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

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Lofland Park Center

DATE SURVEY COMPLETED: May 10, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from May 4, 2023 through May 10, 2023. 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 100. The survey sample totaled 37 residents.		
3201.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, State, and Federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following:		
	Cross Refer to the CMS 2567-L survey completed May 10, 2023: F550, F677, F684, F688, F695, F758, F801, and F812.	Cross Refer to the CMS 2567-L survey completed May 10, 2023 for F550, F677, F684, F688, F695, F758, F801 and F812.	06/12/2023
3201.7	**Plant, Equipment, and Physical Environment Kitchen and food storage areas.**	Due to the COVID pandemic, the needed equipment for meal service impacted the dish room floor. The estimate for the new dish room floor was received on May 3,	6/12/2023

Provider's Signature Tawnya Annis Title Administrator Date 5/26/2023

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3201.7.5	**Facilities shall comply with Delaware food code.** **Delaware Food Code** Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **Delaware Food Code 6-201.11 Floors, Walls, and Ceilings .... floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and Easily cleanable.** 05/04/23 – 10:42 AM During the initial kitchen tour, the vinyl floor of the ware washing room was torn and missing leaving the subfloor exposed to moisture and unable to be effectively cleaned and sanitized. 05/04/23 – 11:05 AM During an interview, E17 (Kitchen Supervisor) confirmed the damage to the ware washing room floor and disclosed that the original vinyl flooring had been damaged and was removed by staff a short time ago. 5/10/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference.	2023. The contract for the floor was signed and the work is scheduled to be completed prior to June 12, 2023.	

Provider's Signature _____ Title _____ Date _____

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 _____	C 05/10/2023

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

(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
E 000	Initial Comments An unannounced Annual and Complaint Survey was conducted at this facility from May 4, 2023 through May 10, 2023. The facility census was 100 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was also conducted by The Division of Health Care Quality, Office of Long Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from May 4, 2023 through May 10, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 100. The investigative sample totaled 37 residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; ADL (Activities of daily living) - tasks needed for daily living, e.g. dressing, hygiene, eating,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/26/2023

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 toileting and bathing; Anxiety - general term for several disorders that cause nervousness, fear, apprehension and worrying or Anxiety is an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth; Bipolar Disorder - mood disorder; BM - Bowel movement; Brief Interview for Mental Status (BIMS) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Cerebral Vascular Accident (CVA) - Stroke; a condition involving reduced blood supply to the brain from intracerebral hemorrhage, thrombosis, embolism, or vascular insufficiency; EMR (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format; Feces - bowel movement; Geri sleeves - knit arm protector to help prevent skin from bruising, skin tears and abrasions; Incontinence - loss of control of bladder &/or bowel function; HS (hs) - at bedtime; MASD - moisture associated skin damage; MDS (Minimum Data Set) - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Nasal cannula- tube placed into nostrils to deliver	F 000		

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F 000	Continued From page 2 oxygen; Oxygen concentrators - device that takes in air from the room and filters out nitrogen; Parkinson's Disease - a progressive disorder of the nervous system that affects a person's movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination; Post-Traumatic Stress Disorder (PTSD) - disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event that can last from months or years, with triggers that can bring back the memories of the trauma accompanied by intense emotional and physical reactions; Psychosis - loss of contact/touch with reality; Pulse Oximetry (ox) - measures blood oxygen saturation levels - desired range 94% to 100%; Restorative Nursing Program (RNP) - restorative nursing interventions to promote the resident's ability to adapt and adjust to living as independently and safely as possible; ROM - range of motion; Schizophrenia - mental disorder with false beliefs of being harmed.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		6/12/23

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F 550	Continued From page 3 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R58) out of one resident reviewed for resident rights, the facility failed to promote dignity when a staff member used foul language (cursed) in R58's resident room with R58 present. Findings include:	F 550	A. Both employees involved were immediately removed from R58 room and placed on administrative leave pending investigation. E7 never returned to the facility and her employment was terminated. E6 received mandatory education on her next scheduled shift. E6 no longer works at the facility.	

