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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085040	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFLAND PARK CENTER	715 E. KING STREET SEAFORD, DE 19973

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 4, 2019 through April 11, 2019. 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 (one hundred one). The survey sample totaled 45 (forty five). Abbreviations/Definitions used in this report are as follows: ADON - Assistant Director of Nursing; Antipsychotic - drug to treat psychosis and other mental/emotional conditions; CNA - Certified Nurse's Aide; Continence/continent - control of bladder and bowel function; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; DON - Director of Nursing; e.g.- for example; EMR - Electronic Medical Records; Gastrointestinal (GI) - esophagus, stomach, small and large intestines, rectum and anus; i.e. - that is to say, or in other words; Incontinence - loss of control of bladder and/or bowel function; lbs. - pounds; LPN - Licensed Practical Nurse; MAR - Medication Administration Record; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Ostomy - surgical opening to bowel/bladder so bowel movements/urine collect in a bag; PASSAR (Preadmission Screening and Resident Review) - screening for signs of serious mental	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2019

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 illness and/or intellectual disabilities, developmental disabilities or related conditions so if in a nursing home they receive all necessary services for their condition; PPE - Personal Protective Equipment; Psychosis - loss of contact/touch with reality; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager;	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to ensure that abuse registries were checked and histories were investigated prior to employment for two (E10 and E17) out of 17 sampled employees. Findings include: A review of the facility policy entitled Abuse Prohibition (last revised 11/28/17) included that the center will not employ or otherwise engage individuals who have been found guilty by a court of law of abuse, neglect, exploitation, misappropriation of property, or mistreatment or	F 607	A. E10 continues to work at facility and all background check information is currently in place. E17 was placed on leave and returned once all information was verified in the State agency background check center (BCC) on 4/19/19. B. Other employees' background checks were reviewed and all other employees had appropriate dates for pre-hire background documentation requirements. C. A root cause analysis was completed	5/26/19

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F 607	Continued From page 2 have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of others or misappropriation of property or have had disciplinary action in effect against his/her professional license by a state licensure body..... A review of the facility policy entitled Background Investigations (last revised 3/13/17) found that a conditional employee may begin work before the background report check is conducted if all of the requirements below are met: ... He/She signs an Attestation of Good Moral Character and does not disclose any adverse information; ... The drug screen requirement has been met. The review of the state agency's personnel audit sheet completed by E11 (Human Resources) revealed: 1. E10's (Dietary) first day in the facility was 1/14/19 and the adult and child abuse registries were checked after employment began on 1/18/19 and 1/22/19, respectively. E10's drug test results were received prior to employment. 4/11/19 (10:10 AM) - An interview with E1 (NHA) revealed that the facility identified the deficient practice when reviewing the completed form. E1 added that he/she had already informed the director of the dietary department that future employees will not start employment until there was proof of background investigations completed. This finding was reviewed with E1 (NHA), E2 (DON) and E6 (Staff Educator) during the exit conference on 4/11/19 beginning at 3:20 PM. 2. E17's (RD) first day in the facility was	F 607	on 4/24/19. A new process was developed for the Employee Benefits Payroll Coordinator or Center Executive Director to visualize all contracted staff files prior to start date to verify State agency BCC was completed correctly. Education on HR205 Background Investigations (Attachment 1) is being provided to current leadership staff. Current staff will receive education on OPS300 Abuse Prohibition (Attachment 2). Education will be completed with current staff by 5/26/19. D. The Center Executive Director will complete audits (Attachment 3) for 100% of contracted staff background checks for 6 months to ensure compliance with all requirements are done prior to hire in the State agency BCC. The results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 607	Continued From page 3 10/15/18. As of 4/16/19, there was no evidence that E17 had been fingerprinted within the State Agency electronic background check system. 4/16/19 (2:37 PM) - E11 (Human Resources) and E1 (NHA) were emailed to request evidence of fingerprinting. 4/18/19 (4:34 PM) - E11 (Humand Resources) confirmed that the facility reached out "to the contracted agency to provide more concrete data." E1 (NHA) had "suspended (R17's - RD) access and and (sic) services until situation can be resolved."	F 607		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for four (R16, R82, R85 and R94) out of 26 residents sampled for investigations. Findings include: 1. Review of R16's clinical record revealed: 10/3/18 - The care plan for bowel incontinence did not include that R16 had an ostomy. 10/13/18 - The Admission MDS included that the resident had an ostomy. 11/14/18 - The care plan for urinary tract infection did not include that R16 had an ostomy.	F 641	A. Correction MDS's were completed for R16, R82, R85 and R94. B. The most recent MDS for current residents will be reviewed and correction MDSs completed as needed by 5/26/19. C. A root cause analysis was completed on 4/24/19. Education was completed with information from the Resident Assessment Instrument Manual for the Registered Nurses completing the MDSs to verify accuracy (Attachment 4) by 5/9/19. Education is being completed with current clinical staff on OPS402 Clinical Record: Charting & Documentations (Attachment 2). All education will be completed by 5/26/19.	5/26/19

