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	085021	A. BUILDING _____ B. WING _____	03/15/2018

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

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E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. at this facility from March 7, 2018 through March 15, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 82. The Stage 2 survey sample size was 25. No deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from March 7, 2018 through March 15, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 82. The Stage 2 survey sample size was 25. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; EMR - Electronic Medical Record; eMAR- Electronic Medication Administration Record F - Fahrenheit; FMD - Facility Maintenance Director; gm - gram (30 grams = 1 ounce); LPN - Licensed Practical Nurse; mcg - micrograms;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/20/2018

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	F 000		

MDS - Minimum Data Set/assessment tool used in long term care;
mg - milligram;
MRR - Monthly Regimen Review;
NHA - Nursing Home Administrator;
RN - Registered Nurse;
SW - Social Worker;
TAR - Treatment Administration Record;
UM - Unit Manager;

Acetaminophen - a medication used to treat pain and reduce fever. Brand names include Tylenol;
Anemia - low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues which may make you feel tired and weak;
BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15, 13-15: Cognitively intact, 08-12: Moderately impaired, 0-7: Severe impairment;
cm / centimeter - measurement of length, width and depth;
Calcium Carbonate - an insoluble salt occurring naturally in bone, used as an antacid, calcium supplement, and phosphate binder, and for treatment of osteoporosis;
Coccyx - tailbone;
Cognitively intact - able to make own decisions;
Dermis- the thick layer of living tissue below the epidermis that forms the true skin;
Diabetes mellitus: More commonly referred to as "diabetes" -- a chronic disease associated with abnormally high levels of the sugar glucose in the blood;
End-Stage Renal Disease - (ESRD) disease where the kidneys stop working;

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F 000	Continued From page 2 Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support; Exudate - any fluid that filters from the circulatory system into lesions or areas of inflammation; can be a pus-like or clear fluid; Hypertension - high blood pressure; leading cause of stroke; Hypothyroidism -under active thyroid gland that includes symptoms such as fatigue, weight gain, muscle weakness, muscle aches, slowed heart rate, memory problems and depression; Hyperthyroidism - over active thyroid gland that accelerates the bodies metabolism significantly and can cause symptoms such as sudden weight loss, a rapid or irregular heartbeat, sweating, and nervousness or irritability; Incontinence - loss of control of bladder &/or bowel function; Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells; Levothyroxine Sodium (Synthroid) - an oral thyroid hormone medication used to treat hypothyroidism (under active thyroid gland); MediHoney - medical-grade honey products for the management of wounds and burns; Non-blanchable - defined area of redness that does not become pale under applied light pressure; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; Osteoporosis - weakened bones with increased risk of breaking;	F 000		

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F 000	Continued From page 3 Pressure ulcer/PU- sore area of skin that develops when the blood supply to it is cut off due to pressure; ROHO cushion - pressure reducing cushion; Sacral /sacrum - large triangular bone at the base of the spine; Slough - yellow, tan, gray, green or brown dead tissue; Stages of pressure ulcers (categorization system used to describe the severity of PUs): - Stage I (1) - a reddened area of intact skin usually over a boney prominence, that when pressed does not turn white. This is a sign that a PU is starting to develop; - Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated; - Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin; - Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; - Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); - Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; TSH - also know as thyroid stimulating hormone, which is a hormone that controls the release of T4 by the thyroid gland; T3 - also know as triodothyronine, which is a hormone produced by the thyroid gland and helps control metabolism and growth;	F 000		

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F 000	Continued From page 4 T4 - also known as thyroxine, which is a hormone produced by the thyroid gland and helps control metabolism and growth; Vitamin D- a group of vitamins essential for the absorption of calcium.	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 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	F 550		6/7/18

