions remained the same. The facility failed to review and revise the urinary incontinence care plan for R30 after the 10/2/14 quarterly MDS revealed a decline in bladder function from frequently to always incontinent.</p> <p>Findings were reviewed by E2 on 11/12/14 at 11:50 AM.</p> <p>3. R101 had an interdisciplinary care plan for self-care deficit related to cognitive[related to memory and thinking] impairment and impaired mobility, created on 6/26/14 and last reviewed on 9/18/14.</p> <p>A physician's order, dated 9/5/14, stated to discontinue R101 from the Restorative Nursing Program (RNP) [restorative nursing interventions promote the resident's ability to adapt and adjust to living as independently and safely as possible] and refer the resident to a Maintenance Program (skilled care to prevent or slow a decline in condition) for ambulation.</p> <p>Review of the self-care deficit care plan on 11/12/14, revealed that it continued to list as a current intervention, "ambulate with RNP with a rolling walker."</p> <p>The facility failed to revise the care plan to reflect R101's change from the RNP to the Maintenance Program, on 9/5/14. On 11/12/14 at 10:09 AM, in an interview, E2 confirmed the findings.</p> <p>4. R136 had an interdisciplinary care plan for a history of falls, created on 12/18/13 and last reviewed on 10/24/14. It listed twice, as part of the plan of action/approach- "Do not leave resident alone in room." One of the duplicated</p>	F 280			

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F 280	Continued From page 9 approaches was highlighted and the other was not.  In an interview on 11/12/14 at 10:09 AM, E2 stated someone forgot to highlight the duplicated approach, highlighting indicates discontinued.  The facility failed to revise the care plan to reflect that this approach was no longer in effect. On 11/12/14 at 10:09 AM, in an interview, E2 confirmed the findings.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: The facility failed to provide services for two (R15 and R60) out of 28 stage 2 sampled residents that meet professional standards of quality. The facility failed to follow their Weight Management policy and failed to notify dietary and rehabilitation (rehab) of R60's severe weight loss of 16.9% in approximately 1 1/2 months. The facility failed to ensure that R15 consumed all of her medications and failed to attempt to identify which of R15's medications was not swallowed before a partially dissolved pill on R15's blouse was discarded by staff on 11/5/14. Findings include:  The facility policy "Weight Management", dated 6/30/10, stated, "... Parameters for evaluating significant unplanned/undesirable weight change are... Interval... 1 month... Significant Gain/Loss	F 281	1. Cross Ref F157: R15 currently receives medications as ordered. R60 is receiving care and services that meet professional standards of Quality to include weight management. 2. Any resident with severe weight loss or who receives medications is at risk. Dietician will provide nursing staff a list of all residents that have had a severe weight loss over the past 30 days. The DON/Designee will review each resident's chart for documentation of appropriate notification. 3. New Practice- MARS will be reviewed at the end of each shift by the nursing staff and RN supervisor to identify medications not given in order for appropriate follow up by the nurse	1/15/2015

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NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 256 POSSUM PARK ROAD NEWARK, DE 19711	
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F 281	<p>Continued From page 10</p> <p>5%... Severe Gain/Loss &gt; (greater than) 5%... If there is an actual 5% or more weight loss/gain in one month, nursing will notify... dietary, rehab... The Dietary Services Director (DSD) will notify the consultant dietitian...".</p> <p>Review of the facility's undated "Vital Signs And Weight Record" in which monthly weights are recorded, stated, "... Identify weight gain or loss in the appropriate WT (weight) CHANGE column by specifying the difference (in pounds) between 'new' weight and previous weight. The DATE NOTIFIED columns need to be completed when it is necessary to notify the individuals listed (Included dietary)... Each entry must be signed by a nurse."</p> <p>1. Review of R60's weights from 1/3/14 through 6/15/14 revealed stable weights ranging from 169.4 to 172 pounds (lbs.). R60's weight on 6/15/14 was 171.3 lbs. and on 7/21/14, R60's weight declined to 142.4 lbs. which represented a severe weight loss of approximately 29 lbs. (16.9%).</p> <p>Review of R60's current Vital Signs And Weight Record lacked notification of dietary and a nurse's signature.</p> <p>Review of R60's clinical record revealed that R60 was not on a planned weight loss program.</p> <p>E32 (Registered Dietitian/RD) was interviewed on 11/10/14 at 2:10 PM. E32 stated she began working in the facility in March 2014 and she comes to the facility 2-3 times a week. E32 stated there was also another RD that comes to the facility as needed. E32 stated she was unable to</p>	F 281	<p>has been completed. This includes but is not limited to identifying missed medications, and physician notification.</p> <p>4. The DON/Designee will report findings to the QA committee monthly for further recommendations.</p>	

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F 281	<p>Continued From page 11</p> <p>recall if anyone in the facility notified her on 7/21/14 when R60's weight loss was identified. E32 stated that the RD's record weights in the Weight Record (not the same as the Vital Signs And Weight Record) and she recorded the 7/21/14 weight of 142.4 on 7/24/14, because it was the first day she was at the facility after the 7/21/14 weight was done. E32 also stated that the Unit Manager's have her phone number to call her for any changes.</p> <p>Review of nurse's notes lacked notification of dietary and rehab for R60's weight loss on 7/21/14.</p> <p>E10 (UM) was interviewed on 11/12/14 at 11:01 AM. After reviewing instructions in the Vital Signs And Weight Record regarding notification of dietary for R60, E10 stated, "we don't really do that." E10 stated she writes who has been notified of resident changes in the nurse's notes. E10 further stated that she did not recall notifying dietary or rehab (as per the Weight Management policy) of R60's severe weight loss.</p> <p>Review of E32's nutritional progress notes revealed there were no notes between 5/19/14 and 7/24/14. On 7/24/14, E32 stated, "... 7/21 wt. (weight)= 142.4# (lbs.) 6/15 wt.= 171.3#... showing sig. (significant) wt. of about 29# x (in) 1 1/2 month.... Rec (recommend) to... liberalize diet... like choc (chocolate) ice cream. Rec for L&amp;D (lunch and dinner). Rec appetite stimulant... Spoke c (with) P2 (attending physician) about wt loss &amp; above interventions... Beneficial wt loss per MD (P2)."</p> <p>The facility failed to follow their Weight Management policy and notify dietary and rehab</p>	F 281		

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F 281	Continued From page 12 of R60's severe weight loss that was identified on 7/21/14. E32 became aware of R60's weight loss when she was in the facility reviewing weights on 7/24/14.  2. On 11/5/14 at approximately 9:20 AM, R15 was observed with a partially dissolved, small white pill on the front of her shirt. When asked about it, R15 removed it and stated that it looked like a pill. The surveyor immediately called E14 (LPN) from R15's doorway to return to the resident's room. E14 was asked to look at what the resident had in her hand. E14 stated, "She must have spit that out. I gave her all her meds (medications)..." R15 denied spitting any pills out and stated that she was not even aware the pill was on her shirt until the surveyor had brought it to her attention. E14 took R15's pill to the med cart and when asked what medication it was, E14 repeatedly stated that he had given R15 "a lot of pills". When asked which medications did he last give the resident, he read off the names of multiple medications from the MAR. When asked which of the medications was he going to document as not given, he stated, "I gave them all to her" and promptly discarded R15's partially dissolved pill in the sharps container. E14 then opened the med cart drawer and began to remove R15's blister paks of medication and stated that it could have been Lasix (used to remove excess fluid from the body) or Atenolol (used to treat high blood pressure)..." E15 (UM) joined the interview and was informed of the observation. E15 asked E14 which pill it was and E14 stated that he did "not know... maybe Lasix..." E15 asked to see the pill and E14 stated that he had discarded it. E15 proceeded to instruct the nurse on the need to monitor R15's vital signs since the pill was not identified before it was thrown out, to notify the	F 281		

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F 281	Continued From page 13 doctor and write a nurse's note. E15 informed E14 that he should have tried to identify the pill prior to discarding it and to have asked for help if needed.  During an interview on 11/5/14 at 9:30 AM, E15 confirmed the findings.  On 11/17/14 at 12:54 PM, E2 (DON) provided a copy of the facility's "Med Pass Technique Audit Tool", dated 12/15/01, which stated, "...Technique...Medication ingestion (consumption/swallowing) observed..." The facility failed to meet professional standards when they failed to ensure that R15 consumed all of her medications and failed to identify which of R15's medications was not administered before discarding it.	F 281		
F 309 SS=D	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 reviews and interviews, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care for two (R101 and R110) out of 28	F 309	1. R101 MAR's were reviewed and current physician orders are being followed. R110 has been re-assessed by the attending physician who has determined that the psychological evaluation is no longer necessary. 2. Cross REF F281 Any resident who receives an order for psych consult or receives PO medications is at risk for this deficient practice. 3. New Practice- MARS will be reviewed by the nursing staff and RN supervisor at the end of each shift to identify medications not received over the next 30 days.	1/15/2015

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F 309	<p>Continued From page 14</p> <p>Stage 2 sampled residents. R110 had a physician's order for a psychology consult which was never completed. R101 had a physician order to administer medication that was not followed. Findings include:</p> <p>1. R110's clinical record revealed a physician's order, dated 7/16/14 for a psychology evaluation. Review of the clinical record lacked evidence that this evaluation was completed.</p> <p>On 11/5/14 at approximately 11:30 AM, findings were reviewed with E2 (DON). E2 provided a list which included R110's name; he was listed to be seen by the psychologist in July 2014. However, E2 was unable to provide a completed psychology consult report.</p> <p>2. The Quarterly MDS assessment, dated 9/15/14, stated that R101 was on antipsychotic (used to treat psychosis [loss of contact with reality] and other mental and emotional conditions) medication.</p> <p>Review of the 11/14 monthly POS revealed that R101 had a physician order to administer Risperidone (antipsychotic), every morning.</p> <p>Review of the MAR revealed blanks (lack of signatures signifying medication was not given) on 11/2/14 and 11/6/14 for the morning dose of Risperidone.</p> <p>Review of nurse's notes from 10/30/14 through 11/10/14 lacked evidence that R101 had received the medications.</p> <p>The facility failed to follow physician's order for R101. On 11/12/14 at 10:09 AM, in an interview,</p>	F 309	<p>Staff will notify physician of any discrepancies identified and follow physician recommendations.</p> <p>4. The DON/Designee will report to the QA committee monthly for further recommendations.</p>	

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F 309	Continued From page 15 E2 confirmed the findings.	F 309		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, It was determined that the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much bladder function as possible for four (R4, R30, R70, and R107) out of 28 Stage 2 sampled residents. The facility failed to accurately assess R107's urinary status upon admission, failed to evaluate a 3 day voiding diary and failed to care plan accordingly based on the resident's individualized needs. As R107's urinary continence declined, the facility failed to comprehensively reassess and they again failed to care plan based on the individualized needs. Although the facility revised the care plan on 9/12/14 to toilet R107 at specific times, there was no evidence that this was being done. R107 was incontinent of bladder on eight (8) out of 55 shifts in June 2014, and progressed to being incontinent on 87 out of 93 shifts in October 2014.	F 315	1.For Residents R4, R30, R70, and R107 continence has been assessed and a 3 day voiding diary has been initiated to determine the appropriate treatment and services needed. 2.The DON/Designee will run a caretracker report to determine each residents continence status. Those identified as incontinent will be assessed and a 3 day voiding diary will be initiated to determine the appropriate treatment and services needed for each resident. 3. New Practice-New admissions and re-admissions will have a 3 day voiding diary initiated and completed and confirmed by the DON/designee. Nursing leadership staff will analyze the the completed voiding diary to identify continence status. Those residents determined	1/15/2015

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F 315	<p>Continued From page 16</p> <p>The facility failed to attempt to prevent a decline or maintain normal bladder function for R4 by failing to comprehensively assess R4's urinary incontinence on admission; failing to follow R4's incontinence care plan intervention to complete a bladder assessment; failing to identify that R4's bladder function was not recorded consistently by CNA's from 6/30/14 through 10/31/14; failing to identify a potential cause for R4 being treated for three UTI's since admission; failing to again comprehensively assess R4's bladder incontinence after the 9/26/14 quarterly MDS revealed a decline in bladder function; and failing to individualize a toileting program. For R30, the facility failed to comprehensively assess R30's bladder function three times since admission and failed to identify potential causes for two UTI's, which resulted in two hospitalizations. For R70, the facility failed to evaluate a 3 day voiding diary, failed to individualize a care plan based on the resident's toileting needs, and failed to follow R70's toileting schedule.</p> <p>Findings include:</p> <p>The facility policy entitled "Bladder Elimination Assessment," revised 6/30/06, stated, "...Each resident will be assessed on admission to determine bladder continence or incontinence. If it is determined that the resident is incontinent an in-depth assessment will be completed using the Bladder Incontinence Evaluation Form. The resident will be re-assessed if there is a significant change and annually. A 3-day bowel and bladder flow sheet will be completed on each incontinent resident. Utilizing the Evaluation Form and the Flow Sheet, the recommendation will be made for a retraining program if appropriate..."</p> <p>The facility policy entitled "Toileting Program Guidelines," dated 1/1/01, stated, "...Purpose To</p>	F 315	<p>to be incontinent will have a incontinent assessment completed. Upon completion of the assessment, the nurse leadership team will develop a comprehensive care plan individualized for each resident. The MDS staff will notify IDT of any changes in incontinence from previous MDS to current MDS. NHA/Designee will review new admissions records weekly to determine the completion of the new process has been successful. MDS staff will report daily at morning clinical meetings and resident who has had a decline in continence status.</p> <p>4. The DON/Designee will report to the QA committee monthly for further recommendations.</p>	

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F 315	<p>Continued From page 17</p> <p>improve and/or maintain a resident's ability to control their elimination and decrease episodes of incontinence...Assessment 1. The assessment includes an evaluation of their incontinence, their voiding pattern, and an appropriate physical examination and testing. 2. It is essential that residents who are incontinent be assessed specifically to identify the cause of their incontinence and to decide if it is reversible..."</p> <p>1. R107 was admitted to the facility on 6/12/14 with diagnoses that included diabetes mellitus (high blood sugar levels) and benign prostatic hypertrophy (enlargement of gland that surrounds the tube that carries urine from the bladder out of the body in men).</p> <p>The facility's Data Collection Tool, dated 6/12/14, completed on admission, noted the resident was continent of urine and that pads/brlefs were used.</p> <p>A Bladder Incontinence Assessment, dated 6/12/14, stated R107 was alert and had complete control of bladder function. The Summary portion of this assessment stated after review of the Bladder Incontinence Assessment and the 3 Day Bowel and Bladder Flow Sheet, a determination was to be made if the resident was a candidate for a retraining program. This information was not completed (as R107 was identified as being continent).</p> <p>A 3-day Bowel and Bladder Flow Sheet was completed from 6/13/14 through 6/15/14, however, it did not capture or identify any episodes of urinary incontinence.</p> <p>The admission MDS assessment, dated 6/19/14, stated R107 was cognitively intact (able to make</p>	F 315		