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F 641	Continued From page 4 4/10/19 (12:18 PM) - An interview with E7 (RNAC) confirmed the errors and E7 stated that they would do corrections since R16 did not have any ostomies. 2. Review of R82's clinical record revealed: 3/20/19 - Admission MDS assessment included that R82 received an antipsychotic every day during the look back period. The question, "Did the resident receive antipsychotic medications since admission..." was answered, "No" which was incorrect. March 2019 - A review of the MAR revealed that R82 received an antipsychotic medication twice a day since admission. 4/10/19 (12:18 PM) - An interview with E7 (RNAC) confirmed the error and E7 stated they would do a correction since R16 received an antipsychotic since admission. 3. Review of R85's clinical record revealed: 3/9/19 - The Quarterly MDS assessment included that the resident did not receive an anticoagulant (blood thinner). March, 2019 - Review of the MAR revealed that R16 received a blood thinner on 6 of the 7 days in the look back period. 4/10/19 (4:10 PM) - The MDS assessment decrepancy was reviewed with E1 (NHA) during an interview and the surveyor requested E7 (RNAC) to review. 4/11/19 (10:13 AM) - An interview with E1 (NHA) confirmed the error and stated, "it was fixed last	F 641	D. The Center Nurse Executive or designee will complete weekly audits (Attachment 5) on 10% of completed MDSs prior to submission until 100% compliance achieved on 3 consecutive reviews. Then audits will occur 2 times per month until 100% compliance achieved on 3 consecutive months. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 641	Continued From page 5 night." 4. Review of R94's medical records revealed the following: 12/10/18 - Review of a NP note reflected "depression/anxiety" under Plan for which R94 was taking an antidepressant every day. 12/22/18 - Review of a NP note reflected "depression/anxiety" under Plan for which R94 was taking an antidepressant every day. 12/22/18 - Review of a quarterly MDS refected that no antidepressants were given and depression was not confirmed under Section I (active diagnoses). 3/18/19 - Review of a NP note reflected "depression/anxiety" for which R94 was taking an antidepressant every day. 3/22/19 - Review of a quarterly MDS reflected that depression was not coded under active diagnoses. Based on record reviews and interviews, it was determined that the facility failed to ensure the MDS assessment accurately reflected the residents' status. Findings were discussed with E1 (NHA), E2 (DON) and E6 (Staff Educator) during the exit conference on 4/11/19 beginning at 3:20 PM.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		5/26/19

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F 656	Continued From page 6 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was	F 656	A. Care plans for R16, R82, R85 and R 92	

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F 656	Continued From page 7 determined that, for four (R16, R82, R85 and R92) out of 26 residents sampled for investigations, the facility failed to develop a comprehensive care plan with measurable goals and/or current interventions for identified needs Findings include: 1. Review of R16's clinical record revealed: 10/3/18 - The care plan for being at risk for cardiovascular symptoms...related to...hypertension (high blood pressure) included a goal that R16's blood pressure will remain within baseline parameters. This goal was not measurable since the parameters were not included. 10/6/18 - The care plan for sleep pattern disturbance as evidenced by insomnia included the goal to maintain a pattern of sleep sufficient to promote health and well being. This goal was not measurable. 4/10/19 (1:50 PM) - An interview with E9 (RN) confirmed the care plan goals for the two care plan problems were not measurable. 4/10/19 (4:10 PM) - An interview with E1 (NHA) revealed that the care plans "were fixed." 2. Review of R82's clinical record revealed: a. 3/10/19 - The care plan included the problem that R82 meets PASRR [PASSAR] level II (2) determination secondary to...dementia. Review of the record revealed that R82 did not meet level II criteria as documented on the PASSAR level 1.5 assessment form dated 2/21/19.	F 656	were updated to reflect measurable goals and/or current interventions for identified needs by 4/10/19. B. Current residents' care plans were reviewed and updates were made to reflect measurable goals and/or current interventions for identified needs. C. A root cause analysis was completed on 4/24/19 and it was determined that education was needed for licensed staff for development/implementation of the comprehensive care plan which includes measurable & realistic goals, resident focused, individualized, and inclusion of current interventions for identified needs (Attachment 2). Education will be completed by 5/26/19. D. The Center Nurse Executive/designee will complete audits (Attachment 6) daily for 10% of the resident population until 100% compliance is achieved on 3 consecutive reviews. Then audits will occur weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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4/10/19 (11:05 AM) - An interview with E4 (Dementia Program Director) confirmed that R82 did not meet PASSAR level II criteria and removed the care plan problem.

b. 3/10/19 - The care plan for being at risk for cardiovascular symptoms...related to...hypertension (high blood pressure) included a goal that R82's blood pressure will remain within baseline parameters. This goal was not measurable since the parameters were not included.