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F 550	Continued From page 5 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 observations, the facility failed to treat 5 (R11, R71, R29, R64, and R77) out of 25 sampled residents with respect and dignity, by not knocking and asking permission before entering their rooms. Findings include: The following observations were made on the first floor after breakfast on 3/14/18, between 8:30 AM and 10:17 AM: - 3/14/18 at 8:30 AM: E9 (LPN) entered room 131 without first knocking and asking permission to enter, and was heard asking R71 if she was done with breakfast; - 3/14/18 at 9:35 AM: E9 entered room 131 without knocking and asking permission to enter, and asked R77 if she needed anything; - 3/14/18 at 10:06 AM: E10 (LPN) entered room 118 while knocking on the door without asking permission to enter, and was heard addressing R64; and - 3/14/18 at 10:17 AM: E9 entered room 139 as she lightly tapped on the door, without asking R11 and R29 for permission to enter. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate	F 550	A. Residents continue to reside at the facility and were not adversely affected by this practice. B. All residents have the potential to be affected by this practice. DON/ED or designee to in-service Nursing Staff on knocking and asking permission before entering resident rooms. C. A root cause analysis has been performed and the results will be discussed at QAPI. DON/Ed or designee to in-service employees on knocking and asking permission before entering resident rooms. D. A weekly random audit to be completed by DON or designee to ensure resident dignity is maintained. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 550	Continued From page 6 Nurse).	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		6/7/18

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F 584	Continued From page 7 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that one resident room(room 108) was maintained in a homelike environment. Finding include: On 3/13/18 at approximately 3:54 PM, it was observed that the B bed bedside table was very worn and the bedside dresser edge was missing. Findings were reviewed and confirmed by E4 (FMD) on 3/13/18 at approximately 4:00 PM. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 584	A. Resident continues to reside at the facility and was not adversely affected by this practice. Room 108 B bed beside table and bedside dresser was replaced. B. All residents have the potential to be affected by this practice. All rooms to be audited by Maintenance Director or designee to ensure resident room furniture is not worn or without defect. C. A root cause analysis has been performed and the results will be discussed at QAPI. Furniture to be inspected monthly on maintenance rounds and repair or place furniture as needed. Maintenance Director to in-service maintenance staff. D. A weekly random audit to be completed by NHA or designee to ensure that resident rooms are maintained in a homelike environment. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		6/7/18

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F 585	Continued From page 8 grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of	F 585		

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F 585	Continued From page 9 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in	F 585		

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F 585	Continued From page 10 accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, and review of facility policy, it was determined that the facility failed to make information available to residents regarding how to file a grievance or complaint. Findings include: The facility policy entitled, Complaints/Grievances, with a date of origin of 1/1/01, a revision date of 11/28/16, and an approval date of 3/22/17, stated, "Information regarding filing Complaints or Grievances is posted in a prominent area in the community." Review of the Resident Council meeting minutes for September 2017 through February 2018, revealed no evidence that information on how to file a grievance was discussed with residents. On 3/8/18 at 2:30 PM, during the Resident Council meeting, in response to the question,"'Do you know how to file a grievance?", 18 residents who attended the meeting responded "no". On 3/12/18 at 11:15 AM, a review of the facility bulletin boards on the first and second floors revealed there was no posted information	F 585	A. No individual resident was cited. Grievance policy to be posted and shared at the next resident council meeting. B. All residents have the potential to be affected by this practice. Grievance policy to be posted and shared at the next resident council meeting. C. A root cause analysis has been performed and the results will be discussed at QAPI. Social Service Director to educate Activities Director to review the grievance policy at monthly resident council meetings. D. Social Services Director to audit resident council meeting minutes monthly to ensure the grievance policy was reviewed. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 585	Continued From page 11 regarding how to file a complaint or grievance with the facility. On 3/13/18 at 1:12 PM, during an interview, E5 (SW), confirmed the process for filing a grievance was not posted in the facility and the information had not been reviewed with residents during the previous six months of Resident Council meetings. The facility failed to follow their own Complaint/Grievance Policy by not making information available to residents about how to file a grievance or complaint. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1(NHA), E2 (DON), and E8 (Corporate Nurse).	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		6/7/18