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F 315	<p>Continued From page 18</p> <p>daily decisions), required limited assist of one staff for transfer and extensive assist of one staff for toilet use. The same MDS stated R107 was always continent during the seven (7) day review time period (6/13/14 through 6/19/14). Review of the electronic Bowel and Bladder Detail Report, completed by CNAs, from 6/13/14 through 6/19/14, revealed R107 had episodes of urinary incontinence on 6/16/14 and 6/19/14. The facility failed to accurately complete the 6/19/14 admission MDS assessment when R107 had episodes of urinary incontinence during the seven (7) day review period. The MDS should have been coded as occasionally incontinent (less than 7 episodes). The CAA Summary, dated 6/24/14, triggered urinary incontinence as a potential problem area and was checked off to proceed with care planning. The CAA Summary Report, dated 6/24/14, stated, "Needs assistance with toileting. He is continent...Will care plan for toileting with ADLs (Activities of Daily Living)."</p> <p>On 6/13/14 a care plan for "self care deficit" was developed and included the following interventions: resident able to make needs known; resident able to use call bell; transfers with 1 person assist limited; requires assist with toileting; wears brlefs/pull-ups-change as needed; keep urlnal within reach." Due to an inaccurate MDS assessment, the facility failed to develop a urinary incontinence care plan for R107.</p> <p>Review of the electronic "Resident Bowel and Bladder by Shift Chart," completed by CNAs revealed the following: - 6/12/14 through 6/30/14 consisted of a total of 55 shifts (3 shifts per day) during which R107 was incontinent on 8 out of the 55 shifts (14.5%).</p>	F 315			

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F 315	<p>Continued From page 19</p> <p>- 7/1/14 through 7/31/14 consisted of a total of 93 shifts during which R107 was incontinent on 16 out of the 93 shifts (17.2%).</p> <p>- 8/1/14 through 8/31/14 consisted of a total of 93 shifts during which R107 was incontinent on 34 out of the 93 shifts (36.5%).</p> <p>- 9/1/14 through 9/30/14 consisted of a total of 90 shifts during which R107 was incontinent on 44 out of the 90 shifts (48.8%).</p> <p>- 10/1/14 through 10/31/14 consisted of a total of 93 shifts during which R107 was incontinent on 87 out of the 93 shifts (93.5%).</p> <p>- 11/1/14 through 11/4/14 consisted of a total of 12 shifts during which R107 was incontinent on 12 out of the 12 shifts (100%).</p> <p>Review of the clinical record revealed that on 9/12/14 a care plan for "Needs assist with participating in scheduled toileting" was developed. The goal of this care plan stated, "will accept assistance from staff with scheduled toileting through next review." Interventions included: check to see if resident has voided; follow schedule for toileting; provide prompt incontinence and prevention care; call bell available and within reach; toilet upon rising, before meals, and at bedtime. Review of the clinical record lacked evidence that a 3 day voiding diary was completed and analyzed prior to development of this toileting schedule. There was no evidence that the facility developed an individualized toileting schedule based on R107's voiding diary and assessed toileting needs for managing his incontinence.</p>	F 315			

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NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(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 315	<p>Continued From page 20</p> <p>A quarterly MDS assessment, dated 9/15/14, stated R107 was cognitively intact, required extensive assist of one staff for transfer and toilet use. The same MDS assessment stated R107 was frequently incontinent (7 or more episodes, but at least one continent voiding).</p> <p>Review of Bowel and Bladder Detail Reports (completed by CNAs) from 9/12/14 through 11/5/14, and since the introduction of the scheduled toileting care plan, lacked evidence that the toileting schedule was being followed. Documentation was only being completed once per shift and did not coincide with the proposed toileting schedule time frames. Additionally, there were various responses such as; "resident asked to be toileted," "resident toileted self," "used bedpan/commode/urinal," and "Checking and changing pads during rounds."</p> <p>The following observations were made of R107:  11/5/14 8:00 AM - observed lying in bed asleep, call light in reach, no urinal within reach.  11/5/14 9:45 AM - observed lying on bed, eyes open, stated has been here for several months. When asked if he is assisted to the bathroom he stated he was but when asked if he was on any schedule to use the bathroom, he stated "no". There was no urinal observed within the resident's reach.  11/5/14 10:40 AM - seated in wheelchair in room next to bed, call light in reach.  11/5/14 11:30 AM - remains seated in wheelchair next to bed; no urinal observed near resident.  11/5/14 12:10 PM - interviewed resident after lunch brought into room. R107 was asked if he had been assisted to the bathroom before lunch and he stated "no." When asked if he was aware</p>	F 315			

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F 315	<p>Continued From page 21</p> <p>of when he needed to urinate, he stated, "not always, but most of the time."</p> <p>11/6/14 8:10 AM - seated in wheelchair eating breakfast in room, call light in reach, no urinal within reach; urinal observed hanging in bathroom.</p> <p>11/6/14 9:25 AM - seated in wheelchair next to bed, call bell in reach, wearing eyeglasses. R107 again asked about toileting, he stated he has not used the bathroom today, stated he usually knows when he has to go, but sometimes does wet and that is why he wears a brief. When asked if staff come regularly to assist him to the bathroom, he stated "no".</p> <p>On 11/6/14 at 2:30 PM during an interview with E3, she stated that after a 3 day voiding diary is completed, the nurse is to analyze it and develop a plan for toileting.</p> <p>On 11/6/14 at 2:45 PM during an interview with E9 (CNA), she stated that if a resident is on a toileting schedule they are able to enter the time of the toileting into their electronic charting system more than once per shift. E9 opened R107's electronic documentation screen and it did not identify that the resident was on a scheduled toileting program.</p> <p>Observation of the CNA care card, taped inside R107's closet, revealed that the resident was to be toileted upon rising, before meals and at bedtime.</p> <p>During an interview on 11/6/14 at 3:20 PM with E2 (DON) and E3 findings were reviewed. E2 acknowledged inaccuracy of the admission MDS and lack of appropriate care planning for R107, who was occasionally incontinent upon</p>	F 315		

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F 315	<p>Continued From page 22</p> <p>admission. Review of electronic data revealed that as each month progressed R107's continence status declined. Despite this progressive decline there was no revision to the care plan until 9/12/14 when a "toileting schedule" was added to the interventions. E2 confirmed there was no evidence that the facility completed a voiding diary at this time to reevaluate R107's current voiding patterns and confirmed there was no individualized toileting plan based on this assessment. Upon review of CNA electronic data, E2 confirmed it lacked evidence that the toileting plan was being implemented. R107 progressed from being occasionally incontinent (4-5 episodes in June) to frequently incontinent of urine.</p> <p>2. R4 was admitted to the facility on 6/30/14 with diagnoses including a broken hip, mild dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning) and UTI.</p> <p>Review of R4's medical record revealed an Interagency Nursing Communication Record (document completed by the hospital to communicate the patient's current medical status to the receiving facility), dated 6/30/14 and timed 10:20 AM, which stated that R4 was "mostly continent with bladder ... wears attends (incontinence briefs)".</p> <p>The 6/30/14 Data Collection Tool (facility's admission assessment) documented that R4 was continent of bladder and pads/briefs were used. Attached to the Data Collection Tool was an undated Bladder Incontinence Assessment, which listed R4's contributing factors/diagnoses as dementia and UTI; recent surgery; disoriented (confused) mental status; limited functional</p>	F 315			

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F 315	<p>Continued From page 23</p> <p>assistance; onset of incontinence as "unable to determine"; and the perception of need to void as "unable to assess". The additional 3 pages of the Bladder Incontinence Assessment remained blank. Despite the hospital communication and the contributing factors noted on the Bladder Incontinence Assessment, the facility failed to perform a comprehensive assessment of R4's bladder function, including initiating a 3-day Bowel and Bladder Flow Sheet (voiding diary that is analyzed to determine voiding pattern).</p> <p>R4 was care planned for occasional incontinence, initiated on 6/30/14 and last revised on 7/24/14, with interventions that included: "... Brief or incontinence pad for protection &amp; provide incontinent (sic) care each round &amp; prn (as needed) ... Complete bowel and/or bladder assessment per protocol." While R4 was care planned for incontinence, the facility failed to follow their intervention of completing the bladder assessment. Review of R4's clinical record from 7/1/14 through 11/7/14 revealed the absence of a completed bladder assessment and 3-day voiding diary.</p> <p>A nurse's note, dated 6/30/14 and timed 3:40 PM, stated that R4 "... does have some control of bowel and bladder ...".</p> <p>Review of the Caregiver's Information Form (completed by nursing), dated 6/30/14, stated that R4 was incontinent of bladder and required the assistance of 1 staff person. This document was used by both nurses and CNA's as a reference tool for providing care to R4.</p> <p>The physician's admission history and physical, dated 7/3/14, documented a review of urinary</p>	F 315		
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F 315	<p>Continued From page 24 system as "? (question mark) incontinence".</p> <p>The admission MDS assessment, dated 7/7/14, revealed that R4 was moderately impaired for dally decision making and required extensive assistance of two (2) staff with toileting. The same MDS assessment also stated that R4 was occasionally incontinent of urine and not on a trial or toileting program.</p> <p>Review of the electronic "Resident Bowel and Bladder by Shift Chart," completed by CNA's, revealed the following:</p> <ul style="list-style-type: none"> <li>- 6/30/14 through 7/31/14 consisted of a total of 95 shifts (3 shifts per day) during which R4 was incontinent on 36 out of 95 shifts (38%).</li> <li>- 8/1/14 through 8/31/14 consisted of a total of 93 shifts during which R4 was incontinent on 56 out of 93 shifts (60%).</li> <li>- 9/1/14 through 9/30/14 consisted of a total of 90 shifts during which R4 was incontinent on 54 out of 90 shifts (60%).</li> <li>- 10/1/14 through 10/31/14 consisted of a total of 93 shifts during which R4 was incontinent on 63 out of 93 shifts (68%).</li> <li>- 11/1/14 through 11/9/14 consisted of a total of 27 shifts during which R4 was incontinent on 22 out of 27 shifts (82%).</li> </ul> <p>From 6/30/14 through 10/31/14, the facility lacked evidence of complete CNA documentation on whether R4 was continent or incontinent each month, which ranged from 3% to 36%. The facility failed to identify that R4's bladder function was not recorded consistently by CNA's.</p> <p>Review of the at risk for UTI care plan, last revised on 9/13/14, revealed that R4 was treated for UTI's three (3) times over the course of three</p>	F 315			

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F 315	<p>Continued From page 25</p> <p>(3) months, specifically 7/28/14, 8/28/14 and 9/13/14, since her admission on 6/30/14.</p> <p>The quarterly MDS assessment, dated 9/26/14, stated R4 was moderately impaired for daily decision making and required extensive assistance with toileting with one staff person. The same MDS assessment also stated that R4 was frequently incontinent of urine, which signified a decline in bladder function since the admission MDS assessment on 7/7/14. R4 was not on a toileting program.</p> <p>Although R4's bladder function decline was identified on the 9/26/14 quarterly MDS assessment, the facility failed again to comprehensively assess R4's bladder function.</p> <p>A physician's order, dated 10/10/14, stated "Toileting schedule: toilet resident upon rising, before and after meals and at bedtime". This was added to R4's care plan on 10/10/14, however, the facility failed to individualize R4's toileting program.</p> <p>In an interview on 11/10/14 at 2:46 PM, E21 (CNA) stated that she could not recall a 3-day voiding diary being done when R4 was admitted on 6/30/14. E21 stated that a 3-day voiding diary was typically done with residents shortly after admission. E21 stated that she could not recall a toileting program for R4, but she checked R4 at least every 2 hours and as needed due to urinary accidents. When asked if R4 is more continent or incontinent, E21 stated that she is more continent.</p> <p>In an interview on 11/13/14 at 8:55 AM, E3 stated that the Restorative Nurse assisted nursing with</p>	F 315			

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F 315	<p>Continued From page 26</p> <p>admissions to the facility. E3 stated that she was the Restorative Nurse from 6/23/13 through 3/30/14. E3 stated the Restorative Nurse position was not filled from 3/30/14 until recently.</p> <p>In an interview on 11/13/14 at 9:30 AM, E10 (UM) stated that the Unit Manager, Restorative Nurse or any nurse could do admissions, which included the Data Collection Tool and initiating the Bladder Incontinence Assessment/3-day voiding diary. E10 stated the 11 PM-7 AM shift would start the 3-day Bowel and Bladder Flow Sheet following admission of a resident. E10 stated after the 3-day voiding diary was done, the Bladder Incontinence Assessment would be analyzed by a Registered Nurse and a toileting program would be recommended. E10 stated that the Restorative Nurse completed the bladder assessments. When asked who was responsible when the Restorative Nurse position was vacant, E10 stated that the Unit Manager was responsible to follow-up on the bladder assessments.</p> <p>The facility failed to attempt to prevent a decline or maintain normal bladder function for R4 by failing to comprehensively assess R4's bladder incontinence on admission; failing to follow R4's incontinence care plan intervention to complete a bladder assessment; failing to identify that R4's bladder function was not recorded consistently by CNA's from 6/30/14 through 10/31/14; failing to identify a potential cause for R4 being treated for three UTI's since admission; failing to again comprehensively assess R4's bladder incontinence after the 9/26/14 quarterly MDS assessment revealed a decline in bladder function; and failing to individualize a toileting program.</p>	F 315		

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F 315	<p>Continued From page 27</p> <p>3. R30 was admitted to the facility on 6/30/14 with diagnoses including advanced dementia, diabetes mellitus and UTI.</p> <p>The 6/30/14 Data Collection Tool (facility's admission assessment) stated that R30 was continent of bladder and pads/briefs were used.</p> <p>On 6/30/14, the Bladder Incontinence Assessment was initiated and listed R30's contributing factors/diagnoses as diabetes mellitus, depression [feeling sad], dementia and UTI; confused mental status; extensive functional assistance; the perception of need to void as diminished; and 2-6 Incontinence episodes per week. A nurse's note documented on the Bladder Incontinence Assessment, dated 6/30/14 and timed 11:00 PM, stated "Pt (patient) has been continent this shift since admission ... Reported as incontinent per hospital ...".</p> <p>A 3-day Bowel and Bladder voiding diary was recorded from 7/1/14 to 7/3/14, however, the diary was not reviewed and analyzed for a voiding pattern. Despite having initiated the Bladder Incontinence Assessment and recorded the 3-day voiding diary, the facility failed to analyze and complete the comprehensive bladder assessment for R30.</p> <p>The admission MDS assessment, dated 7/7/14, revealed that R30 was moderately impaired for daily decision making and required extensive assistance of two (2) staff with toileting. The same MDS also stated that R30 was frequently incontinent of urine and not on a trial or toileting program.</p>	F 315			