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F 550	Continued From page 4 Cross refer F677. Review of R58's clinical record revealed: 7/5/19 - R58's care plans included that R58 was incontinent of bowel and bladder and will have incontinence care needs met by staff. 5/31/21 - A quarterly MDS assessment documented that R58 required extensive assistance of two staff members for toileting, was always incontinent of bowel and was frequently incontinent of urine. 7/3/21 - A typed statement conducted by E8 (RN) with E6 (CNA), regarding the lack of care for R58 included: "R58 had BM on hands and was 'playing' in her feces. E6 clarifies that patient was very wet and did not appear to have received any care that shift. E6 states that she lost her cool and let her emotions control her mouth and she knows she shouldn't have reacted that way. She states that E7 (CNA) called E6 a 'fucking lazy bitch' while in the room." 5/9/23 8:30 AM - During an interview, E1 (NHA) confirmed that using foul language in a resident room/patient care area was a dignity issue. E1 informed the Surveyor that employee E7 (CNA) was terminated. 5/9/23 10:15 AM - During an interview, (E10) LPN confirmed that the altercation and foul language between E6 (CNA) and E7 (CNA) occurred in R58's room while R58 was present and that it was a dignity issue. 5/10/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference.	F 550	B. All residents had the potential to be affected, however, the individuals were immediately addressed at the time of the event. E6 & E7 no longer work at the facility. Resident Council meetings cover Resident Rights every month, as well as who the Ombudsman is and how to contact the Ombudsman . All staff receive Resident Right education upon hire & annually, and employees are addressed individually for violations through the facility disciplinary action process. C. After the event occurred, the unit leader readjusted the C.N.A. assignment sheets for improved workflow. On 5/16/2023, a Root Casus Analysis (RCA) was completed to determine that all staff could benefit from Resident Right/Dignity education. The Nurse Practice Educator (NPE) will complete education (attachment A) with all staff by 6/11/2023. D. The NHA or designee will complete daily audits (attachment B) for 10% of the resident population until 3 consecutive reviews achieve 100% compliance. Then audits will occur weekly until 3 consecutive reviews with 100% compliance, then monthly until 100% compliance on 3 consecutive reviews. Results of audits will be presented to the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R28, R32 and R58) out of eight residents reviewed for ADL's, the facility failed to provide incontinence care for dependent residents. Findings include: The facility policy for ADL care was last updated 6/1/21 and indicated that "The Center must provide necessary care and services to ensure that ADL's are maintained. ADL's include: elimination - toileting. ADL care is documented every shift by the nursing assistant." 1. Review of R28's record revealed: 5/17/21 - R28's care plan for required assistance for ADL care included toileting due to cognitive loss/dementia and had a goal for R28's care needs to be anticipated and met. Interventions included assist as needed with ADLs. 5/26/21 - A quarterly MDS assessment documented the resident was severely cognitively impaired, frequently incontinent of bladder and required extensive assistance with toileting. 8/17/21 - A summary report documented, "CNA [oncoming] 11:00 PM through 7:00 AM shift reported finding R28... in daytime clothing versus night clothing. Resident had been incontinent of urine and had MASD."	F 677	A. Facility followed through with all individual employees for R28, R58 and R32 at the time of the events to include counseling, education, disciplinary action including termination for E7. B. All residents had the potential to be affected by the deficient practice, however, the facility immediately followed up with each individual employee at the time of the events. Other residents dependent for ADLs have been reviewed to ensure care provision. Clinical staff receive education upon hire about the importance for provision and documentation of care. Employees violating this area are addressed individually through our disciplinary action process. C. On 5/16/2023 a Root Cause Analysis (RCA) was completed which determined that clinical staff need education on the importance for the provision and documentation of ADL Care and use of the care Kardex. The Nurse Practice Educator (NPE) will complete education (attachments C & D) with nurses and CNAs by 6/11/2023. D. The DON or designee will complete	6/12/23