3/14/19 - The care plan for GI (gastrointestinal - stomach and intestines) distress included the goal to not develop GI complications. This goal was not measurable nor did the goal address the treatment for indigestion.

March - April, 2019 MAR showed that R82 received four doses of PRN (as needed) liquid medication for indigestion.

4/10/19 (10:45 AM) - During an interview with E9 (RN) , E9 made corrective changes to the care plan goal.

c. 3/15/19 - The care plan problem for being at risk for urinary incontinence included the goal that R82 would have care needs (for incontinence) met by staff to maintain dignity and comfort and to prevent incontinence related complications.

March - April 2019 - Review of CNA documentation found that R82 was continent of urine so the care plan goal was not appropriate for R82.

4/10/19 (10:48 AM) - During an interview with E9

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(RN), E9 made corrective changes to the care plan goal to reflect that R82 was continent.

3. Review of R85's clinical record revealed:

4/10/19 (11:00 AM) - During an interview with E4 (Dementia Program Director) to discuss daytime sleepiness revealed that R85 "is doing better with wearing his/her CPAP" (Continuous Positive Airway Pressure), a medical device used to treat sleep apnea (breathing stops during sleep) by pushing air into the lungs.

Review of R85's care plan revealed it lacked anything about CPAP.

4/10/19 (1:50 PM) - During an interview with E9 (RN), E9 confirmed that the care plan did not include the CPAP. E9 stated the CPAP used to be in the care plan, but it was not added when R85 started using it again.

4. Review of R92's clinical record revealed:

4/5/19 at 12:18 PM - During an interview with R92, R92 revealed that he/she had a "poor appetite" and that food "does not taste good because of medication." R92 further revealed that he/she has lost a lot of weight loss because of illness.

12/21/18 - The EMR (electronic medical record) documented an admission weight of 144 lbs.

3/15/19 - The EMR documented R92 weighed 125 lbs, a 19 pound weight loss in 3 months.

3/27/19 at 3:13 PM - A nutrition note documented "(R92) is on a regular diet with a nutrition supplement two times a day and ice cream with

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F 656	Continued From page 10 all trays ordered. Patient has declined additional supplements in the past but is more willing due to the poor nutritional status. (R92) was encouraged to request additional food and educated on foods that promote weight gain. (R92) was agreeable to 500 mg of vitamin C and 1 ounce of pro heal supplement twice a day with lunch and dinner trays. Also, will send a half a cup of whole milk with breakfast and continue with the ice cream." 4/4/19 - The care plan did not include a nutrition / weight loss care plan that addressed R92's nutritional needs. During an interview on 4/10/19 at 2:10 PM with E3 (ADON) and E5 (RN) it was revealed that R92 was seen by the dietitian and had a very liberal diet. R92 had interventions in place such as supplements at the bedside and a drawer full of snacks, and family brings food in of R92's choice. R92 could request sandwiches and snacks anytime from the facility. R92 took a medication that interfered with the taste of food and appetite. R92 was on a medication to increase his/her appetite. E3 and E5 further confirmed that R92 did not have a care plan addressing R92's nutritional problems and interventions. This finding was reviewed with E1 (NHA), E2 (DON) and E6 (Staff Educator) during the exit conference on 4/11/19 beginning at 3:20 PM.	F 656		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		5/26/19