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F 315	<p>Continued From page 28</p> <p>R30 was care planned for incontinence, last reviewed on 7/25/14, with interventions that included: "... Brief or incontinence pad for protection &amp; provide incontinent (sic) care each round &amp; prn (as needed) ... complete bowel and/or bladder assessment per protocol ...". While R30 was care planned for incontinence, the facility failed to follow their intervention to complete the bladder assessment.</p> <p>A nurse's note, dated 9/19/14 and timed 12:10 PM, stated that R30 had a change in mental status and was lethargic (abnormal drowsiness). A physician's order, dated 9/19/14, was obtained to perform a urine analysis (diagnostic test used to determine presence of infection) for diagnosis of UTI.</p> <p>On the following day, 9/20/14, R30 was prescribed an antibiotic, Cipro, for seven (7) days for diagnosis of UTI. On 9/21/14, R30 was noted to have increased lethargy and fever and a physician's order was obtained to transfer her to the hospital for evaluation.</p> <p>R30 was hospitalized from 9/21/14 through 9/25/14 for urosepsis (severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream). R30 was readmitted to the facility on 9/25/14.</p> <p>The 9/25/14 Data Collection Tool documented that R30 was incontinent of bladder and pads/briefs were used. On 9/25/14, the Bladder Incontinence Assessment was initiated and listed R30's contributing factors/diagnoses as diabetes mellitus, depression and dementia; confused mental status; total functional dependence; the perception of need to void as diminished; and</p>	F 315			

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F 315	<p>Continued From page 29</p> <p>daily incontinence episodes (some control). The facility failed to identify on the 9/25/14 Bladder Incontinence Assessment that R30 had an additional contributing factor/diagnosis: UTI.</p> <p>A 3-day Bowel and Bladder voiding diary was recorded from 9/26/14 to 9/28/14, however, the diary was not completed as the documentation stopped mid-day on 9/28/14. The facility failed to identify that the 3-day voiding diary was incomplete. Furthermore, the facility failed to follow-up and complete the comprehensive bladder assessment for R30.</p> <p>Review of R30's incontinence care plan noted that she was readmitted to the facility on 9/25/14; however, the interventions remained the same.</p> <p>The quarterly MDS assessment, dated 10/2/14, revealed that R4 was moderately impaired for daily decision making and required extensive assistance of two (2) staff with toileting. The same MDS also stated that R30 was always incontinent of urine and not on a toileting program.</p> <p>On 10/11/14, R30 fell and was sent to the hospital for evaluation. R30 was readmitted to the facility on 10/14/14 with diagnoses including fall and UTI. Upon R30's 10/14/14 readmission, she was placed on comfort care (care that helps or soothes a person who is dying).</p> <p>The 10/14/14 Data Collection Tool documented that R30 was incontinent of bladder and pads/briefs were used. However, a comprehensive bladder assessment, including a 3-day voiding diary, were not completed for R30 as per the facility's policy entitled "Data Collection</p>	F 315			

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F 315	<p>Continued From page 30</p> <p>Tool Guidelines," which stated to be completed on readmission.</p> <p>Review of R30's Incontinence care plan noted that she was readmitted on 10/14/14; however, the interventions remained the same.</p> <p>In an interview on 11/6/14 at 2:38 PM, E3 stated that upon admission or readmission to the facility the Data Collection Tool would be completed and if the resident was incontinent a Bowel and Bladder assessment would be completed, which included the 3-day voiding diary.</p> <p>The facility failed to comprehensively assess R30's bladder function three times since admission; failed to follow R30's incontinence care plan intervention to complete a bladder assessment; failed to identify a potential cause for R30's two UTI's, which resulted in two hospitalizations; and failed to review and revise R30's incontinence care plan.</p> <p>Findings were confirmed by E2 on 11/12/14 at 11:50 AM.</p> <p>4. R70 was admitted to the facility on 7/25/13 with diagnoses that included dementia. The admission MDS assessment, dated 7/31/13, stated R70 was able to make daily decisions, required limited assist of one staff for transfer and toilet use. The same MDS stated R70 was frequently incontinent and on a toileting program.</p> <p>The Annual MDS assessment, dated 7/11/14, stated R70 was now moderately impaired (decisions poor; cues/supervision required). The same MDS stated he was now a one person,</p>	F 315			

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F 315	<p>Continued From page 31</p> <p>extensive assist for transfer and toilet use, and was still frequently incontinent, but no longer on a toileting program. The CAA Summary dated 7/11/14, triggered urinary incontinence as a potential problem. The CAA Summary Report under the area of incontinence stated, "Resident has had incontinence with both bowel and bladder. Resident is on a toileting schedule...is to be toileted upon rising, before and after meals, and at bedtime."</p> <p>A Bladder Incontinence Assessment, dated 7/11/14, stated R70 was alert/oriented X1, confused, and had daily incontinence episodes (some control). The summary portion of this assessment states that after review of the Bladder Incontinence Assessment and the 3 Day Bowel and Bladder Flow Sheet, a determination was to be made if the resident was a candidate for a retraining program. This summary portion also stated that a 3 day Bowel and Bladder Flow Sheet was initiated. There was no evidence that this was done until 8/12/14, a month later.</p> <p>A care plan for R70, entitled "Incontinence" initiated on 7/23/14 and reviewed on 10/13/14 has listed as a plan of action/approach to establish and follow toileting plan. Another care plan entitled "Self Care Deficit R/T" (related to) cognitive impairment, impaired mobility, and decondition/weakness initiated 7/23/14 and reviewed on 10/13/14 listed - establish toileting schedule: upon arising, before and after meals, and at bedtime, as an intervention and approach.</p> <p>Review of the clinical record revealed a 3-Day Bowel and Bladder Flow Sheet was completed from 8/12/14 through 8/14/14. The front of the document was filled out, but the back portion was not. There was no evidence the 3-Day Bowel and</p>	F 315		

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NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 315	<p>Continued From page 32</p> <p>Bladder data was analyzed in order to develop an individualized toileting schedule for R70.</p> <p>Review of the clinical record revealed that an undated CNA resident care card indicated that R70 was incontinent of bladder and needed one person assist. It also stated, "please toilet resident upon rising, before and after meals, and at bedtime". Review of the clinical record lacked evidence that this toilet schedule was based on analysis of the 3-Day Bowel and Bladder data. There was no evidence that the facility developed an individualized toileting schedule for R70.</p> <p>Review of Bowel and Bladder Detail Reports (completed by CNAs) from 7/4/14 through 11/5/14, and since the introduction of the scheduled toileting care plan, lacked evidence that the toileting schedule was being followed. Documentation was only being completed once per shift and did not coincide with the proposed toileting schedule time frames. Additionally, there were various responses such as; "resident asked to be toileted," "used bedpan/commode/urinal," and "Checking and changing pads during rounds."</p> <p>Review of the electronic "Bowel and Bladder Detailed Entry Report," from 7/4/14 through 8/14/14, completed by CNAs revealed there was no evidence that R70 was toileted on 7/4/14. This report also revealed the following:</p> <p>-7/7/14 from 1:06 AM to 1:22 PM (no evidence R70 was toileted for over 11 hours).</p> <p>-7/8/14 from 2:21 AM to 2:15 PM (no evidence R70 was toileted for over 11 hours).</p>	F 315			

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F 315	<p>Continued From page 33</p> <p>-8/12/14 from 12:36 AM to 11:03 AM (no evidence R70 was toileted for over 10 hours).</p> <p>-8/13/14 from 12:54 AM to 10:23 AM (no evidence R70 was toileted for over 9 hours).</p> <p>-8/14/14 from 2:27 PM to 11:04 PM (no evidence R70 was toileted for over 8 ½ hours).</p> <p>R70's Quarterly MDS assessment, dated 10/8/14, stated he remained moderately cognitively [thinking and memory] impaired and was still a one person, extensive assist for transfer and toilet use. He was now coded as always incontinent, and not on a toileting program.</p> <p>The following observations were made of R70: -11/5/14 from 10:55AM through 12:00PM, R70 was observed sitting in his room. At 12:00 PM, E9 (CNA) took R70 into the dining room, R70 was not taken to the bathroom or offered to be toileted prior to going to lunch. -11/6/14 at 8:34 AM, R70 returned to his room after eating breakfast. Surveyor observed R70 until 9:37AM (1 hour and 3 minutes) after returning from breakfast, R70 was not toileted after breakfast or offered to be toileted.</p> <p>The facility failed to follow R70's toileting schedule upon rising, before and after meals, and at bedtime.</p> <p>Review of the electronic "Resident Bowel and Bladder by Shift Chart," completed by CNAs revealed the following: - 7/4/14 through 7/31/14 consisted of a total of 84 shifts (3 shifts per day) during which R70 was incontinent on 76 out of the 84 shifts (90.5%).</p>	F 315		

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F 315	<p>Continued From page 34</p> <p>- 8/1/14 through 8/31/14 consisted of a total of 93 shifts during which R70 was incontinent on 85 out of the 93 shifts (91.4%).</p> <p>- 9/1/14 through 9/30/14 consisted of a total of 90 shifts during which R70 was incontinent on 88 out of the 90 shifts (97.8%).</p> <p>- 10/1/14 through 10/30/14 consisted of a total of 89 shifts during which R70 was incontinent on 80 out of the 89 shifts (89.9%).</p> <p>During an interview with E10 on 11/5/14 at 11:36 AM, E10 stated that interpretation of any 3-Day Bowel and Bladder data collected on a resident would be written on the back of this flow sheet to determine a pattern and develop a care plan for that resident. E10 confirmed the findings that the back of R70's flow sheet that would have evaluated his voiding pattern was blank. E10 stated that interpretation of the 3 Day Bowel and Bladder Flow Sheet dated from 8/12/14 to 8/14/14, despite the back portion being blank, was when the undated toileting schedule listed on the CNA resident care card was implemented.</p> <p>On 11/5/14 at 3:24 PM E17 (CNA) stated that it was the practice of the CNA's to chart at the end of the day (shift) when they toileted someone, with the exception of residents that were on a 3 day bowel &amp; bladder program or a toileting program. In these cases the CNA's had to chart immediately after the resident was toileted.</p> <p>On 11/12/14 at 10:59 AM, interview with E16 (MDS Coordinator) confirmed that the resident was on a toileting schedule at the time that she completed R70's Annual MDS assessment on 7/11/14. E16 stated that when assessing a</p>	F 315		

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F 315	Continued From page 35 resident's bowel and bladder function, within that 7day window look back, there are several tools used to gather information. She would look at the CNA electronic "Resident Bowel and Bladder by Shift Chart," 3 Day Bowel & Bladder Flow Sheet, and the Data Collection Tool.  On 11/12/14 at 11:50 AM, during an interview E2 confirmed that R70's toileting schedule was not followed.  On 11/16/14 at 2:30 PM during an interview with E3, she stated that after a 3 day voiding diary is completed the nurse is to analyze it and develop a plan for toileting.  For R70 the facility failed to evaluate a 3 day voiding diary, failed to care plan accordingly based on the resident's individualized needs, and failed to follow R70's toileting schedule.	F 315			
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the resident environment remained as free from accident hazards as is possible for 9 (R83, R99,	F 323	F323 1. The locks were immediately removed from the bathroom doors in rooms 134, 135, 136, 137, and 139. Completed 10/27/2014.  2. All resident rooms were immediately inspected on 10/27/2014 to identify any other rooms with locks that would prevent access in the event of an emergency situation. No other rooms have locks that prevent staff access.  3. The Executive Director informed and educated the maintenance staff of the safety risk regarding doors with inside locks that prevent gaining access to a room. No doors will be installed in the future in a manner that prevents entrance or exit in an emergency. This was communicated on 10/27/2014 by the Executive Director.	10/27/2014	

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F 323	<p>Continued From page 36</p> <p>R111, R131, R140, R212, R215, R216, and R217) out of 101 stage 1 residents. The listed residents resided in rooms 134, 135, 136, 137, and 139 (there were 2 residents in 4 of the rooms and 1 resident in a room by herself). The bathroom doors (accordion style) locked on the inside and were unable to be opened from the outside by staff; thereby the facility lacked the ability to have rapid access to remove the affected residents in an emergency such as fire, falls, and other urgent and emergent medical conditions such as a stroke or heart attack. The doors had a small keyhole on the outside, however, facility staff did not carry keys to open the doors or know that they existed. Findings include:</p> <p>On 10/27/14 at approximately 1:00 PM, a surveyor was in room 135 when a family member advised the surveyor that the bathroom door in the room locked on the inside, but could not be opened from the outside. The visitor stated they were concerned about something happening to a resident while inside the locked bathroom and no one being able to get in to help.</p> <p>After confirming the family members concern regarding the bathroom door, the surveyor interviewed E3 (maintenance worker) on 10/27/14 at 1:03 PM. E3 stated he was unable to get into the bathroom in room 135 when the surveyor locked himself in the bathroom and stated he could remove the locks and use magnets to close the doors to correct the problem.</p> <p>Two surveyors toured the building on 10/27/14 at approxlmately 1:05 PM and checked all resident bathroom doors to ascertain which ones were affected. It was determined that rooms 134, 135,</p>	F 323	<p>4. The Safety Committee utilizes a variety of checklists monthly to identify safety concerns. Members of the Safety Committee will report to the Executive Director any identified concerns related to resident safety, especially related to concerns for the prevention of accidents. The Safety Committee findings will be reviewed with the QA Committee for further monitoring and recommendations.</p> <p>F323 Additions from stage 2</p> <ol style="list-style-type: none"> <li>1. R30 alarms have been evaluated and are in working order. R79 transfer status has been added to the care card and communicated to the staff rendering care and is being followed.</li> <li>2. An audit of residents using alarms will be performed and completed to evaluate and observe that they are properly functioning by the DON/Designee. Any resident identified from the therapy in need of using a slide transfer board will be reviewed, therapy will communicate to the nursing staff, and DON/Designee will place transfer status on care card</li> <li>3. New Practice-Therapy will communicate changes in residents transfer status to nursing. Residents will be listed on the C.N.A. care card for alarms and the current transfer status of the residents. The C.N.A. will check the</li> </ol>	1/15/2015	

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F 323	Continued From page 37 136, 137, and 139 were affected for a total of 9 residents.  E4 (CNA) was interviewed on 10/27/14 at 1:15 PM. E4 stated she had worked in the facility for about 2 months and replied she did not know how she would get into one of the locked bathroom doors after the surveyor demonstrated by locking herself into one of the affected bathrooms. E4 was unable to open the door from the outside.  E5 (maintenance assistant) was observed working on a light fixture in one of the affected rooms on 10/27/14 at 1:20 PM. E5 stated he had worked in the facility since spring and responded "I don't know" when asked what he would do if a resident was locked in the bathroom and needed help. After showing E5 a small round hole that was observed on each of the affected bathroom doors, the surveyor asked E5 what the hole was for and E5 replied it was a "simple keyhole." The surveyor asked if he had a key for the door(s) and he replied he did not know, then he looked through his keys and found one that fit in the lock.  E6 (LPN) was interviewed on 10/27/14 at 1:25 PM. E6 confirmed she was the day shift nurse assigned to the affected rooms on this date and stated she had worked at the facility for 7 years on an as needed basis all over the facility. When asked how she would get into a locked resident bathroom, E6 replied she would "break the door down."  E2 (DON) was interviewed on 10/27/14 at 1:30 PM. After the surveyor locked herself in one of the affected bathrooms, E2 confirmed he was unable to open the door. When asked what he would do, E2 stated that the maintenance director	F 323	the function and placement of alarms upon receiving their work assignment at the onset of each shift. C.N.A.'s will report findings to the licensed nurse who will document function and placement in the MAR. Nursing staff will be educated to the new process of alarm checks and transfer status information. Daily audits be performed by the unit clerk for thirty days for process evaluation and success. 4. The unit clerk will report findings to the ADON. The ADON will report to the QA committee monthly for evaluate the need for further recommendations.	