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F 677	Continued From page 6 8/18/21 9:30 AM - A skin check was performed on R28 and it was documented that, "The following new skin injury/wound(s) were identified: MASD-Moisture Associated Skin Damage(s):Location(s): just below sacrum"(buttocks area)." 8/18/21 untimed - A statement written by E9 (CNA) confirmed that incontinence care was not completed for R28. E9 wrote, "It was a big mistake, but R28 never came to mind... it never dawned on me at all. I never done that before. It was a true mistake." August 2021- Review of CNA documentation regarding completion of toileting for R28 was blank for the evening of 8/17/21. During an interview on 5/8/23 at 10:45 AM, E2 (DON) confirmed that R28 did not receive incontinence care on 8/17/21 and that staff was "educated. We terminated the aide, of course, and reported it." Cross refer F550. 2. Review of R58's clinical record revealed: 7/5/19 - R58's care plans included that R58 was incontinent of bowel and bladder and will have incontinence care needs met by staff. 5/31/21 - A quarterly MDS assessment documented that R58 required extensive assistance of two staff members for toileting, was always incontinent of bowel and frequently incontinent of urine. 7/3/21 4:45 PM - A facility report included:	F 677	daily audits (attachment E) for 10% of the resident population until 3 consecutive reviews achieve 100% compliance. Then audits will occur biweekly until 3 consecutive reviews with 100% compliance, then audits will occur weekly until 3 consecutive reviews with 100% compliance, then monthly until 100% compliance on 3 consecutive reviews. Results of audits will be presented to the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	

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F 677	Continued From page 7 "Patient was noted by 3-11 (3:00 PM - 11:00 PM) CNA, (E6) on first rounds sitting in a large amount of BM. Patient had gotten BM on her hands as well ... 3-11 CNA (E6) alleges that the patient had not received any care for the 7-3 (7:00 AM - 3:00 PM) shift." 7/4/21 untimed - A typed statement interview conducted by E8 (RN) with E7 (CNA) regarding R58's care rendered for 7/3/21 included: "E7 (CNA) states that she did not provide any care for (R58) on Friday" (the date of the allegation of lack of care). July 2021 - Review of the CNA documentation regarding completion of toileting for R58 was blank for the 7-3 shift on 7/3/21. A facility Event Summary for the 7/3/21 4:45 PM allegation of lack of care for R58 included: "Neglect was substantiated and Employee was terminated." 5/10/23 approximately 8:45 AM - During an interview, E2 (DON) confirmed the facility lacked evidence that R58 was provided care on the 7-3 shift on 7/3/21. 3. Review of R32's clinical record revealed: 12/1/20 - R32's care plans for ADLs, with a revision date of 12/21/22, included that R32 had decreased ability to perform ADLs in toileting due to a CVA (stroke) with left sided weakness. 12/7/20 - R32's care plans for incontinence, with a revision date of 2/8/21, included that he was incontinent of urine and needed to be assisted to the toilet at scheduled times, upon rising, before meals, at HS (bedtime), and as needed.	F 677		

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F 677	Continued From page 8 9/23/21- A Quarterly MDS assessment documented that R32 required extensive assistance of one staff person for toileting and was always incontinent of bladder and bowel. 9/30/21- Review of a facility report included: Resident was incontinent of urine and upon the Nurses' investigation it was discovered that E12 (CNA), had not taken the resident to the bathroom for five hours into the 3:00 PM - 11:00 PM shift. 9/30/21 - A written statement by E13 (LPN) at 7:50 PM, documented that E12 was asked... "When was the last time R32 was checked?" E12 said, "I didn't change him all shift." E13 asked E12 a second time..." What time did she check and change R32?" E12 stated, "I didn't change him all shift." A review at the facility Event Summary for 9/30/21 at 11:30 PM revealed that allegations of resident neglect and quality of care for R32 were substantiated. E12 was given education by E1 (NHA) for "Abuse Prohibition." In addition, E12 was counseled and given an "Individual Performance Improvement Plan" on 9/30/21, with an expected outcome that E12 will follow a resident's care plan, effective immediately. 5/10/23 12:00 PM - Findings were reviewed with E1 and E2 (DON) at the Exit Conference.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		6/12/23

