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

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

STATE SURVEY REPORT

NAME OF FACILITY: Millcroft Living Nursing Home

DATE SURVEY COMPLETED: November 26, 2024

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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 11/24/24-11/26/24. Survey Census: 91 Sample Size: 25 Supplemental Residents: 0	Cross refer tags are F553, F583, F625, F641, F657, F684, F689, F690, F695, F758, F761, and F812.	1/23/25
3201	**Regulations for Skilled and Intermediate Care Nursing 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:**		

Provider's Signature Kristopher Brown Title Executive Director Date 1/3/25

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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 _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT LIVING	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 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 11/24/24-11/26/24 Survey Census: 91 Sample Size: 25 Supplemental Residents: 0	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 553		1/23/25

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

Electronically Signed | 12/20/2024

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 553	Continued From page 1 §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure one of 25 sampled residents (Resident(R) 18) was afforded the opportunity to be included in all aspects of person-centered care planning. Findings include: Review of the facility's policy titled, "Care Plan, Comprehensive, Person-Centered Care," revised March 2022, read in pertinent part, "1. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . . . The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care plan conferences." Review of R18's "Face Sheet," located in electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 06/02/22 with diagnoses of major depressive disorder, sarcoidosis, and erythema intertrigo. Review of the "Care Plan Conference Summary	F 553	Corrective Action: " R18 continues to reside in the facility. Corrective actions have been ensured by the Director of Nursing. Resident R18 has been provided an updated copy of the Residents Rights and informed of their right to participate in the development of their Plan of Care. The care plan has been reviewed with the resident and updated to include the residents□ preferences to ensure that resident rights and preferences are honored, and that the resident has had an opportunity to participate in the care planning process. Identification of Other Residents: " All Residents have the potential to be affected. Resident Rights was reviewed in a Resident Council meeting to ensure that Residents know their rights, including participating in care planning, and to verify that other residents have not experienced any concerns with their rights not being honored. No new concern was identified. All other residents were afforded the opportunity to be included in all aspects of person-centered care planning.	

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F 553	Continued From page 2 Form," provided by the facility, revealed no documented evidence that the resident attended the care plan meeting held on 06/05/24. Review of R18's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an Assessment Reference Date (ARD) of 09/09/24, revealed R18 was cognitively intact with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15. Review of the "Care Plan Conference Summary," found under the Care Plan tab of the EMR revealed the last conference meeting was held 09/11/24. There was no documentation the resident attended the meeting. During an interview on 11/24/24 at 2:10 PM, R18 stated, "I have not been invited to the care plan meeting in a while." During an interview on 11/25/24 at 4:03 PM, the Social Services Director confirmed inviting R18 to the care plan meetings had been missed.	F 553	System Changes: " The Root Cause of the concern was the failure by the facility to ensure that the resident was afforded the opportunity to be included in all aspect of person-centered care planning. The facility policies Care Plans, Comprehensive Person-Centered (Rev. 3.2022) and Residents Rights (revised 12.2016) were reviewed and found to meet professional standards. The facility system for managing the Care Planning process has been updated to include a monthly review of compliance with resident participation in care planning in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of a minimum of 10 residents with care plan updates will be reviewed to ensure their participation in the care planning process; Audits will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed on as needed based upon the	

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F 553	Continued From page 3	F 553	level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State	F 583		1/23/25

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F 583	Continued From page 4 law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility policy, the facility failed to maintain the personal privacy of one resident (R3) during medication administration from a sample of 25 residents. This failure had the potential to cause embarrassment to the resident. Findings include: Review of R3's "Admission Record," located in the resident's electronic medical records (EMR) section titled "Profile," revealed the resident was admitted to the facility on 06/05/2020 with diagnoses that included sarcopenia (muscle loss) and osteoarthritis. Review of R3's "Physicians Orders" for November, located in the resident's EMR section titled "Orders," revealed that the resident was to receive a Lidocaine 4% pain patch every morning. Observation during medication administration on 11/26/24 at 9:05 am revealed Licensed Practical Nurse (LPN) 1 administering a Lidocaine pain patch to R3's left shoulder. R3 was seated in her wheelchair at the nurses' station. LPN1 pulled the resident's shirt over the resident's shoulder, exposing the resident's shoulder and upper chest area. The LPN did not ask the resident if she wanted to return to her room to apply the pain patch. There was a male cognitively impaired resident sitting at the nurses' station along with three staff members and a visitor in the hallway. During an interview on11/25/24 at 1:30 PM, LPN1 stated that she should have taken the R3 back to	F 583	Corrective Action: " R3 continues to reside in the facility. Corrective actions have been ensured by the Director of Nursing. The Director of nursing has completed staff education for all nursing staff members on the facility□s policy on privacy, confidentiality and dignity. Identification of Other Residents: " All Residents have the potential to be affected by this deficiency. No other resident noted to have been affected. The Residents right to personal privacy, confidentiality and dignity will continue to be communicated to nursing staff. System Changes: " The Root Cause of the concern was the failure to maintain the personal privacy of the resident during medication administration with the potential to cause embarrassment to the resident. The facility policy□s for Residents Privacy and Confidentiality (rev. 10.2017) and Dignity (rev. 2.2021) were reviewed and found to meet professional standards. The facility system for medication administration by nursing staff has been updated to include a focus on ensuring that resident privacy and confidentiality are being honored during resident and staff interactions. All medication administration must be completed in the privacy of residents room to protect residents privacy and dignity going forward. The Director of	

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F 583	Continued From page 5 her room to apply the pain patch. During an interview on 11/25/24 at 3:30 PM, the Director of Nursing confirmed LPN1 should have taken R3 to apply the resident's pain patch. The DON stated the nurse's action was a violation of R3's dignity and privacy. Review of the facility's policy titled, "Dignity," with a revision date of February 2021 reads in part, "Staff promote, maintain, and protect resident privacy including bodily privacy during assistance with personal care, and during treatment procedure."	F 583	Nursing or Designee will complete education for all staff on residents privacy and confidentiality. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of a minimum of 3 nursing staff and resident interactions will be observed to ensure that staff honor residents rights to privacy and confidentiality; Audits will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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	F 625		1/23/25