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F 323	<p>Continued From page 38</p> <p>had recently left. E2 also stated that no residents had been affected by this; the surveyor replied there was potential for residents to be locked in the bathrooms and in need of help.</p> <p>E1 (NHA) was interviewed on 10/27/14 at approximately 4:00 PM and advised that the inability of staff to rapidly unlock and remove residents in the affected bathrooms was an immediate jeopardy (IJ). Findings were confirmed with E1.</p> <p>At 4:20 PM, E1 advised the surveyor that the issue was abated. Tour of the affected rooms at 4:22 PM with E1 confirmed that E3 (maintenance worker) removed the lock mechanisms from the doors and the IJ was abated at this time.</p> <p>The following two (2) examples were identified during Stage 2 of the annual survey and are not included in the above Immediate Jeopardy identified during Stage 1. Consequently, the following based on statement refers only to these two (2) examples.</p> <p>Based on observations, record reviews and interviews, it was determined that the facility failed to ensure that the resident environment remained as free from accident hazards and received adequate supervision and assistance devices as is possible for 2 (R30 and R79) out of 28 Stage 2 sampled residents. For R30, the facility failed to perform a proper transfer from bed to wheelchair using a sliding board (assistive device used to transfer between surfaces when residents are unable to use their legs) and 2 staff, which resulted in R30 being lowered to the floor (fall) without injury. For R79, the facility failed to</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>ensure that her assistive devices (alarms) were functioning. Findings include:</p> <p>The facility policy entitled, "Fall Management &amp; Investigation Program", last reviewed on 7/2/13, stated, "... Purpose: to utilize all reasonable efforts to provide a system to review the resident's risk potential for falls and provide a proactive program of supervision, assistive devices and interventions to manage and minimize falls and identify resident's continued needs ...".</p> <p>1. R30 was admitted to the facility on 6/30/14 with diagnoses including advanced dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning) and a history of falls.</p> <p>The admission MDS, dated 7/7/14, stated R30 was moderately impaired for daily decision making and required total assistance with transfers with two staff members.</p> <p>R30 was care planned for self care deficit, last reviewed on 10/14/14, with interventions that included "... Transfers with 2 person assist ... slideboard txfers (transfers) bed &lt;-&gt; (vice versa) w/c (wheelchair) c (with) gait belt Ext (extensive) (A) (assist) x 2 ...". In addition, R30 was care planned to be at risk for falls, last reviewed on 10/14/14, with interventions that included "... recommend to use transfer board ...".</p> <p>The facility's incident report form, dated 9/15/14 and timed 5:00 PM, stated that R30 was "lowered to the floor by CNA attempting to transfer ... from bed to wheelchair. No apparent injury noted ... Referral made to rehab (rehabilitation)". Although</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>R30 was to be transferred with 2 staff members, she was transferred with one.</p> <p>The facility's investigation report, dated 9/15/14, revealed that E33 (CNA) stated, "Resident was lowered to the floor while being transferred from bed to wheelchair when resident's legs buckled under her".</p> <p>The Occupational Therapy's Treatment Flow Sheet, dated 9/16/14, stated, "Per report ... 'lowered to floor' last night ... assisting her to w/c not clear but appears sliding board was not used for transfer ... continue to recommend slide board for safe functional transfers ...".</p> <p>In an interview on 11/7/14 at 12:17 PM, E3 (ADON) confirmed the findings of an improper transfer which resulted in R30 being lowered to the floor without injury.</p> <p>The facility failed to ensure R30 was properly transferred from her bed to her wheelchair using a sliding board and with 2 staff members.</p> <p>2. Review of R79's Quarterly MDS assessment, dated 9/2/14, revealed that R79 was coded as severely impaired for decision making and had a history of falls.</p> <p>On 11/7/14 from 9:28 AM to 10:45 AM, R79 was observed sitting in her wheelchair in front of the nurse's station, people watching and conversing with other residents and staff.</p> <p>During an observation on 11/7/14 at 10:45 AM, R79 stood up from her wheelchair, removed her chair sensor/pressure alarm from under her and then replaced it, however, the alarm failed to sound. E10 (UM) went over and redirected R79 to</p>	F 323		

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F 323	<p>Continued From page 41</p> <p>sit back down, but failed to identify that the chair alarm had not sounded. E10 then proceeded to move R79 to another area for activities. The surveyor stopped E10 and asked why the chair alarm had not sounded. E21 (CNA) came to assist E10. They stood R79 up and again, the alarm failed to sound. E10 stated that staff should be checking that the alarms are functional (working properly) when the resident is placed in the wheelchair and the bed. E10 stated that the battery needed to be changed. When asked who was responsible to check the batteries and how often they were checked for functionality, E10 stated that staff should check them whenever they move or transfer residents. When asked if there was anywhere that staff document that they check the functionality of alarms, she stated, "no".</p> <p>On 11/7/14 at 10:50 AM, E24 (assigned CNA), replaced the battery in R79's chair alarm. E24 transferred a battery from one of R79's bed alarms into the chair alarm. E24 denied checking the functionality of any of R79's alarms that morning, stating that R79 was already up in her wheelchair when he received her at the beginning of his shift.</p> <p>On 11/7/14 at 10:55 AM, E10 and E24 were interviewed. E10 confirmed that she did not notice that R70's alarm failed to function when the resident stood up from her wheelchair. E24 stated that E10 gave him a new battery, but when he placed it in R79's chair alarm, the alarm remained non-functional. E24 stated that he went to the resident's room to get another alarm since they were interchangeable. E24 stated he then placed the new battery from the nonfunctioning chair alarm into one of the bed alarms which also had a dead battery. A third alarm was functional.</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/17/2014
NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 256 POSSUM PARK ROAD NEWARK, DE 19711		
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F 323	<p>Continued From page 42</p> <p>R79 had 3 alarms, one chair and two bed alarms to be placed on either side of her bed.</p> <p>On 11/7/14 at 11:05 AM, during an interview, E10 stated that she only had one new battery and she had just brought more batteries and a new alarm. When informed about the other nonfunctioning alarm in R79's room, she stated that she was unaware of that.</p> <p>On 11/7/14 at 11:20 AM, E10 informed the surveyor that a tab alarm (pull cord alarm clipped on the back of the resident's clothing so that if they move too far the pull cord will release the magnet or tab and the alarm will sound) was being added to R79, in addition to her chair and bed alarms.</p> <p>During an interview on 11/7/14 at 2:15 PM, E11 (assigned LPN) was asked about resident alarms and to explain what was being documented on the TAR. She stated that documentation on the TAR was for both the use and functionality of the alarms. E11 stated that she checked on her residents throughout the shift, but not necessarily at the beginning of her shift. E11 stated that if the CNAs have a problem with an alarm, they will report it to nursing. E11 stated that R79 was already seated in her wheelchair across from the nurse's station when she came on duty. E11 stated that R79 was taken to her bathroom for morning care and the CNA would have told her if the alarm was not working. E11 denied checking R79's alarms that morning and stated the CNAs would have checked the alarms when they dressed or toileted R79 in the morning. The surveyor informed E11 that E24 denied checking R79's alarms and the TAR lacked evidence that R79's alarms were checked for function.</p>	F 323			

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F 323	Continued From page 43  R79's care plan, dated 3/19/14 and entitled, "Risk for falls R/T (related to) Hx (history) of falls... listed approaches included, "...fall/safety devices - fall mat/fall alarm...fall alarm to bed/wheelchair- whichever resident is occupying - poor safety awareness...sensor alarm @ (at) bedside... Pressure sensor alarm mat @ bedside AAT (at all times) - while resident in bed...". Despite the need for continuous alarms, the facility failed to ensure that 2 of 3 alarms for R79 were functional. Additionally, review of R79's CNA Care Card, lacked evidence of R79 having alarms.  The facility failed to ensure that R79's assistive devices (alarms) were functioning and failed to identify that R79's sensor alarm was not functioning on 11/7/14 at 10:45 AM, when R79 stood up from her wheelchair and the alarm failed to sound.	F 323		
F 329 SS=E	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	F 329	1. R30 has current behavior monitoring sheet in place as noted since October. R60 is currently appropriately monitored for bowel management. R110 is receiving and nursing is documenting non-pharmacological interventions prior to the use of anti-anxiety medication. 2. Caretracker reports will be run daily at each shift by the shift supervisor and	1/15/2015

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F 329	Continued From page 44 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 reviews and interviews, it was determined that the facility failed to adequately monitor drug regimens for 3 (three) out of 28 Stage 2 sampled residents (R30, R60 and R110). For R60, the facility failed to ensure that pharmacy recommendations were responded to in a timely manner (including the need for laboratory tests), that bowel medications were administered as per physician's order when R60 exceeded 9 shifts without a bowel movement (BM) and the facility failed to implement behavior monitoring for Lexapro (for depression) until October 2014 although R60 received Lexapro since March 2013. For R30, the facility failed to implement behavior monitoring sheets from June 30 - September 15, 2014 for Trazadone (for depression). For R110, the facility failed to attempt non-pharmacological interventions prior to administering Ativan (for anxiety) on multiple occasions from July - September 2014. Findings include:  1A. R60 had a pharmacy Consultation Report (consult), dated 5/6/14, that stated, "REPEATED RECOMMENDATION from 3/6/14: Please respond promptly to assure facility compliance	F 329	communicated to the staff rendering care. This will determine any resident who requires intervention per bowel protocol that has no documented BM exceeding 9 shifts. A pharmacy report will be obtained for residents receiving psychotropic medications to identify residents needing behavior monitoring and non-pharmacological interventions prior to being medicated. 3. New practice- RN supervisors will run the bowel report each shift to identify residents who need intervention. Residents receiving psychotropic medications will have a behavior monitoring sheet which includes non-pharmacological interventions to be used prior to the use of psychotropic medications. The DON/Designee will perform daily audits over the next 30 days to ensure reports are run and responded to by nurse supervisors. The DON/Designee will review weekly pharmacy reports to monitor psychotropic use and to determine if non-pharmacological interventions are performed prior to medication administration. The Staff Developer will in-service nursing staff of the use of non-pharmacological interventions prior to medication administration. The DON/Designee will review monthly the pharmacy consult report to determine that doctors are	

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F 329	<p>Continued From page 45</p> <p>with Federal regulations... received escitalopram (Lexapro) 10 mg daily for depression since 3/15/13... due for annual dose evaluation. Recommendation... consider a gradual dose reduction (GDR)...". On the pharmacy consult, the physician is to indicate whether they accept the recommendation as written, they accept the recommendation with modifications or the physician can choose to decline the recommendation and write the rationale why. After the physician chooses their response, they are to sign their name and list the date they responded.</p> <p>The 5/6/14 pharmacy consult was faxed to P2 (R60's attending physician) on 5/28/14, more than 3 weeks later. P2 responded to the pharmacy recommendation on 5/28/14.</p> <p>E10 (UM) was interviewed on 11/12/14 at 11:28 AM. E10 stated that she faxed the 5/6/14 consult to P2 on 5/28/14. When asked when she received the 5/6/14 consult, E10 stated she did not know. E10 stated that E3 (ADON) reviews the consults first, then gives recommendations to her that require follow up. E10 further stated the pharmacy consults sometimes end up in the wrong physician's folders.</p> <p>B. Review of the pharmacy policy entitled "Suggested Laboratory Monitoring Parameters for Selected Medications", dated 2013, stated that for Lasix (medication used to eliminate excessive fluid in the body), a BMP (set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance) should be done 1-2 weeks after initiation and dosage increases, then every 6 months.</p> <p>Review of the clinical record revealed that R60's</p>	F 329	<p>responding timely with documented responses.</p> <p>4. The DON/Designee and the pharmacist consultant will report monthly to the QA committee to determine if further recommendations are needed.</p>	