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F 623	Continued From page 12 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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	085021	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 13 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 14 Based on record review and interview, it was determined that for one (R15) out of 22 sampled residents, the facility failed to notify the resident and the residents' representative in writing of facility discharge and the reasons for the discharge and they failed to send a copy to the ombudsman. Findings include: Review of R15's clinical record revealed: R15 was admitted to the facility on 2/22/16 and was discharged to the hospital on 11/29/17 due to labored breathing with a return date of 12/4/17. Review of R15's clinical record provided no evidence that R15 and R15's representative were notified in writing of the facility discharge. During an interview with E1 (NHA) on 3/13/18 at 3:30 PM, it was confirmed that the facility failed to notify R15 and R15's representative in writing of the facility discharge and the reason for the discharge. E1 stated that the facility did not know they needed to inform the resident and representative in writing of a facility discharge. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1, E2 (DON), and E8 (Corporate Nurse).	F 623	A. Resident (R15) continues to reside at the facility and was not adversely affected by this practice. A letter will be sent to resident (R15), residents' representative and the ombudsman indicating the facility discharge and the reason for the discharge. B. All residents have the potential to be affected by the practice. The facility will go back three months and issue letters to identified residents, residents' representative and the ombudsman indicating the facility discharge and the reason for the discharge. C. A root cause analysis has been performed and the results will be discussed at QAPI. ED or designee to educate Social Service Director on notifying the resident and the resident's representative in writing of facility transfer/discharge and the reasons for the transfer/discharge and to sending a copy to the ombudsman. D. Social Service Director to review all transfers/discharges weekly at Interdisciplinary Team Meeting to ensure the resident and the resident's representative were notified in writing of facility transfer/discharge and the reasons for the transfer/discharge and a copy was sent to the ombudsman. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		6/7/18

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F 625	Continued From page 15 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for one (R15) out of 25 sampled residents, the facility failed to provide the residents or the residents' representative with a written notice that specified the duration of the bed-hold policy at the time of discharge to the hospital. Findings include:	F 625	A. Resident (R15) continues to reside at the facility and was not adversely affected by this practice. A letter will be sent to resident (R15) and the residents' representative describing the duration of the bed-hold policy. B. All residents have the potential to be affected by the practice. The facility will	

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F 625	Continued From page 16 Review of R15's clinical record revealed: R15 was admitted to the facility on 2/22/16 and was discharged to the hospital on 11/29/17 due to labored breathing with a return date of 12/4/17. Review of R15's clinical record provided no evidence that R15 or R15's representative were provided, at the time of discharge to the hospital, a written notice which specified the duration of the bed-hold policy. During an interview with E1 (NHA) on 3/13/18 at 3:30 PM, it was confirmed that the facility failed to provide R15 or R15's representative with a written notice of the duration of the bed-hold policy on 11/29/17. E1 stated that the facility was unaware that a second bed-hold policy notice needed to be provided when a resident was discharged to the hospital. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1, E2 (DON), and E8 (Corporate Nurse).	F 625	go back three months and issue letters to identified residents and the residents' representative describing the duration of the bed-hold policy. C. A root cause analysis has been performed and the results will be discussed at QAPI. ED or designee to educate Social Service Director on notifying the resident and the resident's representative in writing describing the duration of the bed-hold policy . D. Social Service Director to review all transfers/discharges weekly at Interdisciplinary Team Meeting to ensure the resident and the resident's representative were notified in writing describing the duration of the bed-hold policy. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	
F 656 SS=D	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 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 -	F 656		6/7/18

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F 656	Continued From page 17 (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 determined that for one (R48) out of 25 sampled residents, the facility failed to implement care plan interventions which included the direction to place a ROHO cushion under R48 when he was sitting in a recliner. Findings include: Review of R48's clinical record revealed:	F 656	A. For resident R15, a ROHO cushion was supplied for the recliner. B. All residents with a current order for a ROHO cushion have the potential to be affected by this practice. An audit of all residents with ROHO cushions will be conducted to ensure care plan interventions are being implemented.	