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F 625	Continued From page 6 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 interview, record review, and policy review, the facility failed to provide written notification of the bed hold policy to the resident and responsible party (RP) for one of five residents (Resident (R) 287) reviewed for hospitalization out of a total sample of 25. The failure had the potential to affect the residents planning on returning to the facility. Findings include: Review of R287's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R287 was admitted to the facility on 07/26/23 with acute respiratory failure and dysphagia (difficulty swallowing). On 10/30/23 R287 was diagnosed with COVID-19 and discharged to a hospital on 11/10/23.	F 625	Corrective Action: " The resident R287 no longer resides in this facility. Corrective action was not possible regarding the notification of transfer to the resident representative for R287. To prevent failure to notify a responsible party of transfer in writing in the future, the Director of Nursing or designee have educated all nursing and social service staff regarding the notification requirements for transfer or discharge. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, all nursing and social services staff members will continue to be	

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F 625	Continued From page 7 Review of R287's "Health Status Note," dated 11/10/23 at 9:34 AM and located in the EMR under the "Progress Note" tab, revealed, ". . . Resident sent out to the ER [emergency room] for further evaluation. Spouse notified and she also requested bed hold until issue is resolved . . ." Review of the "Misc (miscellaneous)," "Prog (progress) Notes," and "Evaluations" tabs of R287's EMR revealed no documented evidence that written information regarding the facility's bed-hold policy was provided to the resident or representative. During an interview on 11/26/24 at 3:23 PM, the Social Services Director (SSD) stated the nurses were responsible for verbally notifying families about the bed hold policy when resident went out to the hospital. During an interview on 11/26/24 at 3:28 PM, the Administrator stated a copy of the bed hold paper was sent with the resident or given to emergency medical technicians (EMTs) by nursing or social services as the resident left for the hospital. During an interview on 11/26/24 at 4:05 PM, Unit Manager (UM) 2 reported the bed hold form was in the facility's discharge packet. UM2 stated nursing staff asked the resident to sign it, if able; otherwise, the nurses called the responsible party and documented their verbal response on the form. UM2 stated the form was sent with the resident to the hospital or faxed to the hospital. During an interview on 11/26/24 at 4:12 PM, the Assistant Director of Nursing (ADON) stated the discharge packet the nurses used when sending	F 625	trained on the requirement to provide notice of transfer or discharge to the responsible party in writing. A 100% audit of all discharges and transfers in the last 30 days was completed to ensure responsible party notification. No other concern was noted from audit. System Changes: " The Root Cause of the concern was the failure to provide written notification of the bed hold policy to the resident and responsible party upon transferring to the hospital. The facility policy Bed-Holds and Returns (revised 3.2017) was reviewed and found to meet professional standards. The facility system for daily (Monday to Friday) clinical review meeting has been updated to include a review of all transfers and discharges to ensure that notification has been provided to the responsible party. The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the requirement to provide notice of transfer or discharge to the responsible party. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A 100% audit of all discharges and transfers in the last 30 days has been completed to ensure responsible party notification. Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations,	

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F 625	Continued From page 8 a resident out to the hospital included the bed hold policy and authorization form, and unless the nurse documented they sent it out, there was no evidence the resident or representative received the papers. During an interview on 11/26/24 at 4:45 PM, the ADON stated a "Progress Note" showed R287's wife was called and verbally requested a bed hold. The ADON confirmed there was no documented evidence in the EMR or within other facility files that the resident or spouse were notified in writing about the bed hold policy. Review of the facility's policy titled, "Bed-Holds and Returns," revised March 2022 and provided by the facility, revealed, ". . . All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence [hospitalization or therapeutic leave]. Residents are provided written information about these policies at least twice: well in advance of any transfer (e.g., in the admission packet); and at the time of transfer [or, if the transfer was an emergency, within 24 hours] . . ."	F 625	and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to	F 641	Corrective Action: " There is no opportunity for correction of the MDS for resident R22. The Director	1/23/25

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F 641	Continued From page 9 ensure one resident (Resident (R) 22 out of 25 sampled residents had an accurate Minimum Data Set (MDS) assessment. This had the potential to cause the resident to have unmet care needs. Findings include: Review of the RAI Manual," dated 10/01/19, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. . ." Review of R22's "Admission Record," located in the resident's electronic medical record (EMR) section titled "Profile," revealed the resident was admitted to the facility with diagnoses that included congestive heart failure and shortness of breath. Review of R22's "Physician Orders," dated 09/23/24 and located in the resident's EMR section titled "Orders," revealed the resident was to receive continuous oxygen therapy at two liters via nasal cannula. A review of the R22's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 09/29/24 and located in the resident's EMR section titled "MDS," failed to document in Section "O" Special Procedures, Treatments, and Programs that the resident was receiving continuous oxygen therapy.	F 641	of nursing has educated MDS nurses on the requirements for ensuring assessment accuracy. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be identified by ensuring that the most recent assessment for all current residents is audited for accuracy. A 100% audit of the most recent MDS assessment for all current residents is in the process of been completed by the MDS Coordinators to ensure accuracy. System Changes: " The Root Cause of the concern was the failure to accurately complete the MDS assessment for R22. The facility policy for Comprehensive Assessments and the Care Delivery Process (revised 12.2016) and MDS Error Correction (9.2010) were reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff, including the MDS nurses, on the requirements for assessment and documentation accuracy. The Director of Nursing or designee will ensure weekly review of all completed MDS assessment going forward. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of resident MDS assessments will be completed by the Director of Nursing or	