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F 684	Continued From page 9 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow the plan of care for one out of one resident reviewed for quality of care. R4 had frail skin and was at risk for bruising and skin tears. Findings include: Review of R4's clinical record revealed: 5/14/07 - R4 was admitted to the facility with a diagnosis of right sided weakness. 1/11/23 - A Quarterly MDS Assessment documented that R4 was totally dependent for all ADL's (Activities for Daily Living). 8/9/16 - Review of R4's care plan for being at risk for bruising and skin tears as evidenced by frail skin was revised on 3/27/23. The care plan goal stated the resident will remain free of skin tears and bruising for 90 days. Interventions included: 1. Apply Geri sleeves at all times. 2. May remove for hygiene as needed. 3. Geri sleeves to both hands to protect from injury. 5/20/19 - A Physician's order included: 1. Apply Geri sleeves at all times 2. May remove for hygiene as needed every shift for skin integrity. 5/5/23 8:53 AM - A random observation revealed	F 684	A. R4 care plan was reviewed to determine the appropriateness of Geri sleeves. Geri sleeves are currently in use and are on the nurse Treatment Administration Record (TAR), as well as the CNA care Kardex. B. One other resident had the potential to be affected by the deficient practice and his care plan was also reviewed. Geri sleeves are currently in use and on both the nurse TAR and CNA care Kardex. C. On 5/16/2023 a Root Cause Analysis (RCA) was completed which determined that clinical staff need education on the importance following the plan of care and use of the care Kardex. The Nurse Practice Educator (NPE) will complete education (attachments C & D) with nurses and CNAs by 6/11/2023. D. The DON or designee will complete daily observation audits (attachment F) for all residents with Geri sleeves until 3 consecutive reviews achieve 100% compliance. Then audits will occur biweekly until 3 consecutive reviews with 100% compliance, then audits will occur weekly until 3 consecutive reviews with	

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F 684	Continued From page 10 R4 was not wearing Geri sleeves. 5/5/23 10:42 AM - Another random observation revealed R4 was not wearing Geri sleeves. 5/5/23 11:45 AM - R4 was observed not wearing Geri sleeves. Review of R4's task sheet, however, revealed that E16 (CNA) signed off Geri sleeves at 10:42 AM indicating that they were in place. 5/5/23 12:36 PM - During an observation and interview, E15 (LPN) was asked if she was supposed to sign off for R4's Geri sleeves. E15 said, "I just haven't gotten to my treatments yet." E15 checked the order and went to R4's room and said, "The CNA can put the Geri-sleeves on R4. E15 said, "Let me go and find her and find out what happened." The facility failed to follow the plan of care for the use of Geri sleeves to protect R4's skin. 5/10/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference.	F 684	100% compliance, then monthly until 100% compliance on 3 consecutive reviews. Results of audits will be presented to the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		6/12/23

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	085040	A. BUILDING _____ B. WING _____	C 05/10/2023

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F 688	Continued From page 11 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R4 and R21) out of two residents reviewed for ROM/mobility, the facility failed to provide restorative nursing services to maintain or prevent further decline in function/mobility. R21 did not receive restorative services for walking. For R4, the facility failed to place rolled washcloths in R4's hands for bilateral contractures. Findings include: 6/1/21 - The facility policy on restorative nursing directed staff to implement the restorative nursing program according to specifics on the care plan. 1. Review of R21's clinical record revealed; 5/12/21- R21 was admitted to the facility with multiple diagnoses, including history of a mild stroke with right-sided weakness. 1/26/22 - An order was written for R21 to be discharged from physical therapy and to remain in the facility on the restorative nursing program (RNP) to receive walking 50 feet three times a day. 2/21/23 - A quarterly MDS assessment documented that R21 was cognitively intact and	F 688	A. R21 and R4 plans of care were reviewed 5/26/2023 to reflect current recommendations from the licensed therapist for proper measures to increase/prevent decrease in ROM/mobility. R21 care plan was also revised to reflect her frequent refusals of care. B. Current residents with restorative nursing care plans/interventions have the potential to be affect by the deficient practice. These residents were also reviewed by 5/26/2023 with updates made to care plans as indicated. C. On 5/16/2023 a Root Cause Analysis (RCA) was completed which determined that clinical staff need education on the Restorative Nursing Policy, provision of care, and use of the care Kardex. The Nurse Practice Educator (NPE) will complete education (attachments C, D & H) with nurses and CNAs by 6/11/2023. D. The DON or designee will complete daily observation audits (attachment F) for all residents with use of wash cloths for preventing decrease in ROM until 3	