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F 656	Continued From page 18 R48 was admitted to the facility from the hospital on 1/5/18 with an open area to his coccyx. R48's care plan revealed that starting on 1/16/18, R48 had a stage 3 pressure ulcer to his coccyx and had the potential for additional pressure ulcer development related to mobility and incontinence. Interventions included that R48 required a ROHO cushion to be placed on his wheelchair or his recliner when he was sitting. Review of R48's orders showed that starting on 1/18/18, R48 was to have a ROHO cushion to his chair. Review of R48's January, February, and March 2018 TARs lacked any evidence of staff documenting R48's ROHO cushion being used while he was sitting in his wheelchair or recliner. During observations on 3/8/18 at 10:08 AM and 3/13/18 at 9:30 AM, R48 was observed sitting in his recliner without a ROHO cushion. R48's ROHO cushion was observed to be placed in his wheelchair. During wound care observation for R48 on 3/13/18 at 10:53 AM, E10 (LPN) confirmed that R48 did not have a ROHO cushion under him while he was sitting in the recliner and that R48's ROHO cushion was currently placed in his wheelchair. After wound care E10 did not move R48's ROHO cushion to his recliner, where R48 was sitting, prior to E10 leaving the room. During an observation on 3/15/18 at 9:50 AM, R48 was again observed sitting in his recliner without a ROHO cushion. R48's ROHO cushion	F 656	C. A root cause analysis has been performed and the results will be discussed at QAPI. DON or designee to educate nursing regarding proper placement of ROHO cushion and changing sitting plane. D. DON or designee to conduct random weekly audits of residents with ROHO cushions to ensure care plan interventions are in place. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 656	Continued From page 19 was observed to be placed in his wheelchair. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		6/7/18

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F 657	Continued From page 20 Based on interview and record review, it was determined that the facility failed to include one (R51) resident out of 25 sampled residents in the review and revision of her care plan. Findings include: Review of R51's clinical record revealed the following: 8/8/15- R51 was admitted to the facility with multiple health problems. 5/7/17 - The annual MDS indicated R51's BIMS score was 15 (able to independently make decisions regarding daily life). 7/17/17 - R51's Plan of Care Conference Summary form revealed the signatures of the attendees as E5 (SW). 10/9/17 - R51's Plan of Care Conference Summary form revealed the signatures of the attendees as E12 (UM) and R51's daughter. 2/3/18 - The quarterly MDS indicated R51's BIMS score was 15. 3/8/18 at 10:35 AM - During an interview, R51 stated she felt as if the facility talked to her daughter regarding decisions about her treatment and/or medication, rather than her. R51 stated she does not recall going to any care plan meetings. 3/13/18 at 1:12 PM - An interview with E5 confirmed that R51 was not present at the care plan meetings on 7/17/17 and 10/9/17. The facility failed to ensure that R51 was given	F 657	A. R51 participated in the review and revision of her care plan on 3/19/2018. B. All residents have the potential to be affected by this practice. Social Service Director to go back 60 days to determine if residents participated or declined in their care plan meeting. If there is no record of participation or the resident declining, a care plan meeting will be conducted. C. A root cause analysis has been performed and the results will be discussed at QAPI. ED or designee to educated Social Service Director requiring that all residents be given the opportunity to participate in the review and revision of their care plan. D. Weekly random audits to be completed by NHA or designee to ensure residents have the opportunity to participate in the review and revision of their care plan. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 657	Continued From page 21 the opportunity to participate in the review and revision of her care plan. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R16) out of 25 sampled residents, the facility failed to provide services to meet professional standards of quality. Findings include: The 2017 Tylenol (Acetaminophen) Adult Dosing Chart for healthcare professionals stated, Acetaminophen should not exceed 6 caplets or 3000 mg in 24 hours, and healthcare professionals may exercise their discretion and recommend up to 4000 mg/day. Review of R16's clinical record revealed the following: R16's physician orders revealed two orders for Acetaminophen 325 mg tablets both starting on 2/17/18. One order stated to give 2 tablets orally every 4 hours as needed for pain/fever greater than 100.4 degrees F and not to exceed 3 mg	F 658	A. Resident (R16) had no adverse outcome and R16's order for Acetaminophen was corrected. B. All residents with Acetaminophen orders have the potential to be affected by this practice. An audit of residents with Acetaminophen orders to be competed to ensure that the orders are accurate. C. A root cause analysis has been performed and the results will be discussed at QAPI. DON or designee to educate Licensed Nursing staff on Medication orders transcription to ensure orders are accurate. D. DON or designee to do random weekly audits to ensure orders for Acetaminophen is accurate. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will	6/7/18