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F 641	Continued From page 10 During an observation on 11/25/24 at 4:33 PM, R22 was observed receiving oxygen therapy. During an interview on 11/25/24 at 5:10 PM, the MDS Coordinator (MDSC)reviewed the resident's physician orders and medication and treatment records to determine whether the resident was ordered on oxygen therapy. The MDSC reviewed the admission MDS dated 9/27/24 and confirmed the oxygen therapy had not been recorded in Section O.	F 641	Designee to ensure MDS assessment accuracy; audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting	
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	F 657		1/23/25

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F 657	Continued From page 11 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: Based on observation, interview, record review, and review of facility policy, the facility failed to revise care plans for three of 25 sampled residents (R22, R65, and R70). The care plan for R22 was not revised to reflect his oxygen therapy. The care plan for R65 was not revised to reflect an incident of wandering into a female resident's room. R70's care plan was not revised to reflect the resident's urinary catheter. This failure had the potential to affect care provided to the residents. Findings include: 1. Review of R22's "Admission Record," located in the resident's electronic medical record (EMR) section titled "Profile," revealed the resident was admitted to the facility on 02/24/24 with diagnoses that included congestive heart failure and shortness of breath. Review of R22's "Physician Orders," dated 09/23/24 and located in the resident's EMR section titled "Orders," revealed the resident was to receive continuous oxygen therapy at two liters via nasal cannula. A review of R22's "Care Plan," located in the resident's EMR section titled "Care Plans," revealed the resident's care plan was not revised to reflect the use of continuous oxygen therapy.	F 657	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. The residents (R22, R65, and R70) comprehensive Care plan was reviewed by the Director of nursing or designee to ensure that the current care plan is up to date. The residents Care Plans were updated and revised as determined by the resident□s needs. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, all nursing and social services staff members are being trained on the requirements of the Comprehensive Care Plan, as well as compliance with Care Plan Revisions. A 100% audit of all resident care plans has been completed to ensure that each residents care plan is tailored towards their needs. Additional audits will ensure that any other identified Comprehensive Care Plan concerns are corrected. System Changes: " The Root Cause of the concern was a failure to revise care plans for residents according to facility policy. The facility policy for Care Plans, Comprehensive	

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F 657	Continued From page 12 An observation on 11/14/24 at 1:44 pm revealed R22 in bed reading. The resident was wearing a nasal cannula with oxygen flowing at three liters per minute. 2. Review of R65's Admission Record," located in the resident EMR section titled "Profile," revealed the resident was admitted to the facility on 04/15/24 with diagnoses that included cognitive-communication, dementia, anxiety disorders, and altered mental status. Review of R65's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 04/21/24 and located in the resident's EMR section titled "MDS," revealed the resident was assessed to have a "Brief Interview for Mental Status (BIMS)," score of 00 which indicated R65 was severely impaired in cognitive skills for daily decision making. It was recorded that the resident did not exhibit any wandering behaviors during this assessment period. A review of the facility's "Accident and Incident Log" revealed on 06/17/24, there was an incident of R65 entering a female resident's and pulling down his pants. The facility completed an investigation of the incident; however, the facility failed to revise R65's care plan to reflect the incident and what interventions were put in place to protect other residents from R65's wandering behaviors 3. Review of R70's "Admission Record," located in the resident's EMR section titled "Profile," revealed the resident was admitted to the facility on 10/12/24 with diagnoses that included urinary tract infection (UTI), hydronephrosis, urinary	F 657	Person-Centered (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for the weekly Residents at Risk review meeting has been updated to include a discussion of the Comprehensive Care Plan for all residents admitted within the last 30 days, all residents due for a quarterly or significant change MDS assessment, and other residents identified as at risk, to ensure that the Care Plan is up to date and identified interventions are in place. The Director of Nursing or Designee will complete education for all nursing and social services staff regarding the policy for Comprehensive Care Plans. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all resident care plans has been completed to ensure that the Care Plan is up to date and has been revised appropriately within the last quarter or since significant change. Subsequent audits of a random sample of a minimum of 5 residents Care Plans will be completed by the Director of Nursing or Designee to ensure that the Care Plan is up to date and revised to indicate the residents needs; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be	

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F 657	Continued From page 13 retention, and chronic kidney disease. Review of the R70's admission "MDS," with an ARD of 10/13/24 and located under the "MDS" tab of the EMR, revealed the resident had a "BIMS" score of 13 out of 15, which indicated her cognition was intact and able to make decisions regarding her care. The resident was assessed to be incontinent of bladder and bowel. Review of R70's "Discharge Orders," located in the resident's EMR section titled` "Miscellaneous" and dated 11/20/24, revealed the resident was treated for urinary retention and received a urinary catheter. Review of R70's "Care Plan," located in the resident's EMR section titled "Care Plan," revealed the resident's care plan was not revised to reflect the addition of the urinary catheter. During an interview on 11/25/24 at 5:10 PM, the MDS Coordinator (MDSC) stated that any nurse could revise a resident's care plan to reflect changes in the resident's condition and care needs. On 11/24/24 at 4:15 pm, an interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed that care plans were reviewed and revised during the Interdisciplinary Team Meetings. The ADON and DON confirmed It was an expectation that nurses review and revise a resident's care plan as the need arises. Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," with a revision date of March 2022, revealed, ". . . Assessments of residents are ongoing, and care	F 657	completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 657	Continued From page 14 plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment . . ."	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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 interview, record review, and policy review, the facility failed to increase the frequency of assessments when a resident was diagnosed with COVID-19 for one of three residents (Resident (R) 287) reviewed for COVID-19 infection out of a total sample of 25. The lack of assessment could result in the facility not noticing symptoms which warranted further treatment and intervention. Findings include: Review of R287's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R287 was admitted to the facility	F 684	Corrective Action: " There is no opportunity for correction regarding the COVID-19 infection assessments for resident R287. The resident no longer resides in the facility as of the time of this survey. Nursing personnels are being educated regarding comprehensive assessment of Residents to ensure that residents receive treatment and care in accordance with professional standards of practice. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of all residents	1/23/25