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F 329	<p>Continued From page 46</p> <p>last BMP was on 1/22/14.</p> <p>According to the June 2014 MAR R60 was on Lasix 20 mg twice a week (40 mg per week) since 4/27/14. On 6/15/14, R60's Lasix was increased to 40 mg daily (280 mg per week). R60 lost approximately 29 pounds (16.9%), a severe weight loss, between 6/15/14 and 7/21/14 (about 1 1/2 months) which placed her at extra high risk for fluid and electrolyte imbalances. Despite this, a BMP (due in June 2014) was not done after R60's Lasix was increased.</p> <p>On 10/7/14 the MRR for R60 stated to check BMP and noted to "see report for any noted irregularities and/or recommendations."</p> <p>A pharmacy consult, dated 10/7/14, stated that R60 "... receives lisinopril (for blood pressure) and furosemide (Lasix) but does not have a creatinine/electrolyte evaluation [included in BMP]... within previous 6 months. (last checked Jan 2014)... Please consider monitoring a... [BMP] on the next convenient lab day and then every six months...". E10 (UM) wrote on the consult that she faxed it to P2 on 10/10/14. As of 11/12/14, P2 had not indicated on the consult whether she agreed or disagreed with the pharmacist's recommendation. A 6 month BMP was due on 10/27/14.</p> <p>E10 (UM) was interviewed on 11/12/14 at 11:28 AM. E10 stated there were no standing orders for how often labs should be done and she stated that BMP's should be done every 6 months for resident's receiving Lasix. After showing E10 the pharmacy policy recommendations to do a BMP 1-2 weeks after a dose increase in Lasix, E10 confirmed that the facility should have done a BMP in June 2014.</p> <p>The facility failed to ensure that pharmacy recommendations for R60 were addressed; including monitoring of BMP's.</p>	F 329		

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F 329	Continued From page 47  C. Review of R60's September 2014 Physician Order Sheet (POS) revealed orders, dated 3/15/13, to insert 1 Dulcolax suppository rectally prn (as needed) if no results from Milk of Magnesia (MOM) per bowel protocol and to administer 1 Fleet enema rectally prn if no results from Dulcolax suppository per bowel protocol. The POS also contained a physician order, dated 12/9/13, for MOM 400 mg/ 5 ml (milliliters) take 30 mls orally every day prn for constipation per bowel protocol - hold for loose stool.  Bowel movements (BM's) were reviewed for R60 from 8/1/14 - 11/7/14 and revealed the following:  no BM's from 8/9 shift 1 to 8/14 shift 1- total of 15 shifts no BM's from 9/5 shift 2 to 9/9 shift 2- total of 12 shifts  Record review revealed nothing in the nurse's notes to indicate that the facility attempted to give prn bowel medications as per physician order and facility protocol and there were no resident refusals.  Review of the September and October 2014 MAR revealed that the facility failed to administer prn bowel medications for the above corresponding dates without a BM.  E23 (LPN/medication nurse) was interviewed on 11/10/14 at 10:30 AM. When asked how he knows when a resident needs to have a prn bowel medication administered, E23 stated that either the 11-7 nurse or the Unit Manager on the 7-3 shift prints reports listing which residents have not had a BM for greater than 9 shifts and a	F 329		

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F 329	<p>Continued From page 48</p> <p>copy is given to the nurses. E23 stated that 7-3 shift gives MOM prn, if no BM, 3-11 shift gives a Dulcolax suppository and if no result, 11-7 shift gives a Fleet's enema. E23 confirmed findings after reviewing R60's records.</p> <p>Findings were reviewed with E2 (DON) on 11/10/14 at 11:07 AM. E2 stated during an interview on 11/10/14 at 2:45 PM that he figured out it was "a nursing problem." E2 stated he does not think the sheets to indicate who needed prn bowel medications were given to the appropriate nurses on the days when they triggered for R60 and on the subsequent days.</p> <p>D. Review of R60's records for June 2014 through November 2014 revealed that the facility failed to have behavior monitoring sheets for Lexapro (ordered on 3/15/13) until October 2014.</p> <p>E10 was interviewed on 11/10/14 at 11:25 AM. After reviewing R60's chart, E10 confirmed findings. E10 stated that until recently the facility was only using behavior monitoring sheets for antipsychotics, now they are doing them for psychotropic medications (includes antidepressants).</p> <p>2. R30 was admitted to the facility on 6/30/14 with diagnoses including depression (mental disorder with feelings of sadness).</p> <p>The admission MDS, dated 7/7/14, stated R30's active diagnoses included depression and she received antidepressant (used for depression) medication.</p> <p>R30 was care planned for depression, initiated on</p>	F 329		

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F 329	<p>Continued From page 49</p> <p>6/30/14 and last reviewed on 9/25/14, with interventions that included, "...Administer antidepressant med. (medication) as ordered Trazadone 50 mg... Monitor QS (every shift) for any clinical worsening...or unusual changes in behavior...".</p> <p>Review of R30's clinical record revealed lack of evidence of behavior monitoring for Trazadone from 6/30/14 through 9/15/14, a total of 232 shifts.</p> <p>In an interview on 11/12/14 at 3:15 PM, E10 confirmed that R30 was not being monitored for behaviors for Trazadone. E10 stated that the facility was monitoring behaviors for only antipsychotic (class of medications used to treat psychosis and other mental and emotional conditions) medications.</p> <p>The facility failed to ensure that adequate behavior monitoring was performed from 6/30/14 through 9/15/14 for R30, who was prescribed Trazadone, an antidepressant.</p> <p>3. R110 was re-admitted to the facility, post hospitalization, on 6/20/14.</p> <p>A physician's order, dated 7/1/14, stated R110 was to receive Ativan (anti-anxiety medication) 0.5 mg every 4 hours as needed for agitation. On 7/5/14, an order was written to increase R110's Ativan to 1 mg every 3 hours as needed for agitation.</p> <p>Medication records and nurse's notes reviewed from 7/1/14 through 9/3/14 failed to indicate on multiple occasions that any non-pharmacological interventions were attempted prior to</p>	F 329			

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F 329	Continued From page 50 administration of the Ativan.	F 329		
F 333 SS=E	<p>On 11/5/14 at 11:30 AM during an interview with E2, he confirmed the lack of non-pharmacological interventions prior to use of the Ativan for R110.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure two (R51 and R110) out of 28 Stage 2 sampled residents were free of significant medication errors. For R110 the facility failed to administer the correct dose of Zyprexa, an antipsychotic (medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality) for approximately two (2) months, failed to discontinue the medication Fluconazole (used for a skin condition) as ordered and they incorrectly continued to administer it for approximately three (3) months, and failed to administer the medication Omeprazole (used for gastric reflux) for approximately three (3) months, despite it's never having been discontinued by the physician. For R51, the facility crushed extended release medication on multiple occasions prior to administration. Findings include:</p> <p>1A. R110 was re-admitted to the facility, post-hospitalization, on 6/20/14.</p>	F 333	<ol style="list-style-type: none"> <li>1. R110 and R51 receives current medications per physician orders.</li> <li>2. Cross ref to F309 Any resident receiving medications from the nurse identified are at risk. MARS will be reviewed for the past 30 days from this nurse to determine and other transcription errors.</li> <li>3. The staff development nurse will perform a medication administration pass competency on this particular nurse and a minimum of 10% of the licensed staff. The nurse identified will receive a transcription competency to determine any further need for education or intervention.</li> <li>4. The staff development nurse will report findings to the DON who will report to the QA committee monthly for further recommendations.</li> </ol>	1/15/2015

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F 333	<p>Continued From page 51</p> <p>On 7/22/14, P1 (R110's physician) wrote an order for R110 to receive Zyprexa 2.5 mg by mouth at bedtime for psychosis. Review of the MAR from 7/23/14 through 7/28/14 revealed the Zyprexa was administered as ordered.</p> <p>On 7/28/14, P1 wrote an order to increase the Zyprexa to 5 mg by mouth twice a day. Review of the July, 2014 MAR revealed the order was incorrectly transcribed as Zyprexa 5 mg by mouth at bedtime. A 24 hour chart check (review of all orders written in preceding 24 hours completed by the oncoming 11 PM to 7 AM shift) was signed as completed, however, this check failed to identify the transcription error. On 7/29/14, a monthly recapitulation (recap) of orders was signed off as completed for the August, 2014 monthly POS. The recap process involves a review of the monthly MAR that is ending and a review of all orders written during that month in order to verify accuracy of the new MAR and monthly POS. The monthly recap completed on 7/29/14 failed to identify the transcription error and continued to list it as Zyprexa 5 mg by mouth at bedtime instead of 5 mg twice a day.</p> <p>The September, 2014 monthly POS (pre-printed by the pharmacy) and MAR (pre-printed) revealed the order for Zyprexa 5 mg by mouth twice daily appeared correctly. When the monthly recap of orders was completed on 8/28/14, facility staff wrote "D/C" (discontinued) on the POS and MAR, but failed to write the date the medication was discontinued, as is required. As there was no order to discontinue the twice daily 5mg of Zyprexa, the facility again missed the opportunity to identify this medication error.</p> <p>Review of MARs revealed R110 received Zyprexa</p>	F 333			

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F 333	<p>Continued From page 52</p> <p>5 mg at bedtime instead of 5 mg twice a day from 7/29/14 through 9/30/14, resulting in a total of 64 missed doses of Zyprexa.</p> <p>R110's pre-printed October, 2014 monthly POS and MAR did not list any order for Zyprexa. The monthly recap of orders signed as completed on 9/28/14 failed to identify omission of the Zyprexa. As a result, R110 did not receive any Zyprexa from 10/1/14 through 10/8/14. On 10/8/14, a telephone verbal order stated to continue Zyprexa 5 mg by mouth at bedtime, as this was the last dose R110 received based on the 9/14 MAR. Review of the MAR revealed that although the order was written on 10/8/14, there were no doses signed off as given until 10/10/14. R110 did not receive any Zyprexa from 10/1/14 through 10/9/14, a total of nine (9) days.</p> <p>On 11/5/14 at 7:40 AM, P1 was interviewed and findings were reviewed. P1 was informed that the Zyprexa order was incorrectly transcribed on 7/28/14 and instead of receiving 5mg twice daily, as ordered, the resident was receiving 5mg at bedtime only from 7/28/14 through 9/30/14. Additionally, P1 was made aware that R110 did not receive any Zyprexa from 10/1/14 through 10/9/14. P1 stated he gave a clarification order on 10/8/14 for the resident to receive 5mg at bedtime, as that is what he was told R110 was receiving.</p> <p>Review of R110's clinical record on 11/5/14 at approximately 9:30 AM, revealed that P1 wrote new orders to reduce the Zyprexa to 2.5mg at bedtime for 30 days and then stop it.</p> <p>Findings were acknowledged by E2 (DON) during an interview on 11/5/14 at approximately 11:30</p>	F 333			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/17/2014
NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 266 POSSUM PARK ROAD NEWARK, DE 19711		
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F 333	<p>Continued From page 53 AM.</p> <p>1B. Review of the clinical record revealed R110 had physician orders for Omeprazole 40 mg by mouth daily, ordered 6/21/14, and Fluconazole 100 mg by mouth every seven days, ordered 7/21/14.</p> <p>On 7/28/14, a physician's order stated to "D/C (discontinue) Fluconazole." In parenthesis next to the word Fluconazole was written "Omeprazole." There was no clarification order found pertaining to either Fluconazole or Omeprazole, as these were two (2) different medications.</p> <p>Review of the July, 2014 MAR revealed that Omeprazole, ordered to be given daily, was the medication incorrectly discontinued by the nurse transcribing the order. A 24 hour chart check was signed as completed, but failed to identify these were two (2) different medications and staff failed to get a clarification order.</p> <p>During an interview with P1 on 11/5/14 at 7:40 AM, he confirmed he wrote the order to D/C Fluconazole on 7/28/14. He then stated that the "Omeprazole" in parenthesis was not written by him. P1 was informed that on 7/28/14 the facility discontinued the Omeprazole, instead of Fluconazole, as he ordered. R110 did not receive Omeprazole from 7/29/14 through 11/5/14, and received Fluconazole weekly, when it (Fluconazole) should have been discontinued on 7/28/14.</p> <p>Review of R110's clinical record on 11/5/14 at approximately 9:30 AM, revealed that P1 wrote orders to continue Fluconazole 100 mg every 7</p>	F 333			

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F 333	Continued From page 54 days until 11/30/14 and R110 was to remain off the Omeprazole.  Findings were acknowledged by E2 during an interview on 11/5/14 at approximately 11:30 AM.  2. R51 was prescribed MAPAP (acetaminophen - pain reliever) Arthritis ER (extended release) 1 tablet to be given by mouth twice a day. During the medication pass observation on 10/27/14 at approximately 9:30 AM, while E23 (LPN) was preparing R51's medication, he stated that he had to crush the MAPAP Arthritis ER per the resident's request. The surveyor reminded E23 that this is a medication that cannot be crushed. E23 admitted that he had crushed it in the past before giving it to R51. E23 and the surveyor reviewed the October, 2014 MAR together and discovered that E23 had administered the MAPAP Arthritis ER 14 times. E23 confirmed that he gave it to R51 as crushed.  Findings were confirmed with E10 (UM) on 10/27/14 at approximately 10:00 AM.	F 333		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident	F 353	1. R4, R30, R70, and R107 currently receives care and services to attain and maintain highest practical, mental, and psychosocial well being. 2. Cross F315: Any resident residing on second floor is at risk to be affected. 3. New Practice	1/15/2015

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F 353	Continued From page 55 care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of resident records and other documentation as indicated, It was determined that the facility failed to have sufficient nursing staff to provide nursing services to attain or maintain the highest practicable, mental, and psychosocial well-being of each resident, as determined by resident assessments and plans of care for 4 (R4, R30, R70 & R107) out of 28 sampled stage 2 residents, all of which resided on the 2nd floor of the facility. The facility failed to ensure that bladder assessments were complete and/or analyzed, including 3 day bladder diary's to determine individualized plans of care and to prevent urinary status decline. Findings include:  Cross refer to F315, example #1 1. The facility failed to accurately assess R107's urinary status upon admission, failed to evaluate a 3 day voiding diary and failed to care plan accordingly based on the resident's individualized needs. As R107's urinary continence declined, the facility failed to comprehensively reassess and they again failed to care plan based on individualized needs. Although the facility revised	F 353	Nursing leadership staff will analyze the the completed voiding diary to identify continence status. Those residents determined Nursing staff will be in-serviced by the staff educator on bowel and bladder assessments, 3 day voiding diary analysis, and the development of an individualized care plan. 4. The DON/Designee will report to the QA committee monthly for further recommendations.		