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F 658	Continued From page 22 per 24 hours. The second order stated to give 2 tablets orally every 4 hours as needed for pain and not to exceed 3 mg per 24 hours. Both orders incorrectly referenced 3 mg instead of 3000 mg. The facility failed to provide services that met professional standards of practice by failing to have accurate orders for R16's dosage of Acetaminophen that should not be exceeded in 24 hours. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 658	determine the need for further submissions.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725		6/7/18

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F 725	Continued From page 23 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews it was determined that the facility failed to ensure sufficient staffing levels to meet the residents' needs for 3 (R10, R64 and R75) out of 25 sampled residents in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Findings include: 1. Review of R75's clinical record revealed the following: R75's Admission MDS from 2/19/18 indicated she had a BIMS score of 14 (able to independently make decisions regarding daily life). On 3/12/18 at 11:00 AM, during an interview, R75 stated that she was admitted to the facility on 2/12/18 and was not given a shower until 2/19/18. R75 stated there were many instances when she rang her call bell and had to wait a long time to get to the bathroom, sometimes resulting in incontinence of bowel or bladder. Review of R75's Bathing/Showering record revealed that R75 was scheduled to have showers on Mondays and Thursdays. R75's Documentation Survey Report revealed that for Bathing/Showering, R75 was marked as not applicable on 2/13/18, 2/15/18, and 2/22/18,	F 725	1. A. Resident R75 continuous to reside in the facility with no adverse effects from this practice. B. All residents have the potential to be affected by this practice. Staffing to be reviewed daily to ensure resident needs are met. C. A root cause analysis has been performed and the results will be discussed at QAPI. Supervisors to be educated to review and identify shower/bath needs of the residents to ensure appropriate assistance is provided. D. DON or designee to do random weekly audits to ensure bath/shower schedule is being followed. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions. 2. A. Resident R64 continuous to reside in the facility with no adverse effects from this practice.	

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F 725	Continued From page 24 resulting in R75 having only received two showers in a 14 day period. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse). 2. Review of R64's clinical record revealed the following: R64's 2/15/18 Quarterly MDS indicated that she required two person extensive assistance for toileting. On 3/12/18 at 1:20 PM, the surveyor observed that R64's call bell had been lit for approximately 8 minutes. During an interview, at this time, R64 stated that she had asked to go to the bathroom before lunch (lunch is 12:00 PM) and she was told by E13 (restorative CNA) that she was the only staff member on the floor and needed another staff member to assist with the hoyer lift to put R64 on the bed pan. At 1:39 PM, two CNA's came in to assist R64 with toileting; approximately 1 hour and 40 minutes later. On 3/12/18 at 2:25 PM the surveyor observed two staff members entering R64's room to assist R64. On 3/12/18 at 2:29 PM, during an interview, E13 stated R64 wanted to go to the bathroom at approximately 12:15 PM, but agreed to wait until after lunch as E13 was the only staff member available and R64 was a two person assist for toileting. On 3/12/18 at 2:45 PM, during an interview, R64 confirmed that at 2:25 PM the staff members	F 725	B. All residents have the potential to be affected by this practice. Staffing to be reviewed daily to ensure resident needs are met. C. A root cause analysis has been performed and the results will be discussed at QAPI. Supervisors to be educated to review and identify appropriate amount of staffing is available to ensure resident needs are met. D. DON or designee to do random weekly interviews with residents to determine if an appropriate amount of staff is available to meet resident needs. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions. 3. A. Resident R10 continuous to reside in the facility with no adverse effects from this practice. B. All residents have the potential to be affected by this practice. Staffing to be reviewed daily to ensure resident needs are met. C. A root cause analysis has been performed and the results will be discussed at QAPI. Supervisors to be educated to review and identify appropriate amount of staffing to ensure resident needs are met. D. DON or designee to do random weekly interviews with residents to determine if an appropriate amount of staff is available to meet resident needs. These audits will	