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F 684	Continued From page 15 on 07/26/23 with acute respiratory failure and dysphagia (difficulty swallowing). Review of R287's "Order Summary Report," located in the EMR under the "Orders" tab, revealed an order dated 07/26/23 which read, " Monitor the following at least daily. Vital Signs - Temp, Pulse, Respirations, Pulse OX [oxygen saturation level], B/P [blood pressure], for COVID-19 symptoms of Fever, Chills, Cough, Shortness of Breath . . . if symptoms occur, place resident in transmission-based precautions and notify the physician and your Infection Preventionist." Review of R287's "Health Status Note," dated 10/30/23 at 4:59 PM and located in the EMR under the "Progress Note" tab, revealed, ". . . Resident was tested for Covid-19 during outbreak testing. Covid antigen test was positive . . ." Review of R287's "Care Plan" tab revealed a problem area dated 10/30/23 of COVID-19 with interventions to ". . . Monitor and document vital signs as ordered. Notify MD of significant abnormalities . . . Resident on Droplet Isolation precautions . . ." It was recorded that the problem was resolved on 11/09/23. Review of R287's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 11/01/23 and located in the "MDS" tab of the EMR, revealed R287 scored 14 out of 15 on his "Brief Interview for Mental Status (BIMS)," which indicated he was cognitively intact. It was recorded R287 had diagnoses that included COVID-19. During an interview on 11/25/24 at 2:30 PM,	F 684	was completed by the Director of Nursing or designee to ensure adequate supervision and assessment of residents. No other issue was identified. System Changes: " The Root Cause of the concern was a failure to increase the frequency of assessment of resident diagnosed with COVID-19 infection. The facility system for assessing residents with COVID-19 infection and all other infections has been updated to include daily assessment with vital signs for the duration of the illness. The facility policy for Resident Assessment (rev. 11.2019) was reviewed and found to meet professional standards. The Executive Director and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all residents with COVID-19 infection and any other infection to ensure adequate and comprehensive assessment of residents will be completed by the Director of Nursing or designee; then, an audit of a random sample of 10% of residents with COVID-19 infection or any other infection will be completed by the Director of Nursing or Designee to ensure adequate assessment of the residents; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then	

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F 684	Continued From page 16 Licensed Practical Nurse (LPN) 3 stated nurses completed a "COVID-19 Assessment" located in the EMR under the "Evaluations" tab every shift when a resident had COVID. LPN3 stated the assessment included vital signs, lung sounds, and a symptom tracker. LPN3 stated the Infection Preventionist (IP) put an order into the EMR, and nurses signed off that they completed the assessment every shift for residents who had COVID-19. Review of R287's EMR revealed less than daily documentation of assessments, including vital signs, during a ten-day COVID-19 isolation period from 10/30/24 to 11/09/24. Review of R287's "Evaluations," "Progress Notes," and "Wts (weights)/Vitals" tabs of the EMR revealed no "COVID-19 Assessments." There was no documented evidence that R287's vital signs or lung sounds were assessed on 11/02/23 through 11/05/23, or on 11/07/23 or 11/08/23. During an interview on 11/26/24 at 11:11 AM, the IP stated she input orders for nurses to complete the COVID-19 assessment, and she expected nurses to document a note every shift on a resident with COVID-19, as well as vital signs, symptoms, and any complications. The IP confirmed R287's EMR had no documented evidence that the assessments had been completed. During an interview on 11/26/24 at 12:00 PM, the Director of Nursing (DON) reported he expected nurses to document assessments every shift with vital signs and symptoms at a minimum when a resident had COVID-19. He confirmed less than daily assessments were completed for R287.	F 684	monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 684	Continued From page 17 Review of the facility's policy, "Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents," revised September 2022, revealed, ". . . Clinical monitoring of residents with suspected or confirmed SARS-CoV-2 infection is increased, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection . . ."	F 684		
F 689 SS=D	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 observation, interviews, record review, and review of facility policy, the facility failed to provide supervision for one of five residents (Resident (R) 65) reviewed for supervision out of a total sample of 25. The failure had the potential to cause harm to R65 due to his behavior of wandering. Findings include: Review of R65's Admission Record," located in the resident's electronic medical record (EMR) section titled "Profile," revealed the resident was admitted to the facility on 04/15/24 with diagnoses that included cognitive communication, dementia,	F 689	Corrective Action: " Resident R65 is still a resident in the facility. To prevent a recurrence, all employees received education on the provision of adequate supervision and assistance to all residents to prevent accident hazards due to wandering behavior. The care plan for R65 has been reviewed and updated to prevent a recurrence. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of all residents was completed to identify residents at	1/23/25

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F 689	Continued From page 18 anxiety disorders, and altered mental status. Review of R65's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 04/21/24 and located in the resident's EMR section titled "MDS," revealed the resident was assessed to have a "Brief Interview for Mental Status (BIMS) score of 00 which indicated the resident was severely impaired in cognitive skills for daily decision making. It was recorded that the resident did not exhibit any wandering behaviors during this assessment period. Review of the facility's "Accident and Incident Log" revealed on 06/17/24 there was an incident of R65 entering a female resident's and pulling down his pants. A review of the facility's investigation, dated 06/17/24, revealed that R65 had wandered into a female resident's room during the night. The investigation revealed the R65 had pulled down his pants and sat down on a chair next to the female resident's bed. According to the facility's investigation, the female resident woke up while R65 was in her room. The female resident took pictures of R65 while he was in her room and called for the nursing staff to remove R65. By the time nursing staff arrived in the female resident's room, R65 had returned to his room. The facility's investigation documented that the female resident was examined for any injuries. The female resident informed the staff that R65 had not touched her and that she did not want to report the incident. It was documented the female resident wanted to make sure that R65 never entered her room again. Review of R65's "Care Plan," located under the	F 689	risk. To prevent a recurrence, the Director of Nursing or designee will continue to provide education to all employees on the provision of adequate supervision for all residents identified to be at risk for wandering. System Changes: " The Root Cause of the concern was a failure of the facility to provide adequate supervision for the resident. The facility policy for Safety and Supervision of Residents (rev. 7.2017) and Wandering and Elopement (rev. 3.2019) was reviewed and found to meet professional standards. The nursing management team will identify all residents at risk during the admission assessment process. Residents identified to be at risk are to be provided frequent rounding by nursing staff. The facility system for providing supervision for residents at risk of accidents has been updated to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit to ensure compliance with supervision for safety will be completed by the Director of Nursing or designee for all residents that are potentially at risk; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3	

