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) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center **DATE SURVEY COMPLETED: February 24, 2021**

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 Complaint Survey was conducted at this facility from February 17, 2021 through February 24, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and six (106). The survey sample totaled three (3).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 24, 2021: F689		

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
	085010	A. BUILDING ______ B. WING ______	C 02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	**700 MARVEL ROAD MILFORD, DE 19963**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from February 17, 2021 through February 24, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and six (106). The survey sample totaled three (3). Abbreviations and Definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; Stand pivot transfer - indicates that the person bears at least some weight on one or both legs and spins to move their bottom from one surface to another.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was	F 689	A. R2 did not return to the facility,	3/16/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2021

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 689	Continued From page 1 determined that for one (R2) out of three residents reviewed for accidents, the facility failed to ensure that the appropriate assistive device and supervision were used during transfers. R2 was transferred twice (bed to wheelchair and wheelchair to bed) without a mechanical lift (a machine used to move a resident if the resident cannot safely transfer from surface to surface) and two person assist. This resulted in harm when R2 experienced pain and was found to have a broken leg. Findings include: A facility policy entitled Safe Resident Handling (effective 10/1/2005 with a revision date of 5/12/16) included: "All residents will be assessed on admission...by a licensed nurse for assistance with transfer activities." Review of R2's clinical record included: 2/12/2021 9:15 AM - A Physical Therapy note from the hospital (prior to admission to the facility) documented that the resident was not safe for staff to transfer, and if rehab was not available, R2 would be sent home with a mechanical lift. 2/12/2021 11:54 AM - A Nursing Procedure: Social Worker's note from (a hospital) documented: "Loss of caregivers may limit ability for patient to remain in family care as patient is noted as bed bound x (times) approximately 4 years (per recent case management notes). Daughter reports that with active therapy patient was making progress toward stand pivot transfer to wheelchair but had not achieved status." 2/12/2021 1:50 PM - R2 was admitted to the facility with a urinary tract infection, COVID-19, and a history of a stroke with right-sided	F 689	therefore, there was no opportunity for additional assessments. B. A facility-wide transfer status audit was completed by Unit Manager (DANU) to ensure no other residents were affected. The audit was performed to ensure proper transfer assessments were completed and documented, and appropriate communication stickers have been placed on the exterior of each resident's room. The audit concluded on 2/16 (Attachment A). C. Resident Safe-Handling and Abuse Prohibition education (Attachment B) was provided to all current nursing staff by Center Nursing Executive (CNE) and Assistant Director of Nursing (ADON). Training includes educating staff that a licensed nurse must assess each new admissions' transfer status within 24 hours of admission. Additionally, staff was educated that a lift/transfer assessment must be completed before attempting a resident transfer. CNAs were specifically educated regarding the transfer status communication process, and that all residents can only be transferred according to the transfer status listed on the communication sticker. The training concluded on 3/8/21 with the exception of PRN staff whom will be educated prior to working a shift at the center. ADON or designee will ensure that all new hires are completing Safe-Resident Handling Education prior to taking an assignment. D. CNE or designee will complete an	

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F 689	Continued From page 2 weakness. R2's admission progress note documented that R2 did not have pain at that time. There was no evidence of a lift/transfer assessment being completed at the time of admission. 2/13/2021 7:50 AM - A nursing progress note included: "Resident oob (out of bed) to wheelchair stand pivot transfer. Once pt (patient) in bed and staff exiting her room she started calling staff back and states, my right knee hurts bad 10/10 (on a 0-10 scale, 10 is the worst possible pain), pt (patient) cries out with gentle palpation (touch)." 2/13/2021 4:46 PM - A progress note documented, "1530 (3:30 PM) X-ray right knee shows fracture (broken bone). E6 (Medical Doctor) here and aware. Doctor examines resident and order received to send to (hospital) via 911 for eval (evaluation)." 2/15/2021 1:45 PM (approximately 2 days after R2 was sent from the facility to the hospital) - A late entry progress note for 2/13/2021 at 8:39 AM documented: "Lift assessment attempted however after initial stand and pivot to wheelchair and back to bed, resident c/o (complained of) pain after returned to bed. Assessment could not be completed at this time." 2/22/2021 4:15 PM - During a telephone interview with E4 (CNA), E4 confirmed that R2 was transferred twice without the supervision of a licensed nurse and that R2 could not fully bear weight. E4 stated that it was a short distanced quick transfer and that R2 did not have to bear much weight because the transfer was "1, 2, 3 boom."	F 689	audit within 24 hours of all new admissions to ensure a transfer status assessment has been completed. DANU or designee will also complete audits twice weekly on all new admissions, for a minimum of 3 months, to ensure communication lift stickers are placed on the name plaque located on the exterior of each residents' room. Audits will be brought to the QAPI committee for review each month for at least 3 months or until 100% compliance is achieved.	

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F 689	Continued From page 3 2/23/2021 11:37 AM - During a telephone interview with E5 (LPN), E5 stated if therapy had not evaluated the resident for transfer status, that she would review the hospital paperwork to determine transfer status while the resident was an inpatient at the hospital. E5 confirmed that an admission lift/transfer assessment was not completed, and stated that she asked E4 (CNA) to wait for her, but E4 did not wait for E5's supervision during R2's two transfers. E5 reported that she wanted to complete the lift/transfer assessment, but was unable to related to E4 having transferred R2 alone and the resident at that point was in too much pain. E4 transferred R2 twice without a mechanical lift and adequate supervision resulting in pain and a broken leg. Additionally, a lift/transfer assessment was not completed before attempting a resident transfer. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 2/24/2021, at the exit conference, beginning at 11:30 AM.	F 689		