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F 688	Continued From page 12 was receiving RNP services, walking, several days during the assessment period. R21's care plan for restorative walking, last updated 2/28/23, included the intervention for R21 to walk 50 feet three times a day with staff assistance with a wheelchair following behind the resident. February - April 2023 - Review of the CNA task completion documentation revealed that R21 did not receive the ordered RNP intervention of walking 2 out of 28 days in February, 7 out of 31 days in March, and 5 out of 30 days in April. There were no documented resident refusals and the resident was not out of the building. 5/4/23 10:08 AM - During an interview with R21, the resident reported, "Some of the Aides will not walk me. It's on my paper for them to do it. I have been to E2 (DON) to tell her about it. Every time I ask some of them, they tell me they are too busy or they got their books to do. I said it the other day when we had our meeting. They won't walk me or tell me they won't walk me." 5/9/23 10:42 AM - During an interview with E11 (Medicaid Reimbursement Reviewer), who also monitors the RNP, E11 confirmed the resident should be receiving walking as part of the ordered RNP. 5/9/23 10:49 AM - During an interview, E2 (DON) confirmed that R21 reported that staff were not walking the resident. 2. Review of R4's clinical record revealed: 5/14/07 - R4 was admitted to the facility with a	F 688	consecutive reviews achieve 100% compliance. Then audits will occur biweekly until 3 consecutive reviews with 100% compliance, then audits will occur weekly until 3 consecutive reviews with 100% compliance, then monthly until 100% compliance on 3 consecutive reviews. The DON or designee will complete daily audits (attachment H) for 10% of the total population of residents on a restorative nursing program for ambulation or ROM to ensure the care is occurring as indicated in the plan of care and staff are following the Restorative Nursing Policy until 3 consecutive reviews achieve 100% compliance. Then the audits will occur weekly until 3 consecutive reviews with 100% compliance, then monthly until 3 consecutive reviews with 100% compliance. Results of audits will be presented to the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	

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F 688	Continued From page 13 diagnosis of right-sided weakness. 8/10/16 - Record review of R4's care plan for alterations in functional mobility, last revised on 3/27/23, included the goal to prevent further contractures and maintain skin integrity for 90 days with interventions to: 1. Place rolled up washcloths in hands. 2. Remove for provision of care. 3. Change during AM care and as needed. 4. Check skin every shift. 12/16/22 - A physician's order included: check for placement for rolled up washcloths in hands every shift. 1/11/23 - A Quarterly MDS Assessment documented: R4 was totally dependent for all ADL's (Activities for Daily Living). 5/4/23 - Review of R4's annual range of motion assessment included: R4 has the following contractures: Left wrist min. (minimum) contracture and the right wrist min. contracture. 5/5/23 8:53 AM - A random observation revealed R4 did not have rolled up washcloths placed in her hands. 5/5/23 10:42 AM - Another random observation revealed R4 did not have rolled up washcloths in her hands. 5/5/23 11:45 AM - Review of R4's task sheet revealed that E16 (CNA) signed off for rolled up washcloths at 10:42 AM despite them not being in place. 5/5/23 12:36 PM - E15 (LPN) had not signed off for R4's rolled up washcloths. E15 said, "Let me	F 688		