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F 812	Continued From page 11 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to serve food in a sanitary manner on two (first floor and garden level) out of three nursing units. Findings include: 1. 4/4/19 (11:55 AM - 12:25 PM) The garden level dining observation revealed: - E12 (CNA) performed hand washing for around 15 seconds and used his/her clean right hand to turn off the water faucet, thus contaminating the right hand. E12 then used the same right hand to turn the knob on the side of the paper towel dispenser to obtain a paper towel, again contaminating the right hand. E12 did not re-wash his/her contaminated hands before drying them and putting on a pair of single-use, disposable gloves. - E12 (CNA) contaminated both gloved hands when he/she: Placed the palm of the left hand on the front counter to lean on it for support while uncovering food items with his/her other hand; Rested the right hand on the rear counter to lean on it for support when serving hot food items from	F 812	A. Current employees are being educated on proper serving of food in accordance with professional standards for food service safety. The facility has had no foodborne related illnesses. B. Current residents have the potential to be affected so current employees are being educated on proper serving of food in accordance with professional standards for food service safety. The facility has had no foodborne related illnesses. C. A root cause analysis was completed on 4/24/19 to determine that education was needed on the following policies: 4.6 Hand Washing, 4.7 Food Handling & IC203 Hand Hygiene (Attachment 2). Current staff will be educated on policies by 5/26/19. D. The Center Executive Director/designee will complete daily audits (Attachment 7) of food service delivery to residents until 100%	

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	085040	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 12 the steam table and also on the front counter when handing the plated food to the server; Turned the menu papers over one by one with the left hand; Retrieved additional dishes previously placed on the counter by the back wall; and opened a lower cabinet for more bowls. - E12 (CNA) plated 13 sloppy joes by picking up and opening each roll with his/her contaminated gloved hands. E12 constructed two Italian subs by picking up and opening the roll and placing the meat, lettuce and tomato slices on the roll with contaminated gloved hands. E12 (CNA) did not perform hand hygiene and change gloves throughout the entire meal service. 2. 4/4/19 (beginning at 12:20 PM) The first floor hallway service dining observation revealed: Meal service for the hallway (residents eating in their rooms) was done from a steam table on a cart. -E14 (Dietary Aide) contaminated gloved hands: E14 put on disposable gloves. Next, E14 organized the serving utensils, touching each one of them, thus contaminating his/her hands. -E14 (Dietary Aide) contaiminated two cold sandwiches: While plating the pre-made cold sandwiches, E14 used tongs to pick up the sandwich. As E14 lowered the sandwich onto the plate with tongs using his/her right hand, E14 touched the sandwich with a finger from his/her left hand. E14 plated a second plate of food, using the same disposable gloves, again using tongs in his/her right hand to pick up the sandwich, and then E14 touched the sandwich	F 812	compliance is achieved on 3 consecutive reviews. Audits will then be completed twice a week until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 812	Continued From page 13 with his/her left hand while plating. -E14 (Dietary Aide) continued to contaminate gloved hands: After plating the third sandwich appropriately, E14 opened the doors under the cart to get a fruit bowl, and then handed the bowl to E15 (CNA) for delivery. E14 then also touched lids to food containers as well as utensils. -E14 (Dietary Aide) continued to contaminate food: The forth plate prepared was a sloppy joe sandwich. Keeping the same disposable gloves on, E14 used tongs to pick up the roll, then E14 used a gloved hand to open the roll. E14 (Dietary Aide) performed multiple tasks, but did not perform hand hygiene or change gloves throughout the entire service. 4/5/19 (approximately 4:25 PM) - During an interview with E1 (NHA) to discuss the dining observations, E1 confirmed that the contaminated disposable gloves should have been removed and new ones applied after handwashing. This finding was reviewed with E1 (NHA), E2 (DON) and E6 (Staff Educator) during the exit conference on 4/11/19 beginning at 3:20 PM.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/26/19

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F 880	Continued From page 14 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 15 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R92) out of one sampled residents for transmission based precautions the facility failed to ensure that the infection control practices were followed. Findings include: According to the Centers for Disease Control "Contact precautions are intended to prevent transmission of infections that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves upon entering (i.e., before making contact with the resident or resident's environment) the room or cubicle. Prior to leaving the resident's room or cubicle, the PPE is removed and hand hygiene is performed." http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html Review of the facility policy and procedure for contact precautions, last revised on 3/13/17. "Contact precautions will be used for diseases	F 880	A. R92 remains in facility and isolation precautions have been discontinued. B. Current residents have the potential to be affected when isolation precautions are in place. Facility wide education for current staff is occurring on contact precautions and visitors responsibility for following precautions. C. A root cause analysis was completed on 4/24/19. It was determined that education was needed on the following infection control policies: IC301 Contact Precautions, IC203 Hand Hygiene, and IC206 Visitors, Volunteers, Contract Workers, and other Non-employees (Attachment 2). Education will be completed by 5/26/19. In addition, the facility has adopted the practice that visitors cannot refuse to follow precautions and a supervisor will intervene to ask the visitor to leave the	