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F 689	Continued From page 19 "Care Plan" tab of the EMR, revealed no documented evidence the facility revised R65's care plan to reflect the incident. There was no documented evidence that interventions were identified and implemented to help protect R65 or other residents from R65's wandering behaviors. During an interview on 11/24/24 at 4:30 PM, the Social Services Director (SSD) stated the incident was discussed with the Interdisciplinary team; however, the SSD was unable to provide documentation of what was discussed in the IDT meeting and how the facility ensured the safety of R65 and the female resident. In an interview on 11/25/24 at 6:10 PM, the Medical Director stated he remembered the incident. The Medical Director stated R65 had severely impaired cognition and he felt the resident was attempting to go to the bathroom at night and mistakenly wandered into the female resident's room. During an interview on 11/26/24 at 1:30 PM, the Assistant Director of Nursing (ADON) stated she was unable to provide information of what interventions were in place to ensure R65 did not return to the female resident's room. The ADON stated she was unable to provide any documentation of interventions that were identified and implemented to protect R65 or other residents. Review of the facility policy titled, ". . . Incident/accident reports will be reviewed by the safety committee for trends related to accidents or safety hazards in the facility and to analyze any individual resident vulnerabilities . . ."	F 689	consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 690	Continued From page 20	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		1/23/25

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F 690	Continued From page 21 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for urinary catheters for one of three residents (Resident (R) 70) reviewed for urinary catheters out of a total sample of 25. The facility failed to have physician orders for the use of a urinary catheter and failed to ensure the drainage bag and tubing were not placed directly on the floor, inhibiting the proper flow of urine. The failure had the potential for the resident to develop reoccurring urinary tract infections (UTIs). Findings include: Review of R70's "Admission Record," located in the resident's electronic medical record (EMR) section titled "Profile," revealed the resident was admitted to the facility on 10/12/24 with diagnoses that included urinary tract infection (UTI), hydronephrosis, urinary retention, and chronic kidney disease. Review of the R70's admission "Minimum Data Set (MDS)," with an Assessment Reference Date of ARD of 10/13/24 and located under the "MDS" tab of the EMR, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated her cognition was intact. The resident was assessed to be incontinent of bladder and bowel. Review of R70's hospital "Discharge Orders," located in the resident's EMR section titled` "Miscellaneous" and dated 11/20/24, revealed the resident was treated for urinary retention and received a urinary catheter. Review of R70's "Physicians Orders" for	F 690	Corrective Action: " Resident R70 continues to reside in the facility. No adverse effect noted from deficiency. Corrective actions have been ensured by the Director of Nursing. A physician and care order for Urinary Catheter has been put in place for this resident. The Director of Nursing will ensure that all nurses are educated on the appropriate use of urinary catheters. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of all residents with Urinary Catheters was completed by the Director of nursing or designee to ensure proper physician orders were in place. No new issue was identified. Nursing personnel will be educated to ensure that all Urinary Catheters have appropriate physician and care orders in place to provide appropriate treatment and services. System Changes: " The Root Cause of the concern was a failure by the facility to provide appropriate treatment and services to the resident by not having a physician order in place for urinary catheter; and ensure that the drainage bag and tubing were not placed directly on the floor. The facility policy for Urinary Continence and Incontinence □ Assessment and Management (rev. 09.2010), and Foley Catheter Insertion, Female Resident (rev. 10.2010), and emptying a Urinary Drainage Bag (rev. 10.2010) were reviewed and found to	

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F 690	Continued From page 22 November 2024, located in the resident's EMR section titled "Orders," revealed the ER orders for the resident's urinary catheter were not transcribed to the monthly physician orders. Review of R70's "Care Plan," located in the resident's EMR section titled "Care Plan" revealed the resident's care plan was not revised to reflect the addition of the urinary catheter. During an observation on 11/25/24 at 8:45 AM, R70 was observed lying in bed with her eyes closed. Her urinary drainage bag with privacy covering was lying on the floor. During an observation on 11/25/24 at 1:30 PM, R70 was lying in bed. The resident's urinary drainage bag and tubing were lying on the floor. During an interview on 11/25/24 at 1:30 PM, Licensed Practical Nurse (LPN) 2 stated that R70's urinary drainage tubing and bag were not properly positioned to promote urine flow. LPN 2 stated that R70 was sent to the hospital two weeks ago for a UTI and had the urinary catheter inserted there. During an interview on 11/25/24 at 2:55 PM, the LPN Supervisor and LPN2 revealed the discharge orders for the urinary catheter were not transcribed to the resident's monthly orders. LPN2 stated she thought the evening supervisor had transcribed the orders from the emergency room and revised the resident's care plan to reflect the catheter. LPN2 acknowledged that she should have reviewed the resident's chart to ensure that the orders had been transcribed.	F 690	meet professional standard. The facility system for Foley Catheters management has been updated to include daily (Monday to Friday) Inter-departmental team review of residents with a Foley Catheter in the morning clinical review meeting to ensure proper physician orders for all Foley Catheter, and ensure order is in place to always keep the drainage bag and tubing off the floor. The Director of nursing and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all residents with Foley Catheters to ensure proper physician orders will be completed; then, an audit of a random sample of 10% of residents with Foley Catheters will be completed by the Director of Nursing or Designee to ensure compliance; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		1/23/25