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F 725	Continued From page 25 coming into her room were there to assist her off of the bed pan. R64 stated she rang her bell for assistance at approximately 2:00 PM. R64 stated she 'knows it will take about an hour before they get her off the bedpan. On 3/13/18 at 4:09 PM, surveyor observed R64's light was on. R64 stated she came back from activities at approximately 3:55 PM and asked to go to the bathroom. R64 stated she rang the bell two times. Surveyor waited with R64 to observe when staff would assist her. At 4:30 PM, a nurse came into R64's room to give medication and R64 informed the nurse that she needed to go to the bathroom. The nurse sent two aides in to assist R64 with toileting at 4:32 PM, approximately 37 minutes later. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse). 3. Review of R10's clinical record revealed the following: R10's 12/29/17 Quarterly MDS indicated that she required extensive two person assistance for transfer, and R10 did not walk in her room. On 3/14/18 at 2:15 PM, the surveyor was called into R10's room (R10's call bell was lit). R10 was sitting on the edge of her bed and stated that her feet were cold, and she needed help getting her socks on. R10 stated, "I can't get help when I need it". The surveyor went to the nurses station to ask for assistance for R10. On 3/14/18 at 2:30 PM, during an interview, E14	F 725	be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 725	Continued From page 26 (staff coordinator) stated that over the past year staff had left for various reasons and have not been replaced. On 3/14/18 at 8:30 AM, the surveyor observed that breakfast trays on the first floor were just being delivered by the nursing staff (breakfast in the hallways was scheduled for 7:15 AM and 7:25 AM). On 3/14/18 at 8:40 AM, it was observed that breakfast was not being served in the second floor dining room. 3/14/18 at 8:44 AM, during an interview, E11 (LPN) stated that residents were not eating in the dining room because there was not enough staff to transport the residents to the dining room on the second floor. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 725		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 756		6/7/18

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F 756	Continued From page 27 and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of manufacturer's instructions it was determined that for one (R16) out of 25 sampled residents, the facility's pharmacist failed to identify medication irregularities during their monthly medication regimen reviews (MRRs) and the facility failed to act on an irregularity identified during the pharmacist's MRR. Findings include: The Synthroid websites Full Prescribing Information, dated 2018, stated, "Drugs That May	F 756	A. For resident R16, Levothyroxine Sodium and Calcium with Vitamin D order was changed to reflect the medications should be given at least 4 hours apart and the appropriate diagnosis is correct. B. All residents with Levothyroxine Sodium and Calcium with Vitamin D orders have the potential to be affected by this practice. An audit of residents with Levothyroxine Sodium and Calcium with Vitamin D orders to be competed to	

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F 756	Continued From page 28 Decrease T4 Absorption (hypothyroidism). Potential impact: Concurrent use may reduce the efficacy of Synthroid by binding and delaying or preventing absorption, potentially resulting in hypothyroidism ...Calcium Carbonate may form an insoluble chelate with levothyroxine ...Administer Synthroid at least 4 hours apart from these agents ...Indications and Usage: Hypothyroidism" Review of R16's clinical record revealed: R16 was admitted to the facility on 5/1/15 with diagnoses that included hypothyroidism. On 11/1/16, R16 had a physician's order for Levothyroxine Sodium 50 mcg tablet give 1 tablet by mouth one time a day for hypothyroidism. This order was entered to be administered at 6:00 AM. On 5/2/15, R16 had a physician's order for Calcium with Vitamin D 600 mg- 400 mg tablet give 1 tablet orally one time a day for osteoporosis. This order was entered to be administered at 9:00 AM. On 3/4/17, R16's Levothyroxine Sodium was discontinued and a new order was placed to be started on 3/5/17. This order stated R16 was to receive Levothyroxine Sodium 25 mcg 1 tablet by mouth one time a day for hyperthyroidism. This order was entered to be administered at 6:00 AM and had an incorrect diagnoses of hyperthyroidism instead of hypothyroidism. An MRR was completed by the consultant pharmacist for R16 from March 2017 through February 2018 with irregularities identified on 6/6/17, 9/5/17, and 11/2/17. These did not include	F 756	ensure that the medications are given at least 4 hours apart and the appropriate diagnosis is correct. C. A root cause analysis has been performed and the results will be discussed at QAPI. Pharmacy to educate consultant pharmacist to ensure orders for Levothyroxine Sodium and Calcium with Vitamin D reflect that the medications are given at least 4 hours apart and have an appropriate diagnosis. D. DON or designee to do random weekly audits to ensure orders for Levothyroxine Sodium and Calcium with Vitamin D reflect that the medications are given at least 4 hours apart, have an appropriate diagnosis is correct. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 756	Continued From page 29 any recommendations regarding the timing of administration for R16's Levothyroxine Sodium and Calcium with Vitamin D or the incorrect diagnosis for Levothyroxine Sodium. The 6/6/17 pharmacist recommendation showed no evidence that the facilities medical director reviewed or responded to the pharmacist's recommendation to monitor R16's TSH and free T3. The pharmacist failed to recognize during R16's MRR's from March 2017 through February 2018 the error of the facility administering R16's Levothyroxine Sodium and Calcium with Vitamin D less than 4 hours apart and failed to recognize that the Levothyroxine Sodium had an incorrect diagnoses for the past year. In addition, the facility failed to respond to the consultant pharmacist's recommendation for R16 from 6/6/17. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		6/7/18