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F 880	Continued From page 16 transmitted by direct or indirect contact with the patient's environment." Staff must wear gown and gloves when entering the room ... Remove gown and gloves place in a bag and wash hands before leaving the room. Review of the facility policy entitled infection control policies and procedures, last revised on 11/28/16 for visitors, volunteers, contract workers, and other non-employees... "All visitors,... who interact with patients will be requested to follow Center's infection prevention and control policies and procedures regarding precautions and specific restrictions.... Provide non-employees with information and request cooperation with Center's Infection prevention and control policies and practices." During an interview on 4/4/19 (after lunch) with E5 (RN), it was revealed that R92 was on contact precautions and that no entry beyond the door frame was allowed without wearing a disposable gown and gloves. 4/4/19 at 2:42 PM - E13 (LPN) was observed entering the room inside R92's doorway. E13 entered the room without putting on a gown and gloves and failed to perform hand hygiene upon exiting the room. 4/4/19 at 2:49 PM - R92's visitor asked what he/she should do before going in R92's room. E13 (LPN) stated, "just put the gown on if you are not touching the patient." The visitor waas then observed at the bedside in a gown without gloves. Also, another visitor exited the room without handwashing. 4/9/19 at 11:10 AM - A visitor in R92's room was obsrved sitting in a chair wearing gloves, but no	F 880	facility if needed. D. The Center Nurse Executive/designee will complete daily observation audits of isolation rooms (Attachment 8) until 100% compliance is achieved on 3 consecutive reviews. Then audits will occur twice a week until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 880	Continued From page 17 gown. An interview with the visitor revealed that "only gloves" were needed to visit the resident. 4/9/19 at 11:20 AM - An interview with E5 (RN) revealed that visitors were educated about isolation, but in the end, it is their choice as to whether gown and gloves were worn. 4/9/19 11:14 AM - An interview with E5 (RN) revealed that the facility did not make the visitors wear gowns and gloves and stated, "Our policy is to educate and they make the choice." Findings were reviewed with E1 (NHA), E2 (DON) and E6 (Staff Educator) during the exit conference on 4/11/19 beginning at 3:20 PM.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		5/26/19

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F 883	Continued From page 18 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on review of medical records, it was determined that for one (R199) out of five residents reviewed for infection control, the facility failed to ensure that the pneumococcal vaccine was properly administered. Findings include: Guidelines from the Centers for Disease Control	F 883	A. R199 medical provider was notified on 3/15/19 regarding the early dose the pneumonia 23 vaccine dose 2 and documented no intervention was needed. B. Current residents were reviewed and all other residents received vaccinations in	

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F 883	Continued From page 19 (CDC) specified that there should be at least one year between the administration of PCV (Prevnar) 13 and the pneumonia 23 vaccination. https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf 4/11/19 at 11:16 AM - Review of computerized immunization records revealed that R199 received the PCV (Prevnar) 13 vaccination on 9/10/18 and then received the pneumonia 23 vaccine Dose 2 on 3/15/19, which was six months too early. The facility failed to administer the pneumonia 23 vaccination in accordance with the CDC's recommended timeframe. This finding was reviewed with E1 (NHA), E2 (DON) and E6 (Staff Educator) during the exit conference on 4/11/19 beginning at 3:20 PM.	F 883	accordance with the CDC's recommended timeframe. C. A root cause analysis was completed on 4/24/19 to determine that licensed nurses needed education on policy IC601 Pneumococcal Vaccination - Prevnar 13 (PCV13) or Pneumovax (PPSV23). In addition, education will include the importance of verifying the correct vaccine history in the electronic medical record is updated to ensure correct vaccination dosage and timing is administered (Attachment 2). Education will be completed by 5/26/19. D. The Center Nurse Executive/designee will complete daily audits on 10% of the resident population with vaccinations (Attachment 9) until 100% compliance is achieved on 3 consecutive reviews. Then audits will occur twice a week until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Lofland Park Center
DATE SURVEY COMPLETED: April 11, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from April 4, 2019 through April 11, 2019. 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 (one hundred one). The survey sample totaled 45 (forty-five). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation and interviews.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0			
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by:		

Provider's Signature Vanessa Dennis, DO, MHA Title Center Executive Director Date 5/10/2019

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NAME OF FACILITY: Lofland Park Center
COMPLETED: April 11, 2019

DATE SURVEY

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Cross Refer to the CMS 2567-L survey completed April 11, 2019: F607, F641, F656, F812, F880 and F883.	Cross Refer to the CMS 2567-L for F607, F641, F656, F812, F880 and F883.	5/26/2019

Provider's Signature Tawnya Dennis, FAD, NHA Title Center Executive Director Date 5/10/2019