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F 695	Continued From page 23 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, the facility failed to administer oxygen at the physician prescribed dose for two of five residents (Residents (R) 9 and 22) reviewed for respiratory care out of a total sample of 25. This had the potential to cause the residents respiratory distress. Findings include: 1. Review of R9's "Admission Record," located in the "Profile" tab of the electronic medical record, (EMR) revealed the resident was admitted to the facility on 09/20/24 with diagnoses that included pneumonia, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure. Review of R9's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 09/26/24 and located under the "MDS" tab of the EMR, revealed R9 had a "Brief Interview for Mental Status (BIMS)" score of 10 out of 15, which indicated the resident was moderately cognitively impaired. Review of R9's "Physician Orders," located in the	F 695	Corrective Action: " Residents R9 and R22 continue to reside in the facility. No adverse effect of deficiency noted. Corrective actions have been ensured by the Director of Nursing. The Oxygen administration dose for R9 and R22 were corrected to match the Physician prescribed dose. All nurses will continue to be educated to ensure that Oxygen administration is always provided according to the physician order. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of all residents on Oxygen therapy was completed to ensure proper oxygen administration. No other resident found to be affected. Nursing personnel will continue to be educated to ensure that Oxygen administration is always provided according to the physician order. System Changes: " The Root Cause of the concern was a failure to administer oxygen to residents	

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F 695	Continued From page 24 EMR under the "Physician Orders" tab, revealed an order dated 10/16/24 for oxygen for symptoms of hypoxia via nasal cannula at 3 LPM. During an observation on 11/24/24 at 12:25 PM, R9 was observed seated in her wheelchair in her room with her eyes closed. The resident had an oxygen cannula in place, running from a concentrator that was set at 4.5 liters per minute (LPM). During an observation on 11/25/24 at 9:15AM, R9's oxygen concentrator was again set at 4.5 LPM. During an interview on 11/25/24 at 6:11PM, the Medical Director stated that R9 had a risk potential for hypoxia due to ongoing "lung concerns" related to COPD. He added that the resident's oxygen should be set at the ordered level and any variation required physician notification. During an observation and interview on 11/26/24 at 10:37 AM, R9 was seated in her wheelchair in her room. The resident's oxygen concentrator was set at 2LPM. Licensed Practical Nurse (LPN) 1 confirmed the oxygen concentrator was set at 2 LPM. LPN1 confirmed the oxygen was to be set at 3 LPM. She stated she had checked the concentrator's settings when she began her shift and believed another staff member may have changed the settings by mistake. 2. Review of R22's "Admission Record," located in the resident's electronic medical record (EMR) section titled "Profile," revealed the resident was admitted to the facility on 02/24/24 with diagnoses that included congestive heart failure and	F 695	at the physician prescribed dose. The facility policy for Oxygen Administration (rev. 10.2010) was reviewed and found to meet professional standards. The facility system for managing oxygen administration has been updated to include every shift rounds by nursing supervisors to observe residents with oxygen and ensure that the Oxygen flow rates match the physician order. The Director of nursing and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all residents with Oxygen to ensure that Oxygen administration is provided according to the physician order at all times will be completed; then, an audit of a random sample of 10% of residents with oxygen will be completed by the Director of Nursing or Designee to ensure compliance; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 695	Continued From page 25 shortness of breath. Review of R22's "Physician Orders," dated 09/23/24 and located in the resident's EMR section titled "Orders," revealed the resident was to receive continuous oxygen therapy at two liters via nasal cannula. Review of R22's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 09/29/24 and located in the resident's EMR section titled "MDS" failed to record the resident was receiving continuous oxygen therapy. Review of R22's "Care Plan," located in the resident's EMR section titled "Care Plans," revealed the resident's care was not revised to reflect the use of continuous oxygen therapy. During an observation on 11/24/24 at 1:44 PM, R22 was observed lying in bed reading. The resident was wearing a nasal cannula with oxygen flowing at three liters per minute. The tubing was dated 11/22/24, and the oxygen concentrator filter had a large amount of dust debris. During an observation on 11/25/24 at 2:00 PM, R22's oxygen setting was at three liters per minute, and the filter on the oxygen concentrator had a built up of dust debris. During an interview on 11/25/24 at 4:30 PM, the Medical Director stated the expectation was that oxygen would be delivered according to the physicians' orders. The Medical Director stated if there was a need to change the oxygen setting to increase the resident's oxygen level saturation	F 695		

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F 695	Continued From page 26 levels the nurses are expected to inform the physician of the change. During an interview on 11/26/24, the Licensed Practical Nurse (LPN) Supervisor confirmed the nurses were responsible for cleaning the filters on the oxygen concentrators and ensuring the oxygen setting was according to the physicians' orders.	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;	F 758		1/23/25

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F 758	Continued From page 27 §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 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 interview, record review, and policy review, the facility failed to document an end date for an as needed (PRN) psychotropic medication for one of six residents (Resident (R) 294) reviewed for unnecessary medications out of a total sample of 25. The failure had the potential for residents to receive psychotropic medications without ongoing assessment by a physician or practitioner for continued appropriateness. Findings include: Review of R294's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed R294 was admitted to the facility on 09/12/24. R294 had diagnoses which included anxiety, depression, and bipolar disorder.	F 758	Corrective Action: " R294 still resides in this facility. Corrective actions have been ensured by the Director of Nursing. The medication for Resident R294 has been clarified to include a stop date. The party responsible was notified of changes to stop the date of the medication. Nurses and Nurse Practitioners were educated about the 14 days limit rule for all PRN psychotropic drugs. Identification of Other Residents: " All Residents have the potential to be affected. A 100% audit of all antipsychotic medications to ensure a stop date for all as needed orders has been completed.	

