

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from April 24, 2019 through May 3, 2019. The facility census the first day of the survey was 108. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 23, 2019 through May 3, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 108. The survey sample totaled 48 (forty eight) residents. Abbreviations used in this report are as follows: ADLs - activities of daily living, tasks needed for daily living, such as- dressing, hygiene, eating, toileting, bathing; ADON- Assistant Director of Nursing; Antipsychotic - medication to treat psychosis; ALS (Amyotrophic Lateral Sclerosis) - disease of the nerve cells in the brain and spinal cord that control voluntary muscle movement; Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness; Aphasia - neurological condition affecting speaking / understanding language;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/04/2019
--	-------	-----------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>Continued From page 1</p> <p>Axillary - placing thermometer in the arm pit area to obtain a temperature;</p> <p>BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15;</p> <p>Blood Pressure (BP) - the measure of the force of blood against the walls of a blood vessel;</p> <p>BM - bowel movement;</p> <p>BUN (Blood Urea Nitrogen) - blood test to determine kidney function, high levels show kidney damage (normal 3-18);</p> <p>cm (centimeter) - a metric measurement of length; 1 centimeter = 0.39 inches;</p> <p>Cognitively impaired - mental decline including losing the ability to understand, talk or write;</p> <p>CNA - Certified Nurse's Aide;</p> <p>Cognition - mental processes or thinking;</p> <p>Continence - control of bladder and bowel function;</p> <p>Contracture - joint with fixed resistance to passive stretch of a muscle and cannot straighten;</p> <p>Creatinine (creat) -blood test to determine kidney function, high levels show kidney damage (normal 0.51-0.95);</p> <p>CVA (Cerebrovascular Accident) - stroke; poor blood flow to the brain causing cell death and loss of function such as speech, muscle strength, memory and thinking;</p> <p>Dehydration - condition when the body has less than normal fluid;</p> <p>Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation;</p> <p>Diabetes Mellitus (DM) - disease where blood sugar levels are too high;</p> <p>DON- Director of Nursing;</p> <p>DSS - Director of Social Services;</p> <p>Dysphagia - difficulty swallowing;</p> <p>e.g. - for example;</p>	F 000		
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>Continued From page 2</p> <p>eMAR - electronic medication administration record;</p> <p>EMR - electronic medical record;</p> <p>Enteral feeding tube -tube going directly into the stomach for feeding;</p> <p>Etc. (etcetera) - and so on;</p> <p>E-Tank - large portable oxygen tank;</p> <p>= - equals;</p> <p>Flank - area between ribs and hip on the side of the person;</p> <p>Ger Chair - reclining chair;</p> <p>Glucerna 1.5 - tube feeding formula for people with diabetes;</p> <p>Hematocrit - ratio of red blood cells to the total volume of blood, levels rise with dehydration (normal 36-46);</p> <p>Hemiplegia - half of body paralyzed or very weak (right or left);</p> <p>I&O (Intake and Output) - measuring amount of fluids drank and amount of body fluids made like urine, vomit, diarrhea;</p> <p>Incontinence - loss of control of bladder and/or bowel function;</p> <p>Intact - skin is unbroken;</p> <p>Kardex - CNA plan of care for individual residents;</p> <p>Kg (Kilogram) - metric unit of weight, 2.2 pounds = 1 kg;</p> <p>LPN- Licensed Practical Nurse;</p> <p>MAR - medication administration record;</p> <p>MD - doctor;</p> <p>Meds - medications;</p> <p>Minimum Data Set (MDS) - assessment tool used to assess nursing home residents;</p> <p>Milligram (mg) - metric unit of weight, mass;</p> <p>Milliliters (mL) - metric unit of liquid;</p> <p>NHA - Nursing Home Administrator;</p> <p>NP - Nurse Practitioner;</p> <p>O2 - oxygen;</p>	F 000		
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>Continued From page 3</p> <p>Olivopondrocerebellar degeneration (OPCD) - a progressive condition characterized by the degeneration of nerve cells in specific areas of the brain;</p> <p>Organisms - various types of bacteria/germs;</p> <p>Potassium - blood test that rises with kidney damage (normal 3.5-5.0);</p> <p>PRN - as needed;</p> <p>Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain;</p> <p>% - percentage;</p> <p>Physician Order Sheet (POS) - monthly report of active physician orders;</p> <p>Pulse Oximetry (pulse ox) - measures blood oxygen levels (desired range 94% to 100%);</p> <p>po - by mouth;</p> <p>post - after;</p> <p>pre - before;</p> <p>PRN - as needed;</p> <p>PT - Physical Therapist / Therapy;</p> <p>PU (Pressure Ulcer) -sore area of skin that develops when the blood supply to it is cut off due to pressure;</p> <p>Psychotropic (drugs) - medications capable of affecting the mind, emotions and behavior;</p> <p>Pneumonia - lung infection;</p> <p>RD - Registered Dietitian;</p> <p>RMS (Risk Management System) - computerized program for entering / tracking incidents including falls;</p> <p>RN - Registered Nurse;</p> <p>RNAC - Registered Nurse Assessment Coordinator;</p> <p>ROM- Range of Motion - extent to which a joint can be moved safely;</p> <p>RP - Responsible Party/Reporting Person;</p> <p>Saliva / Secretions - liquid produced in the mouth;</p> <p>SOB - shortness of breath;</p>	F 000		
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	Continued From page 4 Sodium - high levels indicate less than normal fluid in body (normal 135-145); Stroke - reduced blood supply or bleeding in the brain; TAR (Treatment Administration Record) - where nurses write when an ordered treatment is completed; Tylenol (Acetaminophen) - a mild pain reliever; UM - Unit Manager; Urine specific gravity - test to determine concentration of urine, over 1.015 means body has low fluid volume; WBC (white blood cells) - high level indicates infection (normal 4-12); X - times; X-ray - picture taken of bones or organ.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		6/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 561	<p>Continued From page 5</p> <p>with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview it was determined that the facility failed to honor preferences for two (R16 and R60) out of 23 active residents sampled for investigations. Findings include:</p> <p>1. Review of R16's clinical record revealed:</p> <p>10/27/16 - The care plan for requires assistance / is dependent for ADL care included the goal that R16's ADL care needs would be anticipated and met. Review of the interventions did not include anything about getting out of bed to the chair.</p> <p>10/26/18 - The Quarterly MDS Assessment documented that R16 was totally dependent with two staff for transfer in and out of bed.</p> <p>3/27/19 - A care plan meeting note documented "up in the Gerry (Geri) Chair every day for 2 hrs (hours). 1400 to 1600 hrs (2:00 PM to 4:00 PM)." The evaluation included that R16 was "gotten up daily with complete assist of 2 CNA's" with (name of mechanical lift).</p> <p>April 2019 - Review of R16's current orders lacked an activity order for being out of bed.</p>	F 561	<p>A. R60 has noted on his meal ticket that he does not like cranberry juice. R16's tasks and care plan were reviewed and his family member's request to have him out of bed daily is clearly indicated to staff. A physician's order is not required for a mobility preference. R16's tasks and care plan were updated to reflect current preferences.</p> <p>B. All residents with preferences for food and mobility have the potential to be affected. A whole house audit for food dislikes was completed and updated for current preferences 5/31/19. In accordance with the information gathered in the audits, tray tracker, tasks, Kardex and care plans were updated. To ensure range of motion, ambulation or out of bed schedules are clearly communicated, a whole house audit of current tasks and care plans for ADLs, restorative, and prevention or treatment of deformities was completed and updates/changes made as indicated.</p> <p>C. A RCA was completed for communication of resident preferences and follow through to ensure preferences are followed. The RCA identified several</p>	
-------	--	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 561	<p>Continued From page 6</p> <p>April 2019 - Review of R16's current CNA tasks / documentation and Kardex showed the entry of "OOB (out of bed) to reclining chair, seating and positioning..." Under the time column was " every shift (every shift)" without a specific time frame.</p> <p>4/26/19 - An Annual MDS Assessment documented that R16 was totally dependent on two staff for transfer out of bed into the chair.</p> <p>4/29/19 (10:30 AM) - R16's mother was observed visiting at the bedside.</p> <p>4/29/19 (2:35 PM and 3:45 PM) - Observed R16 in bed and not in the chair. R16's mother was no longer visiting at the bedside.</p> <p>April 2019 - Review of CNA documentation revealed that R16 was not gotten out of bed daily and was not out of the facility. R16 was up in the chair 40% (12 out of 30 days) in April.</p> <p>5/1/19 (2:20 PM and 3:10 PM) - Observed R16 in bed and not in the chair.