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F 757	Continued From page 30 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of manufacturer's instructions, it was determined that for one (R16) out of 25 sampled residents, the facility failed to ensure that the resident was free from unnecessary medications. The facility failed to have the correct amount of time per manufacturer's instructions between the administration of R16's levothyroxine sodium (Synthroid) and calcium carbonate and failed to have an appropriate diagnosis for R16's levothyroxine sodium order. Findings include: The Synthroid website Full Prescribing Information, dated 2018, stated, "Drugs That May Decrease T4 Absorption (hypothyroidism). Potential impact: Concurrent use may reduce the efficacy of Synthroid by binding and delaying or preventing absorption, potentially resulting in hypothyroidism ...Calcium Carbonate may form an insoluble chelate with levothyroxine ...Administer Synthroid at least 4 hours apart from these agents ...Indications and Usage: Hypothyroidism"	F 757	A. For resident R16, Levothyroxine Sodium and Calcium with Vitamin D order was changed to reflect the medications should be given at least 4 hours apart and the appropriate diagnosis. B. All residents with Levothyroxine Sodium and Calcium with Vitamin D orders have the potential to be affected by this practice. An audit of residents with Levothyroxine Sodium and Calcium with Vitamin D orders to be competed to ensure that the medications are given at least 4 hours apart and the appropriate diagnosis. C. A root cause analysis has been performed and the results will be discussed at QAPI. DON or designee to educate Medical Director and licensed nursing staff to ensure orders for Levothyroxine Sodium and Calcium with Vitamin D reflect that the medications are given at least 4 hours apart and have an appropriate diagnosis. D. DON or designee to do random	

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F 757	Continued From page 31 Review of R16's clinical record revealed: R16 was admitted to the facility on 5/1/15 with diagnoses that included hypothyroidism. On 11/1/16, R16 had a physician's order started for Levothyroxine Sodium 50 mcg tablet give 1 tablet by mouth one time a day for hypothyroidism. This order was entered to be administered at 6:00 AM. On 5/2/15, R16 had a physician's order started for Calcium with Vitamin D 600 mg- 400 mg tablet give 1 tablet orally one time a day for osteoporosis. This order was entered to be administered at 9:00 AM. On 3/4/17, R16's Levothyroxine Sodium was discontinued and a new order was placed to be started on 3/5/17. This order stated R16 was to receive Levothyroxine Sodium 25 mcg 1 tablet by mouth one time a day for hyperthyroidism. This order was entered to be administered at 6:00 AM and had an incorrect diagnoses of hyperthyroidism instead of hypothyroidism. Review of R16's eMAR's from March 2017 through March 2018 revealed that R16 received Levothyroxine Sodium at 6:00 AM and Calcium with Vitamin D at 9:00 AM and had an incorrect diagnoses for Levothyroxine Sodium for all months. The facility failed to have R16's Levothyroxine Sodium and Calcium with Vitamin D administered at least 4 hours apart per manufacturer's instructions and failed to have an appropriate diagnoses for R16's Levothyroxine Sodium order.	F 757	weekly audits to ensure orders for Levothyroxine Sodium and Calcium with Vitamin D reflect that the medications are given at least 4 hours apart and have an appropriate diagnosis. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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F 757	Continued From page 32 During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 757		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to obtain laboratory services in an accurate and timely manner to meet the needs of one (R65) out of 19 Stage 2 sampled residents. Findings include: Review of physician orders revealed that R65 was prescribed Levothyroxine. The physician ordered a TSH lab test on 10/15/17. The initial attempt to draw blood for the test on 10/16/17 was unsuccessful, however, the second attempt was not drawn until 2/16/18, 4 months later. The finding was reviewed and confirmed with E2 (DON) on 3/15/18 at approximately 10:00 AM.	F 773	A. Resident R65 continuous to reside in the facility with no adverse effects from this practice. Labs were drawn and the results given to the physician. B. All residents with lab orders have the potential to be affected by the deficient practice. An audit of residents with lab orders will be conducted to ensure lab services are accurate and timely. All labs that were not drawn will be communicated for further recommendation. C. A root cause analysis has been performed and the results will be discussed at QAPI. DON or designee to educated licensed nursing staff to ensure lab services are accurate and timely.	6/7/18