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F 353	<p>Continued From page 56</p> <p>the care plan on 9/12/14 to toilet R107 at specific times, there was no evidence that this was being done. R107 was incontinent of bladder on 8 out of 55 shifts in June 2014 and progressed to being incontinent on 87 out of 93 shifts in October 2014.</p> <p>Cross refer to F315, example #2</p> <p>2. The facility failed to prevent a decline or maintain normal bladder function for R4 by failing to comprehensively assess R4's urinary incontinence on admission; failing to follow R4's incontinence care plan intervention to complete a bladder assessment; failing to identify that R4's bladder function was not recorded consistently by CNA's from 6/30/14 through 10/31/14; failing to identify a potential cause for R4 being treated for 3 UTI's since admission; failing to again comprehensively reassess R4's bladder incontinence after the 9/26/14 quarterly MDS revealed a decline in bladder function; and failing to individualize a toileting program.</p> <p>Cross refer to F315, example #3</p> <p>3. For R30, the facility failed to comprehensively assess R30's bladder function three (3) times since admission and identify potential causes for two (2) UTI's, which resulted in two (2) hospitalizations.</p> <p>Cross refer to F315, example #4</p> <p>4. For R70, the facility failed to evaluate a 3 day voiding diary, failed to individualize a care plan based on the resident's toileting needs and failed to follow R70's toileting schedule.</p> <p>In an interview on 11/13/14 at 8:55 AM, E3 (ADON) stated that the Restorative Nurse assisted nursing with admissions to the facility.</p>	F 353			

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F 353	Continued From page 57 E3 stated that she was the Restorative Nurse from 6/23/13 through 3/30/14. E3 stated the Restorative Nurse position was not filled from 3/30/14 until recently.  In an interview on 11/13/14 at 9:30 AM, E10 (UM) stated that the Unit Manager, Restorative Nurse or any nurse could do admissions, which included the Data Collection Tool and initiating the Bladder Incontinence Assessment/3-day voiding diary. E10 stated the 11 PM - 7 AM shift would start the 3-day Bowel and Bladder Flow Sheet following admission of a resident. E10 stated after the 3-day voiding diary was done, the Bladder Incontinence Assessment would be analyzed by an RN and a toileting program would be recommended. E10 stated that the Restorative Nurse completed the bladder assessments. When asked who was responsible when the Restorative Nurse position was vacant, E10 stated the UM was responsible to follow-up on bladder assessments.	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on resident interviews and one of two test tray results, it was determined that the facility failed to serve food that was palatable. Findings include:	F 364	1. R211, and R15 have not voiced any other concerns regarding food. The cook continues to take food temperatures prior to the start of the tray line. 2. Any resident residing here is at risk for non-palatable food by their preference. 3. While the food was at appropriate temp, It did not meet the preference of 2 residents who receive meals in the first floor dining room. The dining rooms are staffed with both dietary and nursing personnel who will observe and immediately correct residents food preference to ensure it is palatable. The dining staff will	1/15/2015

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F 364	Continued From page 58  1. During an interview on 10/28/14 at 1:54 PM, R211 stated that "sometimes the food is a little bit lukewarm".  2. During an interview on 10/28/14 at 1:44 PM, R15 stated that the food is served "warm or cold... It is not hot enough".  On 11/6/14 at 12:30 PM, a test tray was sampled In the first floor dining room for flavor and palatability. Although the temperature of the beef and cheddar sandwich was adequate at 135.9 degrees Fahrenheit, it was determined to be lukewarm, bland and not palatable.  Findings were reviewed at the exit meeting with E1 (NHA) and E2 (DON) on 11/17/14 at approximately 3:30 PM.	F 364	communicate to the Food Service Director/Designee daily to meet the preferences of the residents. The Food Service Director will update residents preferences.  4. The Food Service Director will report to the QA committee monthly for further recommendations.	
F 371 SS=E	483.35(i) 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  This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to distribute and serve food under sanitary conditions. Findings	F 371	1. The staff have been observed to be using proper sanitary techniques with cutting food and washing hands. 2. All resident could be affected. 3. 1 staff member failed to follow proper food handling and hand washing according to policy. The staff member identified has been in-serviced on proper sanitation and food handling. 4. The Food Service Directory/Designee will report findings to the QA committee for further recommendations.	1/15/2015

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F 371	Continued From page 59 include:  1. During a dining observation on 10/30/14 at 12:00 PM, R211 requested that her sandwich be cut in half. E18 (CNA) stated that she had just washed her hands and proceeded to cut R211's sandwich with a knife, while holding the sandwich with her bare hand.  During an interview on 10/30/14 at 12:30 PM, E18 confirmed that she held the sandwich with her bare hand and that a fork would have been a better way to hold R211's sandwich.  2. On 10/30/14 at 12:40 PM and 12:45 PM, E19 (Dietary Aide) was observed wearing gloves while removing dirty dishes from resident tables, using hand sanitizer on top of her soiled gloves and then serving desserts to residents wearing the same gloves. Immediately following these observations, E19 and E20 (Dietary Aide) were interviewed. When E19 was asked why she was wearing gloves in the dining room, she stated that she wore them because of "germs". When asked why she used sanitizer on top of her soiled gloves, she repeated, "germs" and that she did not like germs. The surveyor then asked E19 if it was the facility's policy to use sanitizer gel to clean soiled gloves. E20 stated, "No. It was not the facility's policy" and informed E19 that she was supposed to wash her hands and that disposable gloves were for single-use only. E20 confirmed the findings.  Findings were reviewed at the exit meeting with E1 (NHA) and E2 (DON) on 11/17/14 at approximately 3:30 PM.	F 371			
F 386	483.40(b) PHYSICIAN VISITS - REVIEW	F 386			

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F 386 SS=E	<p>Continued From page 60 CARE/NOTES/ORDERS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the physician failed to review one (R60) out of 28 stage 2 sampled residents' total program of care at each visit. P2 (attending physician) failed to respond to multiple pharmacy recommendations in a timely manner. Additionally, P2 failed to order a BMP (Basic Metabolic Panel - set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance) since January 2014 although R60 received Lasix (medication used to eliminate excessive fluid in the body). R60's Lasix dose was increased substantially on 6/15/14. R60 consequently lost approximately 29 pounds in 1 1/2 months after the Lasix was increased; this severe weight loss placed R60 at greater risk for fluid and electrolyte imbalances. A BMP should have been done 1-2 weeks after the Lasix dose increase and then every 6 months. Findings include:</p> <p>Cross refer to F329, example 1A and 1B 1A. R60 had a pharmacy Consultation Report</p>	F 386		

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F 386	<p>Continued From page 61</p> <p>(consult), dated 5/6/14, that stated, "REPEATED RECOMMENDATION from 3/6/14: Please respond promptly to assure facility compliance with Federal regulations... received escitalopram (Lexapro) 10 mg daily for depression since 3/15/13... due for annual dose evaluation. Recommendation... consider a gradual dose reduction (GDR)...". On the pharmacy consult the physician is to indicate whether they accept the recommendation as written, they accept the recommendation with modifications or the physician can choose to decline the pharmacist's recommendation and write the rationale why. After the physician chooses their response, they are to sign their name and list the date they responded.</p> <p>Although P2 wrote physician's progress notes (unable to read notes except few words due to handwriting) for R60 on 3/24/14 and 4/27/14, she failed to address the 3/6/14 pharmacy consultation.</p> <p>The 5/6/14 pharmacy consult was faxed to P2 on 5/28/14. P2 responded to the pharmacy recommendation on 5/28/14, approximately 2 1/2 months after the initial pharmacy consult dated 3/6/14 and stated to continue with the same dose.</p> <p>B. Review of the pharmacy policy entitled "Suggested Laboratory Monitoring Parameters for Selected Medications", dated 2013, stated that for Lasix, a BMP should be done 1-2 weeks after initiation and dosage increases, then every 6 months.</p> <p>Review of the clinical record revealed that R60's last BMP was on 1/22/14.</p>	F 386	<p>1. R60's pharmacy recommendation was reviewed by the attending physician with appropriate actions taken.</p> <p>2. Any resident receiving pharmacy recommendations are at risk. Pharmacy recommendations will be reviewed for the past 60 days to identify any unanswered recommendation that needs a response noted.</p> <p>3. New practice-Pharmacy recommendations will be reviewed monthly over the next 60 days by the DON/Designee and Medical Director to evaluate the timely response of physician's. The medical director has informed the identified physician as to the expectation of responding timely with appropriate documentation.</p> <p>4. The DON/Designee will report findings to the QA committee for further recommendations.</p>	1/15/2015	

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F 386	<p>Continued From page 62</p> <p>Review of the June 2014 MAR revealed that R60 was on Lasix 20 mg twice a week (total of 40 mg per week) since 4/27/14. On 6/15/14, R60's Lasix was increased to 40 mg daily (total of 280 mg per week). R60 lost approximately 29 pounds (16.9%), a severe weight loss, between 6/15/14 and 7/21/14 (about 1 1/2 months) which placed her at extra high risk for fluid and electrolyte imbalances. Despite this, there was no physician order for a BMP (due in June 2014) after R60's Lasix was increased.</p> <p>On 10/7/14 the MRR (kept in the resident's record) for R60 stated to check BMP and noted to "see report for any noted irregularities and/or recommendations."</p> <p>The pharmacy consult, dated 10/7/14, referred to in the 10/7/14 MRR, was not found in R60's chart. E10 (UM) found the 10/7/14 consult in P2's folder. The consult, stated that R60 "... receives lisinopril (for blood pressure) and furosemide (Lasix) but does not have a creatinine/electrolyte evaluation [included in BMP]... within previous 6 months. (last checked Jan 2014)... Please consider... a... [BMP]... next convenient lab day and then every six months...". E10 (UM) faxed the consult to P2 on 10/10/14. As of 11/12/14, P2 had not indicated on the consult if she agreed or disagreed with the pharmacist's recommendation.</p> <p>Although P2 wrote physician's progress notes for R60 on 11/9/14, she failed to address the 10/7/14 pharmacy recommendations to recheck a BMP for R60.</p> <p>E10 was interviewed on 11/12/14 at 11:28 AM and findings were reviewed. E10 stated she faxes pharmacy recommendations to P2 as she (P2)</p>	F 386		

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F 386	Continued From page 63 usually comes in the evenings and weekends when she (E10) is not in the facility. After locating R60's 10/7/14 pharmacy recommendation in P2's folder, E10 stated, " She (P2) must not have looked in there."  E2 (DON) was interviewed on 11/12/14 at 12:33 PM and findings were reviewed. E2 stated when he worked in the facility about 4 years ago, they had the same problem with P2.  P2 failed to review R60's total program of care at each visit.	F 386			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to ensure that for three (R30, R60 and R110) out of 28 Stage 2 residents sampled, the pharmacist identified and reported irregularities to the attending physician and the DON. Findings include:  1. Cross refer to F333, examples 1A and 1B	F 428	1. R30, R60, and R110 no longer have irregularities on the MAR as they have been reconciled and corrected.  2. All residents are at risk that receive medications. The Omnicare pharmacy will complete a full house audit to determine if others have been affected.  3. New Practice-A pharmacist consultant will provide a 20% random audit of charts monthly over the next 90 days. The consultant will report to the DON any discrepancies. The nursing staff will and/or physician will make necessary corrections.	1/15/2015	

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NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 265 POSSUM PARK ROAD NEWARK, DE 19711	
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F 428	<p>Continued From page 64</p> <p>On 7/28/14, P1 wrote an order to increase R110's Zyprexa (antipsychotic-medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality) to 5 mg by mouth twice a day. Review of the 7/14 MAR revealed the order was incorrectly transcribed as Zyprexa 5 mg by mouth at bedtime. This transcription error was carried over onto both the August 2014 MAR and POS.</p> <p>Review of the clinical record revealed that R110 had physician orders for Omeprazole (used for gastric reflux) 40 mg by mouth daily, ordered 6/21/14, and Fluconazole (used for a skin condition) 100 mg by mouth every seven days, ordered 7/21/14.</p> <p>On 7/28/14, a physician's order stated to "D/C (discontinue) Fluconazole." In parenthesis next to the word Fluconazole was written "Omeprazole." There was no clarification order found pertaining to either Fluconazole or Omeprazole, as these were two (2) different medications.</p> <p>Review of the July 2014 MAR revealed that Omeprazole, which was ordered to be given daily, was the medication incorrectly discontinued by the nurse transcribing the order. As a result, R110 did not receive Omeprazole from 7/29/14 through 11/5/14, and incorrectly received Fluconazole weekly, when it (Fluconazole) should have been discontinued on 7/28/14.</p> <p>Review of R110's clinical record revealed that a MRR was completed by E12 (consultant pharmacist) on 8/6/14. The review stated that no irregularities were found, despite the above noted medication errors.</p>	F 428	4. The Pharmacist consultant will report to the DON monthly, who will report to the QA committee for further evaluation and recommendations.	

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F 428	<p>Continued From page 65</p> <p>On 11/5/14 at approximately 9:15 AM, E12 was interviewed. E12 stated it was part of her practice to review the POS and MAR for possible transcription errors. E12 stated she recalled questioning nursing about the Fluconazole order written on 7/28/14 and she recalled being told the order was clarified and that it was Omeprazole that was to be discontinued. She confirmed there was no clarification order written.</p> <p>The consultant pharmacist failed to identify medication irregularities pertaining to Zyprexa, Fluconazole and Omeprazole during the August 2014 MRR and lacked evidence of having reported these irregularities to the physician and DON.</p> <p>Findings were acknowledged by E2 (DON) during an interview on 11/5/14 at approximately 11:30 AM.</p> <p>2A. Review of the June 2014 MAR revealed that R60 started taking Lasix (medication used to eliminate excessive fluid in the body) 20 mg twice per week (total of 40 mg per week). On 6/15/14 R60's Lasix was increased to 40 mg daily (total of 280 mg per week).</p> <p>R60 lost approximately 29 pounds (16.9%), a severe weight loss, in about 1 1/2 months after her Lasix was increased.</p> <p>Review of the pharmacy policy entitled "Suggested Laboratory Monitoring Parameters for Selected Medications", dated 2013, stated that for Lasix (medication used to eliminate excessive fluid in the body), a BMP (set of eight tests that measure blood sugar and calcium levels, kidney</p>	F 428		

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F 428	<p>Continued From page 66</p> <p>function, and chemical and fluid balance) should be done 1-2 weeks after initiation and with dosage increases, then every 6 months.</p> <p>Chart review revealed that the pharmacy failed to identify in the MRR that R60 should have had a BMP 1-2 weeks after her Lasix dosage increase on 6/15/14. Record review revealed that R60's last BMP was done on 1/22/14.</p> <p>E10 (UM) was interviewed on 11/12/14 at 11:28 AM. After reviewing the pharmacy policy, E10 confirmed that R60 should have had a BMP in June 2014 after her Lasix was increased.</p> <p>B. Review of the June 2014 MAR revealed that R60 received Lexapro 10 mg by mouth daily for depression since 3/15/13.</p> <p>Review of R60's records for June 2014 through November 2014 revealed that the facility failed to have behavior monitoring sheets for Lexapro until October 2014.</p> <p>E10 was interviewed on 11/10/14 at 11:25 AM. After she reviewed R60's chart, E10 confirmed the findings. E10 stated that until recently the facility was only using behavior monitoring sheets for antipsychotics, now they are doing them for psychotropic medications (includes antidepressants).</p> <p>E2 was interviewed on 11/12/14 at 2:49 PM. E2 stated that he identified that the facility lacked behavior monitoring sheets when he began working at the facility about 2 months ago.</p> <p>The pharmacy failed to identify the facility's lack of behavior monitoring sheets for Lexapro for</p>	F 428		