</p> <p>5/2/19 (8:55 AM) - During an interview with E2 (DON) to discuss the frequency and timing for R16 to be out of bed, E2 said, "We get (R16) up around two (2:00 PM) for day shift, then (R16) is up into evening shift." R16's mother wants R16 out of bed daily. The surveyor mentioned that the Kardex, CNA tasks, and care plan did not delineate a time and that R16 was observed being in bed for two afternoons recently. E2 commented that when R16 was out of the facility for appointments, he/she may not be gotten out of bed in the afternoon.</p> <p>5/2/19 - Review of April 2019 nursing progress</p>	F 561	<p>areas that potentially affect the ability of the Center to adhere to resident preferences. Four people have access to tray tracker for documentation of food preferences, the assessment completion requirements are not consistent across departments (Recreation, Nutrition, Social Services, Nursing) and all departments do not update or initiate care plans. The results of the RCA clearly indicate a need for improved communication between departments. Social Services, Recreation, Nursing and Dietary will attend the daily clinical meeting to discuss new admissions and communicate any identified preferences to the Interdisciplinary Team. At this time, care plans, tasks and tray tracker can be updated to include those preferences. Education for honoring resident preferences was completed with staff (Attachment A). Education for the change in clinical meeting was provided to department managers (Attachment B). D. The Center Executive Director or designee will audit communication of dietary preferences to ensure residents dislikes are documented appropriately (Attachment C). The Center Nurse Executive or designee will audit compliance with mobility preferences (Attachment D). Audits will occur daily until 100% compliance is achieved 3 consecutive days, then 3 times a week for 3 weeks, weekly for 3 weeks and monthly for 3 months. Results of the audits will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 561	<p>Continued From page 7</p> <p>notes revealed that R16 was not out of the facility on days that R16 remained in bed.</p> <p>2. Review of R60's clinical record revealed:</p> <p>3/15/19 - A care plan for "routines that are meaningful" included an the intervention "I like to snack between meals and prefer water and apple juice."</p> <p>3/17/19 - The Nutritional Assessment identified that R60 required nectar thick liquids in order to drink safely and "likes to drink water and apple juice. "</p> <p>4/24/19 - Review of the current Kardex listed "Encourage resident to consume all fluids of choice _____ during meals." The space was blank and did not list R60's preference. The statement "I like to snack between meals and prefer water and apple juice" was also written on the Kardex.</p> <p>4/24/19 (12:30 PM) - During lunch observation R60 was served a cup of apple juice and a cup of cranberry juice. F1 (R60's spouse) was at the bedside and informed the CNA serving the juice that R60 would not drink cranberry juice and asked for thickened water instead. F1 expressed to the surveyor that he/she wanted either "two apple juices, two waters, or one of each" and stated that he/she had informed the facility previously of R60's juice preference.</p> <p>4/26/19 (9:00 AM) - During breakfast observation a cup of cranberry juice and a cup of liquid supplement was sitting on R60's bedside table prior to being fed the meal.</p>	F 561		
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 561	Continued From page 8 4/29/19 (12:55 PM) - During an interview with F1 (R60's spouse) it was stated that "they tried to serve cranberry juice again at lunch... I asked for water." 4/30/19 (8:50 AM) - The interview with E3 (RN, UM) to inform of the observations of R60 being served cranberry juice, E3 stated he/she would "add it to allergies" so it appears at the top of the eMAR for the nurses and add it "to tasks for CNAs to see." At 9:12 AM, E3 informed and showed the surveyor the inclusion of cranberry juice under allergies, on the CNA tasks, and within R60's dehydration care plan.	F 561		
F 606 SS=D	Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 606		6/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 606	<p>Continued From page 9</p> <p>§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and review of other facility documentation it was determined that the facility failed to ensure that abuse registries were checked and histories were investigated prior to employment for one (E12) out of 16 sampled employees. Findings include:</p> <p>Review of the facility policy entitled Abuse Prohibition (last revised 7/1/18) included that the center "will not employ or otherwise engage individuals who have been found guilty by a court of law of abuse, neglect, exploitation, misappropriation of property, or mistreatment or have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of others or misappropriation of property or have had disciplinary action in effect against his/her professional license by a state licensure body....."