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F 773	Continued From page 33 The finding was reviewed was reviewed with E1 (NHA) and E2 on 3/15/18 at approximately 3:30 PM.	F 773	D. DON or designee to do random weekly audits to ensure lab services are accurate and timely. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	
F 812 SS=D	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 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 ensure food was served under sanitary conditions during dining for one (R52) out of 25 sampled residents. Findings include:	F 812	A. Resident R52 continuous to reside in the facility with no adverse effects from this practice B. All residents have the potential to be affected by this practice. No resident had any adverse effect by this practice.	6/7/18

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F 812	Continued From page 34 During a lunch dining observation of the 2nd floor dining room on 3/8/18 at 12:18 PM, E15 (CNA) was observed assisting other residents with their meals and then picked up R52's roll with bare hands and put butter on it. During the exit conference on 3/15/18 at approximately 3:30 PM, findings were reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 812	C. A root cause analysis has been performed and the results will be discussed at QAPI. DON or designee to educate direct care and wait staff on serving food in accordance with professional standards for food service safety. D. DON or designee to do random weekly audits to ensure care staff serves food in accordance with professional standards for food service safety. These audits will be done weekly for a month until 100% success is achieved. Results of this audit will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that one call bell (room 108B) in the facility was functioning properly. Findings include: On 3/13/18 at approximately 3:54 PM, it was observed that the bedside call bell was not functioning.	F 919	A. Room 108 B bed call bell was repaired. B. All residents have the potential to be affected by this practice. All rooms to be audited by Maintenance Director or designee to ensure resident call bells are functioning C. A root cause analysis has been	6/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	03/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 35 The finding was confirmed by E7 (RN) on 3/13/18 at approximately 4:00 PM. During the exit conference on 3/15/18 at approximately 3:30 PM, the finding was reviewed with E1 (NHA), E2 (DON), and E8 (Corporate Nurse).	F 919	performed and the results will be discussed at QAPI. Maintenance to conduct monthly rounds to ensure the call light system is working. Maintenance Director to educate maintenance staff. D. A weekly random audit to be completed by NHA or designee to ensure resident call bells are functioning. These audits will be done weekly for 4 weeks until 100% success is achieved. Results of the weekly audits will be submitted to the QAPI committee. The QAPI committee will determine the need for further submissions.	

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: Millcroft Nursing Home

DATE SURVEY COMPLETED: March 15, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual Survey and Emergency Preparedness Survey were conducted at Millcroft Nursing Home from 03/07/18 through 03/15/18. The facility census the first day of the survey was 82. The Stage 2 survey sample size was 25.		
3201	**There were no deficiencies cited for the Emergency Preparedness survey.** **Regulations for Skilled and Intermediate Care Facilities** **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. Cross Refer to the CMS 2567-L survey completed March 15, 2018: F550, F584, F585, F623, F625, F656, F657, F658, F725, F756, F757, F773, F812 and F919.	Cross Reference POC for CMS 2567L survey completed March 15, 2018, F-Tags: F550, F584, F585, F623, F625, F656, F657, F658, F725, F756, F757, F773, F812 and F919. Completion Date June 7, 2018	June 7, 2018

Provider's Signature _____ Title Executive Director Date 4/20/18