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F 758	Continued From page 28 Review of R294's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 09/28/24 and located in the "MDS" tab of the EMR, revealed R294 scored 14 out of 15 on her "Brief Interview for Mental Status (BIMS)," which indicated she was cognitively intact. Review of R294's "Encounter," dated 09/20/24 at 1:00 AM and located in the EMR under the "Progress Note" tab, revealed a Nurse Practitioner entry, ". . . Currently on buspirone [an anti-anxiety medication] 10 mg, endorses anxiety and wants clonazepam [an anti-anxiety medication] . . ." Review of R294's "Order Summary Report," located in the EMR under the "Orders" tab, revealed an order dated 09/20/24 for clonazepam 0.5mg every 24 hours as needed for anxiety." There was no end date for the as needed anti-anxiety medication. During an interview on 11/25/24 at 1:06 PM, R294 stated she took her PRN anxiety medication "once in a blue moon." She stated she typically did not need it due to getting buspirone twice a day. During an interview on 11/25/24 at 2:20 PM, Licensed Practical Nurse (LPN) 3 stated the unit managers entered new orders into the EMR. LPN3 stated PRN psychotropic medications were expected to have an end date of 14 days, unless ordered for longer. LPN 3 confirmed R294 had orders in the EMR for PRN clonazepam since 9/20/24 with no end date. During an interview on 11/25/24 at 2:50 PM, Unit	F 758	No new concerns regarding antipsychotic medication orders were noted as a result of this audit. To prevent other residents from being affected, all nursing personnel will continue to be educated on the requirements regarding antipsychotic medication use, including limiting as needed medication order to 14 days. System Changes: " The Root Cause of the concern was a failure of the facility to document an end date for an as needed (PRN) psychotropic medication. The facility policy for Antipsychotic Medication Use (rev. 7.2022) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirements for Antipsychotic Medication use. All new Antipsychotic medication orders will be reviewed at the daily (Monday to Friday) Inter departmental team meeting going forward. The Executive Director and nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A 100% audit of all antipsychotic medications to ensure proper orders and stop dates has been completed. Subsequent Audits of a random sample of 10% of antipsychotic medications will be completed by the Director of Nursing or Designee to ensure complaince; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3	

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F 758	Continued From page 29 Manager (UM) 1 reported the unit managers entered or verified orders in the EMR. UM1 stated the PRN clonazepam order for R294 was entered by a nurse practitioner and verified by a unit manager. UM1 stated the nurse practitioner was expected to enter a stop date for PRN psychotropics, and the unit manager who verified orders was expected to check and reach out to the nurse practitioner for an end date of 14 days or a rationale for orders with end dates beyond 14 days. During an interview on 11/25/24 at 3:00 PM, the Assistant Director of Nursing (ADON) stated that PRN psychotropic medications were expected to have a 14-day end date and then be renewed as needed. During an interview on 11/25/24 at 3:05 PM, the Director of Nursing (DON) reported the expectation that PRN psychotropics have a 14-day end date or rationale to extend past that. Review of the facility's policy, "Psychotropic Medication Use," dated July 2022, revealed, ". . . Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to l4 days. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order . . ."	F 758	consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		1/23/25

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F 761	Continued From page 30 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, and a review of facility policy, the facility failed to secure one of three (Second floor medication cart) medication carts on one of two nursing units. The facility failed to dispose of expired supplies in one of two (Second floor medication storage room) medication storage rooms. These failures had the potential to result in residents being subject to unsafe or ineffective treatment or adverse effects leading to more serious illnesses and could permit unauthorized	F 761	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. All nurses have been educated on medication storage and standards, including always maintaining a locked medication cart when it is unattended, and disposal of expired supplies. Identification of Other Residents: " All Residents have the potential to be	

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F 761	Continued From page 31 access to residents' medications. Findings include: 1. Observation on 11/24/24 at 6:34 PM revealed the second-floor medication cart was unlocked and was located between rooms 221 and 223, approximately six steps away from the nurses' station. The cart remained unlocked for nine minutes and fifty-eight seconds. The top drawer contained insulin pens and over-the-counter medications. The second drawer contains residents' medications and a locked narcotic box. No staff were present, and the cart was not within the line of sight of any staff member. Resident (R) 36 was seated in a wheelchair at the nurses' station, making several attempts to stand up. Two other unidentified residents were seated at the nurses' station. Review of R36's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 11/15/24 revealed R36 was severely impaired in decision-making skills, utilized a wheelchair and walker for mobility, and had no range of motion limitations. During an interview on 11/24/24 at 6:50 PM, Licensed Practical Nurses (LPN) 4 and LPN 5 revealed they were both sharing a cart and unaware that the medication cart was unlocked. LPN 5 acknowledged that R36 tended to wander, and the unlocked medication cart posed a hazard for the resident. 2. On 11/25/24 at 10:15 am an inspection of the medication room on the second floor revealed the following concerns:	F 761	affected. To prevent residents from being affected, all nursing staff members will be educated by the Director of Nursing or Designee on the requirements regarding medication storage, locking medication carts and disposal of expired medication. An initial 100% audit of all medication carts and medication rooms to assess compliance with medication storage and expired medication disposal requirements was completed. No new concerns identified by this audit. System Changes: " The Root Cause of the concern was a failure by the facility nurse to secure a medication cart and failure to dispose of expired supplies in the medication storage room. The facility policy□s for Medication labeling and Storage (rev. 2.2023) and Security of Medication Cart (rev. 4.2007) were reviewed and found to meet professional standards. The facility system for medication storage has been updated to include a monthly Quality Assurance Committee review of the medication storage audits and consultant pharmacist review reports. The Director of Nursing or Designee will complete education for all nursing staff members on the requirements regarding medication storage, and disposal of expired supplies. The Director of nursing or designee will ensure that weekly stock taking of medication in the Medication rooms are completed to identify and remove expired medications. The nursing management team will provide oversight to ensure ongoing compliance.	