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F 428	Continued From page 67 R60.  3. Cross refer to F329, example 2. Review of R30's clinical record lacked evidence of behavior monitoring for Trazadone, an antidepressant (used to treat depression), from 6/30/14 through 9/15/14.  The pharmacy's MRR for the months of July, August and September 2014 stated "no irregularities".  In an interview on 11/12/14 at 3:15 PM, E10 confirmed the findings. E10 stated that the facility was monitoring behaviors for antipsychotics (class of medications used to treat psychosis and other mental and emotional conditions) only.  The pharmacy consultant failed to identify the lack of behavior monitoring for Trazadone for R30 from 6/30/14 through 9/15/14.	F 428			
F 431 SS=E	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	F 431			

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F 431	Continued From page 68 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: Based on observation, review of facility records and interviews, it was determined that the facility failed to ensure that all drugs and biologicals are stored in locked compartments and permit only authorized personnel to have access to the keys for 2 out of 2 med rooms. In addition, the facility failed to ensure that a system for the reconciliation of controlled medications (medications whose use and distribution is tightly controlled by regulations) was performed by two licensed nurses at each shift change in 2 out of 5 hallways. Findings include:  1. On 11/5/14 at 9:40 AM, E8 (Medical Records Clerk 1st floor) opened the medication (med) room door for the surveyor using the keypad entry code. Non-narcotic stock medications were	F 431	1. The med room door no longer has a coded key pad for entry. Narcotics were inventoried and no discrepancies noted. 2. The first and second med rooms are at risk for unauthorized entry. Any med cart supplied with narcotics is also at risk. 3. Keypad Installation from previous staff were installed without consideration of the risk of unauthorized entry. Locks have been installed and only nursing staff have position of the keys. The staff have been informed that anyone entering the med room who is not a licensed staff member need to be supervised by a nurse. Nursing staff have been informed that the medication reconciliation must be performed at the start of the shift to include when staff are working a double shift. The DON/Designee will audit narcotic sheets weekly for four weeks to identify and confirm completion and signature from each nurse. 4. The DON/Designee will report findings to the QA committee monthly for further recommendations.	1/15/2015

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F 431	<p>Continued From page 69</p> <p>observed stored on open shelves and a tackle box containing oral and injectable non-narcotic medications was stored on top of the counter. The facility failed to ensure that only authorized personnel had access to the med room keypad entry code since medications were not in a locked cabinet and were accessible to anyone who entered.</p> <p>2. On 11/5/14 at 10:50 AM, E4 (Medical Records Clerk 2nd floor) was observed entering the code on the med room entry keypad and then entering the med room. E4 was asked at this time if anyone could get into the med room and she responded that only the nurses could.</p> <p>Observation of the second floor medication room on 11/6/14 at 8:05 AM with E6 (LPN) revealed medications such as Multivitamins, Aspirin, Tylenol and Milk of Magnesia (laxative) were stored on an open shelf. Additionally, a tackle box was stored on top of the counter containing the backup supply of various other non-narcotic medications, both oral and injectable forms. In an interview with E6 at this time, she stated that only nurses know the code to enter the med room and if anyone else needed something stored in there, the nurse would open the door for them and wait until they got what they needed.</p> <p>The facility failed to ensure that only authorized personnel had access to the med room keypad entry code since medications were not in a locked cabinet and accessible to anyone who entered.</p> <p>3. On 11/6/14 at 3:10 PM, E5 (Physical Therapy Assistant) was observed standing in front of the first floor medication room. E5 leaned back and E7 (LPN), who was standing near E5, was</p>	F 431			

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F 431	<p>Continued From page 70</p> <p>observed whispering into E5's ear. E5 was observed entering the code on the med room entry keypad and then entered the room leaving the door open. E5 was observed exiting the room a short time later with a portable oxygen tank. E5 was interviewed at this time and was asked about knowing the code for entry into the med room. E5 stated that she did not know the code to the keypad. E6 was informed that she was observed entering the keypad code and entering the med room. E5 again stated she did not know the code and stated that her mind was such that she "could not remember anything."</p> <p>The first floor medication room was observed on 11/6/14 at approximately 3:30 PM with E2 (DON) and E3 (ADON). Non-narcotic stock medications were observed stored on open shelves and a tackle box containing oral and injectable medications were stored on top of the counter.</p> <p>The facility failed to ensure that only authorized personnel had access to the med room keypad entry code since medications were not in a locked cabinet and accessible to anyone who entered.</p> <p>Findings were acknowledged by E2 and E3 on 11/6/14 at approximately 3:30 PM.</p> <p>4. The facility policy entitled, "Controlled Substances Management", last reviewed 7/2/13, stated, "... A physical inventory ("narcotic count") of each controlled substance (or a change of shift audit) must occur, at minimum: At the end of every shift by the nurse going off duty and the nurse coming on duty ...".</p> <p>Review of the facility's narcotic count forms</p>	F 431			

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F 431	Continued From page 71 revealed the following:  a. Review of the 2nd floor Side 1 hallway from 10/3/14 through 11/9/14 revealed that for 34 out of 114 shifts, either the nurse going off duty or the nurse coming on duty failed to sign the Narcotic Inventory Count Verification form. In addition, there were eleven (11) missing shift inventory counts where both the nurse going off duty and the nurse coming on duty failed to sign the Narcotic Inventory Count Verification form.  b. Review of the 2nd floor Side 2 hallway from 10/3/14 through 11/9/14 revealed that for 17 out of 114 shifts, either the nurse going off duty or the nurse coming on duty failed to sign the Narcotic Inventory Count Verification form.  The facility failed to ensure that the second floor narcotic inventory counts were reconciled by two nurses during shift changes from 10/3/14 through 11/9/14.  Findings were confirmed with E2 and E3 on 11/12/14 at 10:55 AM. E2 stated that the facility would in-service the nurses immediately.	F 431			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was	F 463	1. Call bells for R60, R93, and R98 are in working order and no longer coiled around bar in bathrooms. 2. Any resident who uses the call bell for assistance is affected. An audit was performed by maintenance to determine that call bells are working properly and properly placed.	1/15/2015	

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F 463	Continued From page 72 determined that the facility failed to ensure that the call bell system was functional for three (R60, R93 and R98) out of 28 Stage 2 sampled residents. Findings include:  1. On 10/29/14 at 9:50 AM, R60's bedside call bell was observed to be non-functional. This was confirmed by E10 (RN) at the time and she then notified maintenance.  2. On 10/29/14 at 12:08 PM, R93's bathroom call bell was observed coiled around the grab bar causing it to be non-functional when pulled. Once uncoiled, the call bell worked. Although there was a button on the wall device requiring that it be pressed to activate the call bell, this would not be accessible to the resident if he/she fell.  Findings were confirmed by E11 (LPN) on 10/29 at 12:08 PM.  3. On 10/29/14 at 12:08 PM, R98's bathroom call bell was observed coiled around the grab bar causing it to be non-functional when pulled. Once uncoiled, the call bell worked. Although there was a button on the wall device requiring that it be pressed to activate the call bell, this would not be accessible to the resident if he/she fell.  Findings were confirmed by E11 on 10/29 at 12:08 PM.	F 463	3. New practice-Maintenance will perform monthly call bell testing to check for function. Nursing staff will perform routine checks at the on-set of their scheduled shift for call bell placement. Staff will utilize the maintenance log book to communicate any call bell problems for repairs. 4. The maintenance staff will report to the ED monthly who will report to QA findings for further evaluations.		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 490			

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F 490	Continued From page 73 well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined that the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:  Cross refer to F315, F323, F329, F333, F353, F386, F428, F431, F501, F520, and F524.  1. Cross refer to F323 The facility failed to ensure that the resident environment remained as free from accident hazards as is possible for 9 (R83, R99, R111, R131, R140, R212, R215, R216, and R217) stage 1 residents that resided in rooms 134, 135, 136, 137, and 139. The bathroom doors (accordion style) locked on the inside and were unable to be opened from the outside by staff. The doors had a small keyhole on the outside, however, facility staff did not carry keys to open the doors or know that they existed. The facility did not have access to remove the affected residents in an emergency. This resulted in an IJ that was identified and abated on 10/27/14.  Additionally, during stage 2 of the survey, a CNA improperly transferred R30 by herself on 9/15/14 and R30's knees buckled, which caused her to be lowered to the floor with no injury. The facility also failed to ensure that R79's alarms were functioning and they failed to identify that R79's sensor alarm was not functioning on 11/7/14 at	F 490	1. All issues identified for sampled residents in the survey have been addressed/corrected SEE F 157, F272, F280, F281, F309, F315, F323, F329, F333, F353, F364, F371, F386, F428, F431, F497, F501, F514, F520, F524 2. Any resident residing in the community could be affected. 3. Previous DON, and ED failed to implement and monitor consistent systems to maintain positive outcomes. The turnover in leadership from previous DON and ED, staff development, social services, and maintenance has created a temporary vacuum related to the required learning curve of new building and new company policies. The new DON and ED will systematically work together with the regional team to implement and maintain a systematic approach to managing the facility. 4. The ED and DON will implement an effective QA committee to identify and correct system failures, training needs, barriers to communications, and knowledge of company policies.	1/15/2015	

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F 490	<p>Continued From page 74</p> <p>10:45 AM, (when the resident stood up from her wheelchair and the alarm failed to sound) until after it was brought to the staff's attention.</p> <p>2. Cross refer to F315 The facility failed to ensure that 4 residents (R4, R30, R70 and R107) received appropriate treatment and services to restore as much bladder function as possible. The facility failed to have accurate and complete urinary status assessments/reassessments, they failed to implement and/or complete 3 day voiding diary's and analyze the data, they failed to have accurate and complete CNA documentation related to bladder function, and they failed to care plan accordingly based on the resident's individualized needs. Although the facility care planned to toilet some of the residents at specific times, there was no evidence that this was being done. For R4 the facility failed to identify the cause of the resident's repeated UTI's. The facility failed to prevent a decline or maintain normal bladder function for R4, R30 and R107, resulting in a harm level citation.</p> <p>3. Cross refer to F524 The facility failed to have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure.</p> <p>4. Cross refer to F329, F333, F428, F431, and F501 The facility failed to monitor residents' drug regimens, failed to ensure residents were free from significant medication errors, and failed to ensure pharmacy services identified and reported</p>	F 490		

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F 490	<p>Continued From page 75</p> <p>irregularities to the physician and DON. The facility failed to identify systemic failures related to medication administration and review, medication monitoring, medication storage and narcotic reconciliation. Additionally, the facility failed to involve the Medical Director when indicated.</p> <p>5. Cross refer to F353 The facility failed to have sufficient nursing staff to provide nursing services to attain or maintain the highest practicable, mental, and psychosocial well-being of each resident, as determined by resident assessments and plans of care for 4 (R4, R30, R70 &amp; R107) out of 28 sampled stage 2 residents, all of which resided on the 2nd floor of the facility. The facility failed to ensure that bladder assessments were complete and/or analyzed, including 3 day bladder diary's to determine individualized plans of care and to prevent urinary status decline.</p> <p>6. Cross refer to F386 The physician failed to review R60's total program of care at each visit. P2 (attending physician) failed to respond to multiple pharmacy recommendations in a timely manner. Additionally, P2 failed to order a BMP (set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance) since January 2014 although R60 received Lasix (medication used to eliminate excessive fluid in the body). R60's Lasix dose was increased substantially on 6/15/14. R60 consequently lost approximately 29 pounds in 1 1/2 months after the Lasix was increased; this severe weight loss placed R60 at greater risk for fluid and electrolyte imbalances. A BMP should have been done 1-2 weeks after the Lasix dose increase and then every 6 months.</p>	F 490			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/17/2014
NAME OF PROVIDER OR SUPPLIER  MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(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 490	Continued From page 76  7. Cross refer to F520 An interview on 11/13/14 at approximately 10:49 AM with E2 (DON) revealed that the QA committee failed to identify deficient practices concerning residents with urinary incontinence, failed to implement the facility policy for urinary incontinence management, thereby failing to develop and implement appropriate plans of action to correct the deficient practices.  E2 acknowledged these findings on 11/13/14 at approximately 10:49 AM.  Findings were reviewed with E1 (NHA) and E2 during the exit conference on 11/17/14 at approximately 4:30 PM.	F 490			
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE  The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497	1. Performance evaluations have been completed for employees #26, #28, #29, and #30. 2. Employees who have been employed for at least 12 months or greater are at risk. Human Resources will perform a 100% employee audit to determine who needs an evaluation. 3. Human Resources (HR) and previous leadership failed to have a systematic approach to identify staff due for reviews. HR will provide a monthly list to each department head of employees who are due for review. The ED will be copied and ensure that all reviews/evaluations are completed timely.	1/15/2015	