</p> <p>Review of the State Agency's personnel audit sheet completed by E29 (Human Resources) revealed:</p> <p>E12's (RD) first day in the facility was 10/16/18 and the adult abuse registry and fingerprint clearance did not occur within the State Agency electronic background check system until 4/23/19. The child abuse registry check occurred on 4/3/19, approximately 6 months after employment began.</p>	F 606	<p>A. E12 was placed on leave and returned once all information was verified in the State agency background check center (BCC) on 4/19/19.</p> <p>B. Other employees background checks were reviewed and had appropriate dates for pre-hire background documentation requirements.</p> <p>C. A root cause analysis was completed on 5/29/19. A new process was developed for the Employee Benefits Payroll Coordinator, Center Executive Director, or designee to visualize all contracted staff files prior to start date to verify State Agency BCC was completed correctly. Education on HR205 Background Investigations (Attachment B) was provided to current leadership staff.</p> <p>D. The Center Executive Director or Designee will complete audits (Attachment E) for 100% of contracted staff background checks for 6 month to ensure compliance with all requirements are done prior to hire in the state agency BCC. The results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	---	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 606	Continued From page 10 This finding was reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference starting at 11:15 AM.	F 606		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined, that for two (R9 and R16) out of two	F 609	A. Potential neglect was reported and investigated for R16. R16 had no adverse	6/10/19

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 609	<p>Continued From page 11</p> <p>residents sampled for abuse or neglect, the facility failed to identify and immediately report allegations of neglect or abuse. Findings include:</p> <p>Facility policy entitled Abuse Prohibition policy (revised 7/1/18) defined abuse "as the willful infliction of injury...with resulting physical harm, injury..." Neglect was defined as "the failure of the center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish or emotional distress..."</p> <ul style="list-style-type: none"> - "Prevention actions include identifying, correcting and intervening in situations in which abuse, neglect and/or misappropriation of patient property is more likely to occur... - Staff will identify events - such as suspicious bruising of patients... - Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property, is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. - The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation." <p>1. Review of R16's clinical record revealed:</p> <p>10/28/16 - A care plan problem for potential for skin breakdown included the intervention to turn and/or reposition and check skin every 2 hours or as specified by the plan of care.</p> <p>4/26/19 - The Annual MDS Assessment identified R16 as being totally dependent on two staff for repositioning in bed.</p>	F 609	<p>affects to skin integrity and employees involved received disciplinary action per policy. Information provided to the state investigator in November 2018 for R9 was given to the survey team during survey.</p> <p>B. All residents in the facility have the potential to be affected by lack of abuse identification and reporting. EMAR progress notes were reviewed for abuse identification for the preceding month and completed on 5/31/19. Any abuse allegations reported from acute care facilities will be reported by the facility to DLTRP.</p> <p>C. Federal regulation and abuse policy reviewed by Center Executive Director and leadership team. A RCA was completed and identified two causes for the system breakdown. Education needed to clarify that any allegation, even if reported by another healthcare agency, was reportable by the Center. Also, the documentation indicating potential neglect was located in an EMAR progress note. Those notes do not populate on the progress note report generated for daily review by the nursing management team. Education provided to general staff regarding reporting all abuse allegations regardless of the generating entity (Attachment A). Education also provided to the nurse management team re: reviewing EMAR progress notes in addition to the 24-hour report generated by the PointClickCare EHR system (Attachment F).</p> <p>D. The Center Executive Director or designee will ensure that all abuse allegations are reported to the DLTRCP.