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F 688	Continued From page 14 go and find the CNA she can put on the Geri-sleeves and rolled up washcloths." The facility failed to provide care and services for a resident that was at risk for further contractures. 5/10/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R4) out of two sampled residents for respiratory care, the facility failed to follow a Physician's order for oxygen. In addition, the facility failed to follow the manufacturer's instructions for cleaning the oxygen concentrator's filter. Findings include: Review of R4's clinical record revealed: 3/8/22 - R4's care plan included oxygen as ordered by nasal cannula. 11/17/22 - A Physician's order included: Oxygen at one liter a minute by nasal cannula to maintain pulse oximetry greater than or equal to ninety two	F 695	A. R4 oxygen was checked on 5/4/2023 by licensed nurse to make sure her oxygen was set at the appropriate liter flow per physician order. A physician order was also added on 5/5/2023 on R4 for weekly cleaning of the oxygen concentrator. B. Current residents with oxygen orders were checked by Nurse Practice Educator (NPE) on 5/5/2023 to ensure proper liter flow and filter cleaning order in place. All residents affected by this deficient practice have been reviewed and have appropriate respiratory care in place per policy.	6/12/23

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F 695	Continued From page 15 percent every shift and maintain pulse oximetry greater than ninety two percent continuously. 1/11/23 - A Quarterly MDS Assessment documented that R4 was totally dependent for all ADL's. 5/4/23 9:50 AM - An observation of the filter in R4's concentrator revealed the filter had clumps of gray lint and dust particles. 5/4/23 11:30 AM - The Surveyor observed the oxygen concentrator setting at 4.5 liters by nasal cannula. E14 (LPN) stated, "I am a traveling Nurse, I will need to look at the order." E14 reviewed the order summary in the EMR, which read: "Oxygen at one liter a minute by nasal cannula to maintain pulse oximetry greater than ninety two percent." E14 observed R4's concentrator setting at 4.5 liters and changed the setting to 1 liter. 5/5/23 9:01 AM - A random observation of the filter in R4's concentrator revealed it had not been cleaned. 5/5/23 1:37 PM - During an interview with E10 (LPN), E10 said, "The maintenance department cleans the concentrators monthly." 5/5/23 2:00 PM - The Surveyor observed E15 (LPN) check the filter on R4's concentrator. E15 stated, "Yes, it is dirty." 5/8/23 11:38 AM - Review of manufacturer's recommended instructions to clean the concentrator filter included: 1. Remove the filter and clean at least once a week. 2. Note environmental conditions that may require more	F 695	C. On 5/16/2023 a Root Cause Analysis (RCA) was completed which determined that licensed clinical staff need education on proper oxygen liter flow, oxygen order set, and cleaning of concentrator filters. The Nurse Practice Educator (NPE) will complete education (attachment I) with licensed nurses and by 6/11/2023. D. The DON or designee will complete daily audits (attachment J) for 50% of the resident population on oxygen for proper liter flow until 3 consecutive reviews achieve 100% compliance. Then audits will occur biweekly until 3 consecutive reviews with 100% compliance, then audits will occur weekly until 3 consecutive reviews with 100% compliance, then monthly until 100% compliance on 3 consecutive reviews. The DON or designee will complete weekly audits (attachment K) for 100% of the resident population using an oxygen concentrator to make certain filters have been cleaned until 100% compliance has occurred on 4 consecutive reviews. Then audits will occur monthly until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	

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F 695	Continued From page 16 frequent cleaning of the filters that include high dust, and air pollutants. 5/10/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		6/12/23