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NAME OF PROVIDER OR SUPPLIER  MILLCROFT	STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711
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F 497	<p>Continued From page 77</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that 4 out of 5 sampled CNAs (E26, E28, E29 and E30) received their mandatory annual performance reviews on an annual basis. Findings include:</p> <p>The facility's undated Employee Handbook stated, "... To formally evaluate the performance of each employee at least annually. At approximately each employment anniversary, the employee's immediate supervisor will schedule a time to discuss ... specific employee oriented goals and objectives. The employee's supervisor will prepare a written performance evaluation. This evaluation will be discussed with employee during the performance meeting ... Performance evaluations will be kept in the employee's personnel file."</p> <p>1. Review of E26's personnel file on 11/17/14 at approximately 8:10 AM revealed the absence of an annual performance review. E26 was hired on 9/9/13.</p> <p>2. Review of E28's personnel file on 11/17/14 at approximately 8:15 AM revealed the absence of an annual performance review. E28 was hired on 7/1/13.</p> <p>3. Review of E29's personnel file on 11/17/14 at approximately 8:20 AM revealed the absence of an annual performance review. E29 was hired on 4/26/10.</p> <p>4. Review of E30's personnel file on 11/17/14 at approximately 8:25 AM revealed the absence of</p>	F 497	4. HR will report to the ED monthly, who will report to the QA committee for further recommendations.	
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NAME OF PROVIDER OR SUPPLIER  <b>MILLCROFT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 POSSUM PARK ROAD NEWARK, DE 19711</b>		
(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 497	Continued From page 78 an annual performance review. E30 was hired on 7/1/13.	F 497			
F 501 SS=E	<p>In an interview on 11/17/14 at 8:30 AM, E31 (Human Resources Director) confirmed the findings.</p> <p><b>483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR</b></p> <p>The facility must designate a physician to serve as medical director.</p> <p>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the coordination of R60's medical care related to pharmacy recommendations regarding laboratory tests and gradual dose reduction for an antidepressant. The Medical Director was unaware of another physician's untimely responses to Pharmacy recommendations. Findings include:</p> <p>Cross refer to F329 examples 1A and 1B, and F386</p> <p>1A. R60 had a pharmacy Consultation Report (consult), dated 5/6/14, that stated, "REPEATED RECOMMENDATION from 3/6/14: Please respond promptly to assure facility compliance with Federal regulations... received... (Lexapro) 10 mg daily for depression since 3/15/13 and is</p>	F 501	<p>1. Cross Ref to F392 &amp; F386. R60 Is receiving appropriate physician care.</p> <p>2. Any resident who is under the care of the identified physician is at risk. The DON/Designee will review previous 60 days of pharmacy recommendations and notify Medical Director of any outstanding recommendations requiring a response.</p> <p>3. New practice- The facility will provide monthly the pharmacy report to the medical director for review and to ensure timely and documented responses have been completed for all attending physicians. The medical director will be responsible to hold the attending physicians accountable for compliance.</p> <p>4. The Ed/Designee will report to QA monthly for further recommendations.</p>	1/15/2015	

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F 501	<p>Continued From page 79</p> <p>due for annual dose evaluation. Recommendation: Please consider a gradual dose reduction (GDR)...". On the pharmacy consult the physician is to indicate whether they accept the recommendation as written, accept it with modifications or the physician can choose to decline the pharmacist's recommendation and write the rationale why. After the physician chooses their response, they are to sign their name and list the date they responded.</p> <p>The 5/6/14 pharmacy consult was faxed to P2 (R60's attending physician) on 5/28/14. P2 responded to the pharmacy recommendation on 5/28/14, approximately 2 1/2 months after the initial pharmacy consult, dated 3/6/14.</p> <p>B. Review of the pharmacy policy entitled "Suggested Laboratory Monitoring Parameters for Selected Medications", dated 2013, stated that for Lasix, a BMP (blood test that measures blood sugar level, kidney function and fluid balance) should be done 1-2 weeks after initiation and with dosage increases, then every 6 months.</p> <p>Review of the clinical record revealed that R60's last BMP was on 1/22/14.</p> <p>Review of the June 2014 MAR revealed that R60 was on Lasix 20 mg twice a week (40 mg per week) since 4/27/14. On 6/15/14, R60's Lasix was increased to 40 mg daily (280 mg per week). R60 lost approximately 29 pounds (16.9%), a severe weight loss, between 6/15/14 and 7/21/14 (about 1 1/2 months) which placed her at high risk for fluid and electrolyte imbalances.</p> <p>On 10/7/14 the MRR for R60 stated to check BMP and noted to "see report for any noted</p>	F 501		

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F 501	Continued From page 80 irregularities and/or recommendations."  The pharmacy consult, dated 10/7/14, was found in P2's folder. The consult stated that R60 "... receives lisinopril (for blood pressure) and furosemide (Lasix) but does not have a creatinine/electrolyte evaluation [included in BMP]... within previous 6 months. (last checked Jan 2014)... consider... a... [BMP] next... lab day and then every six months...". E10 (UM) wrote on the consult that she faxed it to P2 on 10/10/14. As of 11/12/14, P2 had not indicated on the consult whether she agreed or disagreed with the pharmacist's recommendation.  Although P2 wrote physician's progress notes for R60 on 11/9/14, she failed to address the 10/7/14 pharmacy recommendations to recheck a BMP for R60.  E13 (Medical Director) was interviewed on 11/17/14 at 12:18 PM and findings were reviewed. When asked what her position as Medical Director involved, E13 stated, "...oversee the MD (Medical Doctor) services...". When asked how E13 coordinated and oversaw other MD's care, E13 stated that she and the pharmacist do monthly medication reduction meetings on all residents, alternating floors so that each floor was done every other month. Desplte participating in monthly medication reduction meetings, E13 stated, "...I did not know about this particular situation... next time I will be more diligent... I will talk to (P2)".	F 501			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE	F 514			

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NAME OF PROVIDER OR SUPPLIER  MILLCROFT		STREET ADDRESS, CITY, STATE, ZIP CODE 266 POSSUM PARK ROAD NEWARK, DE 19711		
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F 514	<p>Continued From page 81</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined that the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for three (R60, R110 and R172) out of 28 Stage 2 sampled residents. For R110 the facility failed to accurately transcribe a diagnosis and for R60 and R172 the facility failed to have a complete record. Findings include:</p> <p>1. Review of the clinical record, revealed the pharmacy consultant, made recommendations during the 8/5/14 and 10/7/14 MRR. These two Consultation Reports contain pharmacy recommendations and require a doctor's signature indicating whether they agree with the recommendations or not agree were absent from the chart.</p> <p>On 11/7/14 at 11:38 AM, in an interview with E10 (UM), she stated that she could not find the original documents. She stated that R172 was on</p>	F 514	<p>1. R60, R110, and R172 medical records have been updated and are complete.</p> <p>2. Any resident who had a room change that included moving from one floor to another is at risk. A census report will be generated to identify room moves between floors in order to have a record review to identify completion in regards to orders with diagnosis and consult reports available on the chart.</p> <p>3. New practice-The Medical records clerk will review census report for rooms moves and consolidate records as appropriate. Nursing will review verbal orders daily and identify orders without diagnosis for correction at each morning clinical meeting.</p> <p>4. DON/Designee will report findings to the QA committee for further recommendations.</p>	1/15/2015

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F 514	<p>Continued From page 82</p> <p>the first floor in August, and that she asked a nurse from the first floor and medical records if they had it, but the August Consultation Report could not be found. E10, stated that in October, R172 was on the second floor, and the October Consultation Report could not be found either.</p> <p>E10 gave the surveyor Pharmacy copies of the two missing Consultation Reports that were both missing physician's signatures.</p> <p>The facility failed to have a complete record for R172. On 11/7/14 at 11:38 AM, findings were confirmed by E10.</p> <p>2. On 7/22/14, P1 (R110's physician) wrote an order for R110 to receive Zyprexa 2.5 mg by mouth at bedtime for psychosis (loss of contact/touch with reality). Review of MARs from 7/28/14 through 9/30/14 revealed that the facility incorrectly transcribed that the Zyprexa was being used for depression (persistent feeling of sadness and loss of interest) instead of psychosis as was specified by the physician. Findings were confirmed by E2 (DON) during interview on 11/5/14 at approximately 11:30 AM.</p> <p>3. R60 had a pharmacy Consultation Report (consult), dated 5/6/14, that stated, "REPEATED RECOMMENDATION from 3/6/14: Please respond promptly to assure facility compliance with Federal regulations... received escitalopram (Lexapro) 10 mg daily for depression since 3/15/13 and is due for annual dose evaluation. Recommendation: Please consider a gradual dose reduction (GDR)..."</p>	F 514			

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F 514	Continued From page 83  Review of R60's clinical record and thinned records dated back to 3/1/14 lacked the 3/6/14 consult.  Findings discussed with E10 on 11/12/14 at 11:28 AM and with E2 on 11/12/14 at 12:33 PM during interviews. E10 confirmed that she was unable to find the 3/6/14 consult in the active record. E2 was provided the thinned records. Neither E10 or E2 provided the missing 3/6/14 pharmacy consult as of the 11/17/14 exit conference.	F 514			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520	1. Cross reference F315. The current QA committee consists of all required members. 2. All departments with monitoring tools could be affected. 3. Previous leadership failed to have a systematic approach to performance improvement. Current leadership has only been here long enough to have 1 quarterly QA meeting and to set expectations for staff to monitor outcomes. DON/Designee will report all findings to the QA committee monthly to include root cause analysis, and a current action plan for deficient practices. 4. ED will monitor all QA committee activity to determine that root cause analysis is being performed, appropriate monitoring tools are being utilized, and improvements can be measured.	1/15/2015	

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F 520	Continued From page 84 a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interview, it was determined that the facility failed to have a quality assessment and assurance (QA) program that identified and corrected quality deficiencies. Findings include:  Cross refer F315 An interview on 11/13/14 at approximately 10:49 AM with E2 (DON) revealed that the QA committee failed to identify deficient practices concerning residents with urinary incontinence, failed to implement the facility policy for urinary incontinence management, thereby failing to develop and implement appropriate plans of action to correct the deficient practices.  E2 acknowledged these findings on 11/13/14 at approximately 10:49 AM.	F 520			
F 524 SS=F	483.75(s) FACILITY CLOSURE  The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility failed to have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility	F 524	1. A closure plan has been developed for the community by the Regional and Corporate staff. 2. The community is at risk in the event of the need to close the facility without a specific plan. 3. The current ED will work with regional and corporate staff to complete a closure plan. 4. ED will review completed closure plan with the QA and safety committee and provide a copy to the disaster manual.	1/15/2015	

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F 524	Continued From page 85 closure. Findings include:  In an interview on 11/17/14 at 11:26 AM, E1 (NHA) stated that the facility does not have a closure plan.  Finding reviewed during the exit conference on 11/17/14 at approximately 4:30 PM with E1, E2 (DON) and E3 (ADON).	F 524		





**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-8861

STATE SURVEY REPORT

Page 1 of 3

NAME OF FACILITY: Millcroft Nursing Home

DATE SURVEY COMPLETED: November 17, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<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 10/27/14 through 11/17/14. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 101. The Stage 2 survey sample totaled 28 residents.</p> <p>During the annual survey immediate jeopardy (IJ) was identified on 10/27/14, the first day of the survey, when it was determined that the facility had 5 bathrooms with a total of 9 residents with accordion style doors that could be locked from the inside and staff lacked the knowledge and ability to have rapid access to remove the residents in an emergency such as fire, falls, stroke and heart attack. Although the affected bathroom doors had a small keyhole, facility staff did not carry a key(s) to open the doors or know that they existed. The facility was notified of the IJ on 10/27/14 at 4 PM.</p> <p>The IJ was abated on 10/27/14 at 4:20 PM after the lock mechanisms were removed from the affected bathrooms. Post IJ, F323 remained at a "D" level due to other identified issues in this tag.</p>	<p>3201.1.2 Cross refer to the CMS 2567-L survey completed 11/17/14, F157, R272, F280, F281, F309, F315, F323, F329, F333, F353, F364, F371, F386, F428, F431, F463, F490, F497, F501, F514, F520 and F524.</p> <p>3209.9.6 1. R30's incident report remains Missing. 2. Any resident who requires an incident report to be completed is at risk. 3. Incident reports are currently reviewed every morning by new Leadership staff and filed timely. Incident logs are electronically submitted and will be reconciled with incident reports weekly for the next 30 days. This is the responsibility of the new ADON.</p>	<p>1/15/2014</p>

Provider's Signature

*[Handwritten Signature]*  
K. H. Duca

Title Executive Administrator Date

12/16/14  
1/15/15



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6681

STATE SURVEY REPORT

Page 2 of 3

NAME OF FACILITY: Millercroft Nursing Home

DATE SURVEY COMPLETED: November 17, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	Regulations for Skilled and Intermediate Care Nursing Facilities	4. ADON will report to QA monthly and will confirm reports are completed and filed. ADON will review all incident reports daily for two weeks, then weekly for two weeks to ensure accuracy, completion, and filed appropriately.	
3201.1.0	Scope		
3201.1.2	<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:</p> <p>Cross refer to the CMS 2567-L survey completed 11/17/14, F157, R272, F280, F281, F309, F315, F323, F329, F333, F353, F364, F371, F386, F428, F431, F463, F490, F497, F501, F514, F520 and F524.</p>		

Provider's Signature [Signature] Title Ex. Director Date 12/16/14  
[Signature] 4/5/15



**DELAWARE HEALTH  
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Division of Long Term Care  
Residents Protection

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3 Mill Road, Suite 308  
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(302) 577-6661

STATE SURVEY REPORT

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NAME OF FACILITY: Millicroft Nursing Home

DATE SURVEY COMPLETED: November 17, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201.9.0</p> <p>3201.9.6</p>	<p><b>Reports and Records</b></p> <p>All incident reports whether or not required to be reported shall be retained in facility files for three years.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review and interview, it was determined that the facility failed to retain an incident report of a fall on 7/10/14 for 1 (R30) out of 28 Stage 2 sampled residents. Findings include:</p> <p>R30's care plan for risk for falls stated that a fall occurred on 7/10/14 at 9:40 AM.</p> <p>Review of the nurse's note, dated 7/10/14 and timed 9:40 AM, stated, "Called to assess resident s/p (status post) fall ... Assessment done. No injuries noted ...".</p> <p>In an interview on 11/6/14 at 1:53 PM, E2 (DON) and E3 (ADON) confirmed that R30 fell, but they were unable to locate the incident report in the facility's files.</p>		

Provider's Signature [Signature] Title Ex. Director Date 12/15/14  
1/5/15





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3 Mill Road, Suite 308  
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(302) 577-6661

**STATE SURVEY REPORT**

Page 1 of 2

NAME OF FACILITY: Millcroft Nursing Home

DATE SURVEY COMPLETED: February 12, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<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 follow-up survey to the Annual survey ending November 17, 2014 and the Federal Monitoring survey ending December 12, 2014 was conducted at this facility from February 4, 2015 through February 12, 2015. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 97. The survey sample totaled 18 residents.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></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</p>	

Provider's Signature: *Adrienne Procelline* Title: Executive Director Date: 3/6/15



**DELAWARE HEALTH AND SOCIAL SERVICES**

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Residents Protection

DHSS - DLTCRP  
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(302) 677-6661

STATE SURVEY REPORT

Page 2 of 2

NAME OF FACILITY: Millcroft Nursing Home

DATE SURVEY COMPLETED: February 12, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>evidenced by:</p> <p>Cross refer to the CMS 2567-L surveys ending 2/12/15 [events # WD5D12 &amp; 18WM12], F272, F279, F280, F315, F333, F411, F425, and F514.</p>	<p>Cross refer to Federal tag, F272, F279, F280, F315, F333, F411, F425, F514.</p>

Provider's Signature

*Shirley Proctor* MHA

Title

*Executive Director*

Date

*3/6/15*