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MILLCROFT LIVING	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 761	Continued From page 32 One of two boxes of Magellan hypodermic safety needles with an expiration date of 08/31/24 (47 needles in the box). One of one box of three cc syringes 23-gauge x 1-inch needles with an expiration date of 08/31/22. Seven of seven Care fusion extension sets with clear connectors with the expiration dates ranging from 07/2021 to 01/2023. One of one container of Osmolyte 1.5 calorie nutritional supplement with expiration date of 06/1/24. Two of two Meflix dressings with expiration dates of 05/2021 and 03/2020. One of One Mesalt Cleansing dressing with 20% Chloride with an expiration date of 8/28/24. Five of five Kendall Amorphous Hydrogel Wound dressings with expiration dates of 02/26/24 and 09/20/23. During an interview on 11/25/24 at 11:15 AM, the LPN Supervisor for the unit revealed he tried to inspect the medication room on a weekly basis. He stated he had missed those items found during the inspection of the medication. room Review of the facility's policy titled, "Security of Medication Cart," with a revision date of April 2007, revealed, ". . . The medication cart shall be secured during medication passes . . . Medication carts must be securely locked at all times when out of the nurse's view . . . When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room . . ." Review of the facility's policy titled, "Medication Storage and Labeling," with a revision date of February 2023, revealed, ". . . If the facility has	F 761	Success Evaluation: " An initial 100% audit of all medication carts and medication rooms to assess for compliance with medication storage requirements will be completed. Any new concerns identified by this audit will be corrected upon discovery. Subsequent Audits of a random sample of a minimum of 10% of residents medication storage and 1 medication room will be completed by the Director of Nursing or Designee to ensure compliance with medication storage requirements; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 33 discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . . ."	F 761		
F 812 SS=F	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 observations, interviews, and policy review, the facility failed to ensure food was served under sanitary conditions and failed to ensure the kitchen was kept in a clean and sanitary manner to prevent contamination from foreign substances and the potential for development of foodborne illnesses. This deficient practice has the potential to affect 89 of 91 residents who received meals and beverages prepared in and served from the facility's kitchen.	F 812	Corrective Action: " Corrective actions have been taken by the Executive Director and the Food and Beverage Director. The Kitchen floor has been thoroughly cleaned in order to ensure proper sanitary conditions. The Executive Director or designee now reviews the kitchen sanitary condition on daily rounds. All kitchen staff have been educated on sanitary requirements for the	1/23/25

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F 812	Continued From page 34 Findings include: During the initial kitchen tour on 11/24/24 at 8:54 AM, upon entrance to the kitchen through the dishwasher area, observation of the floor, the floor underneath the dishwasher, freezer, cooler, and shelf revealed trash, food debris, dust/dirt, and a greasy blackish-brown substance. The substance was found throughout the kitchen on the floors, legs/feet of equipment, and underneath freestanding coolers and freezers, as well as the range, ovens, prep tables, and shelving. The greasy substance stained the baseboards and walls. Observation of the commercial juice machine revealed the water lines were stained with a brownish-red colored substance. The outside of the tubing was also covered in dust. The drip tray was stained with a reddish colored substance. The reddish colored substance covered the spout covers. The 3-compartment sink was observed, and a black grease interceptor box was located underneath the area. The box was covered in food debris and a brownish greasy substance. During the tour Cook1 was asked who was responsible for cleaning the floor. He confirmed that it was cleaned twice daily. Review of the kitchen's "Utility Cleaning Schedule" provided by the Certified Dietary Manager (CDM) on 11/24/24, outlined each area of the kitchen and how often it was to be cleaned. The schedule was broken down into daily, weekly, and monthly requirements. Per the schedule, staff were to "sweep/mop kitchen	F 812	kitchen, including the floor. The cleaning schedule has been reviewed and updated. Identification of Other Residents: " All Residents have the potential to be affected. In order to prevent other residents from being affected, the food and beverage director or designee will ensure that the kitchen floor is maintained so that it is clean and in sanitary condition at all times. System Changes: " The Root Cause of the concern was a failure to ensure that food was served under sanitary conditions and failure to ensure that the kitchen was kept in a clean and sanitary manner. The facility policy for Preventing Foodborne Illness □ Employee Hygiene and Sanitary Practices (rev. 10.2017) was reviewed and found to meet professional standards. The facility system for kitchen sanitation rounds has been updated to include daily rounds by the Executive Director or designee for observation and weekly rounds with the dietician and food service director to ensure that the kitchen has no sanitation concerns, including the floor. The Food and Beverage Director or Designee will complete education for all dietary staff regarding appropriate standards for kitchen sanitation, including ensuring that the kitchen floor is in proper sanitary standards and all other areas of the kitchen storage and equipment are maintained in good repair. A commercial cleaning company has been contracted for a thorough cleaning of the kitchen. The	

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F 812	Continued From page 35 floors, under equipment and dry storage" twice daily and as needed. During an interview on 11/24/24 at 11:17 AM, the CDM was advised of the concerns related to the juice machine, the interceptor box, and the floor. She stated that the floors were cleaned daily along with the area around the interceptor box. The CDM added that the juice machine vendor was responsible for cleaning the internal parts of the machine including the tubing, but that the facility staff were to clean the drip pan daily and run the grate through the dishwasher. During a subsequent kitchen observation on 11/25/24 at 10:51 AM, the floor appeared to have been cleaned, but there was still debris and the brownish stains still visible underneath the kitchen equipment. The CDM was asked about the floor, and she stated that the staff was cleaning the floor as scheduled but stated that the floor was hard to keep clean. During an interview on 11/26/24 at 10:32 AM, the Administrator was advised of the concerns with the kitchen floor. He stated that he felt the concern was related to the meal delivery carts tracking dirt, dust, and debris in the kitchen, but added that he felt the kitchen could use a deep cleaning.	F 812	Executive Director or Designee will provide oversight to ensure ongoing compliance. Success Evaluation: " A food service sanitation audit to ensure compliance regarding with kitchen sanitation standards, including the ensuring that the kitchen floor is clean with no sanitation concerns will be completed by the Food and Beverage Director or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team at the monthly Quality Assurance meeting.	