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F 758	Continued From page 17 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R58 and R63) out of five residents reviewed for unnecessary medications, the facility lacked evidence of consistent side effect monitoring for psychotropic medications. Findings include: A facility policy entitled "Psychotropic Medication Use" (last revised 10/24/22) included: All medications used to treat behavior should be monitored for harm or adverse consequences. 1. Review of R58's clinical record revealed: 6/27/19 - R58 was admitted to the facility with Parkinson's Disease, and was additionally diagnosed with Anxiety, Depression, Bipolar Disorder, Psychosis, Schizophrenia, and Post-traumatic stress disorder (PTSD). R58 had Physician's orders for two antipsychotic	F 758	A. R58 side effect monitoring was change to an electronic version in the Point Click Care documentation system on 5/23/2023. R63 was discharged from the facility. B. Current residents on psychotropic medications were reviewed and all were changed to an electronic version in the Point Click Care documentation system on 5/23/2023. C. On 5/16/2023, a Root Casus Analysis (RCA) was completed to determine that a new system was needed for licensed nurses to document side effects for psychotropic medications (attachment L). In addition, it was determined that licensed nurses need education on side effect monitoring for psychotropic medications (attachment M). The Nurse	

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F 758	Continued From page 18 medications (Seroquel and Nuplazid), an antianxiety medication (Ativan) and an antidepressant medication (Fluoxetine), which required side effect monitoring. Review of February medication side effect monitoring flowsheets revealed: -for 16 out of 84 opportunities, the facility failed to monitor for antipsychotic medication (med) side effects (s/e's); -for 17 out of 84 opportunities, the facility failed to monitor for antianxiety med s/e's; -for 18 out of 84 opportunities, the facility failed to monitor for antidepressant med s/e's. Review of March medication side effect monitoring flowsheets revealed: -for 19 out of 93 opportunities, the facility failed to monitor for antipsychotic med s/e's; -for 18 out of 93 opportunities, the facility failed to monitor for antianxiety med s/e's; -for 23 out of 93 opportunities, the facility failed to monitor for antidepressant med s/e's. Review of April medication side effect monitoring flowsheets revealed: -for 28 out of 90 opportunities, the facility failed to monitor for antipsychotic med s/e's; -for 30 out of 90 opportunities, the facility failed to monitor for antianxiety med s/e's; -for 31 out of 90 opportunities, the facility failed to monitor for antidepressant med s/e's. Review of May medication side effect monitoring flowsheets revealed: -for 5 out of 20 opportunities, the facility failed to monitor for antipsychotic med s/e's; -for 5 out of 20 opportunities, the facility failed to monitor for antianxiety med s/e's;	F 758	Practice Educator (NPE) will complete education (attachment M) with licensed nurses by 6/11/2023. D. The NHA or designee will complete daily audits (attachment N) for 20% of the resident population on psychotropic medications until 3 consecutive reviews achieve 100% compliance. Then audits will occur weekly until 3 consecutive reviews with 100% compliance, then monthly until 100% compliance on 3 consecutive reviews. Results of audits will be presented to the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	

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F 758	Continued From page 19 -for 5 out of 20 opportunities, the facility failed to monitor for antidepressant med s/e's. 2. Review of R63's clinical record revealed: 11/3/21- R63 was admitted to the facility with a diagnosis of Parkinson's Disease, and was additionally diagnosed with Psychotic Disorder with Hallucinations, Anxiety, Major Depression, and Disorientation. 5/8/23 12:31 PM - Review of R63's Physician orders revealed R63 was taking the following antidepressant medications: 1. Duloxetine 60 milligrams daily, 2. Mirtazapine 15 milligrams at bedtime. R63 was taking the following Anxiolytic (Anxiety) medication: 1. Alprazolam 0.5 milligrams three times a day, as needed. 5/9/23 11:31 AM - Review of the facilities monitoring tool titled "Psychoactive Side Effect Monitoring Tool" revealed the following missed opportunities for documentation for side effects for R63's antidepressant and antianxiety medications for February, March and April 2023. Review of February medication for side effect monitoring flowsheets revealed: - for 19 out of 84 opportunities, the facility failed to monitor for antidepressant medication (med) side effects (s/e's); - for 20 out of 84 opportunities, the facility failed to monitor for antianxiety med s/e's. Review of March medication side effects monitoring flowsheets revealed: - for 21 out of 93 opportunities, the facility failed to monitor for antidepressant med s/e's; - for 21 out of 93 opportunities, the facility failed	F 758		

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F 758	Continued From page 20 to monitor for antianxiety med s/e's. Review of April medication side effects monitoring flowsheets revealed: - for 31 out of 90 opportunities, the facility failed to monitor for antidepressant med s/e's; - for 32 out of 90 opportunities, the facility failed to monitor for antianxiety med s/e's. The facility failed to consistently monitor for the presence of any observed potential side effects from psychoactive medications. 5/10/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference.	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of	F 801		6/12/23

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F 801	Continued From page 21 a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant	F 801		

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

(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 801	Continued From page 22 management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that a qualified person in charge of the kitchen was present during all hours of operation. Findings include: 5/4/23 10:37 AM - During an interview, E17 (Kitchen Supervisor) and E18 (Cook) disclosed that no members in the facility's food service department possessed valid Food Protection Manager certificates from an Accredited Food Safety Program.	F 801	A. The District Manager providing support to the kitchen had an active ServSafe Certification. The Food Service Director completed her State Food Safety Food Manager Certification on 5/11/2023 (attachment O). B. All residents had the potential to be affected by the deficient practice, however, the current Food Service Director now has the appropriate national certification for food service management and safety from a national certifying body (attachment O). C. On 5/17/2023, a Root Cause Analysis (RCA) was completed to determine that a new process was needed for verifying proper certification for a qualified dietary	

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F 801	Continued From page 23	F 801	staff member. Since the dietary department is a contracted provider, credentialing paperwork is maintained by Heath Care Services Group (HCSG). The new process requires HCSG to provide a copy of the appropriate proof for the full-time qualified dietary staff member to the NHA where that copy of proof will be maintained in the Survey Readiness Binder and reviewed at least annually to ensure the proof is current with the regulatory requirements. Attachment O is currently in the Survey Readiness binder. D. This area does not require an audit as the current certification is good for 5 years. The new process was discussed in the Quality Assurance Performance Improvement Committee meeting on 5/25/2023. The NHA assumes responsibility for ensuring the proper proof of a qualified dietary staff member is met when recertification is needed or in the event of a personnel change occurs.	
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. (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	F 812		6/12/23

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F 812	Continued From page 24 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 monitor food temperatures in accordance with professional standards for food safety for cooking/reheating food items. Findings include: 5/4/23 1:27 PM - During a review of the food temperature logs, the Surveyor observed one hundred-nine (109) meals out of two hundred sixty-seven (267) reviewed for temperatures had no pre-service food temperatures recorded. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. Fish, meat, and poultry must be heated to an appropriate specific temperature depending on the type of food and the method used to prepare it. Vegetables must be heated to one hundred thirty-five (135) degrees Fahrenheit (F) and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. 5/10/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the Exit Conference .	F 812	A. Current residents had the potential to be affected by the deficient practice. A new system was developed and education for cooks on the importance of recording food temperatures. B. Current residents had the potential to be affected by the deficient practice. A new system was developed and education for cooks on the importance of recording food temperatures. C. On 5/17/2023, a Root Cause Analysis (RCA) was completed to determine a new system was needed for completing and filing food temperature logs (attachment P). A binder with the food temperature logs will be maintained in the administrative conference room. In addition, it was determined that the Food Service Director and the cooks need education regarding the food temperature recordkeeping (attachments P, Q, R). The NHA will educate the Food Service Director (attachment P) and the Food Service Director will educate all cooks (attachments Q & R). All education will be completed by 6/11/202	

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F 812	Continued From page 25	F 812	D. The NHA or designee will audit food temperature logs (attachment S) daily for each meal until 100% compliance is achieved on 3 consecutive days for all 3 meals. Then the audits will occur bi-weekly until 3 consecutive reviews achieve 100% compliance, then weekly until 100% compliance on 3 consecutive reviews, then monthly until 100% compliance on 3 consecutive reviews. Results of audits will be presented to the monthly Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	