</p>		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 609	<p>Continued From page 12</p> <p>5/2/19 (8:40 AM) - While reviewing R16's combined progress notes and eMAR notes the following comments were written by E16 (LPN) under the eMAR entry "Turn and Reposition every 2 hours...and document which side patient is on...":</p> <ul style="list-style-type: none"> - 4/12/19 (8:43 PM): "resident was not turned." - 4/16/19 (8:24 PM): "was not turn (sic)." - 4/17/19 (8:33 PM): "Resident was not turn (sic)". - 4/20/19 (8:30 PM): "was not turned." - 4/26/19 (6:15 PM): "not turned." - 4/30/19 (6:00 PM): "was not turned." - 4/30/19 (10:20 PM): "Aid (sic) stated that she can not turn (R16) by (him/herself) so (he/she) did not turn (R16)." - 5/1/19 (6:44 PM): "was not turned." - 5/1/19 (10:38 PM): "CNA stated that (he/she) will not turn resident." <p>5/2/19 (8:50 AM) - During an interview E2 (DON) revealed the allegation of neglect found among eMAR notes was not reported to administration.</p> <p>5/2/18 (1:35 PM) - During a follow-up interview with E2 (DON), E2 stated the facility was investigating the allegation of neglect and had already reported it to the State Agency.</p> <p>5/2 (3:08 PM) - During an interview E2 (DON), provided the surveyor with copies of employee statements and investigation documents and E2 stated that E16 (LPN) received "a final written disciplinary warning" and that "I will terminate the aide tomorrow." It was revealed that the aide was hired through an agency providing temporary staff. Review of investigation documents found that E16 (LPN) admitted to not informing anyone that R16 was not turned. E21 (CNA) indicated</p>	F 609	<p>As a corrective action, EMAR progress notes will be reviewed for potential neglect or abuse in addition to the 24 hour report. These notes will be audited to ensure compliance with federal regulations and policy. Audits will occur daily until 100% compliance is achieved 3 consecutive days, then 3 times a week for 3 weeks, weekly for 3 weeks and monthly for 3 months (Attachment G). Results of the audits will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	<p>Continued From page 13</p> <p>that "all the other aides were busy" and that E16 "told me 'her back' when I asked if he/she was going to help me."</p> <p>2. Review of R9's clinical records revealed:</p> <p>11/4/18 - A Skin Check Assessment was completed for R9. No injury/wound found.</p> <p>11/10/18 7:19 AM - A progress note revealed that at 7:00 AM the resident agreed to be sent to emergency room. R9 was sent to the hospital by ambulance at 7:20 AM.</p> <p>11/10/18 7:35 AM - Hospital Discharge Documentation (provided to facility from the hospital) listed, under "History of Present Illness," that R9 presented with "bruising to both sides of the neck" which raised concerns. "These could be finger marks." Hospital Discharge Documentation also lists "Neck: Supple, there appear to be bilateral bruising at the base of the patients neck as if (R9) was grabbed by the neck."</p> <p>11/13/18 1:32 PM - A Progress note documented that R9 was readmitted to facility. The reason for admission to the hospital was an UTI.</p> <p>11/13/18 - A Skin Check Assessment was completed for R9. A skin injury/wound was identified. The skin injury/wound was documented as not being a new concern and detailed as being "discoloration on chest area." No previous Skin Check Assessments described this skin injury/wound.</p> <p>4/25/19 - All Allegations of Abuse investigations were requested for the previous 6 months. There</p>	F 609		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 609	<p>Continued From page 14 were no investigations for R9.</p> <p>5/1/19 12:49 PM - An interview with E2 (DON) revealed that a call was received from the hospital regarding the allegations and the caller informed the facility that the findings were being reported to the State Survey Agency. R2 stated that an investigation was completed by the facility.</p> <p>5/1/19 1:10 PM - The facility's folder on this incident included R9's face sheet, skin check assessments, progress notes surrounding the incident and several witness statements from witnesses present when R9 was discharged to the hospital.</p> <p>5/2/19 2:11 PM - During an interview, E2 (DON) explained that the Emergency Room nurse called as a courtesy and told the facility's charge nurse that a concern was being reported regarding R9 because it "looked like someone strangled her." Later, R9's family member mentioned the concern of the ambulance and hospital staff, as well. E2 revealed that the statements were gathered to determine if there was an incident, such as a fall, that E2 was unaware of, that could have caused the markings. E2 stated that this situation was never considered an allegation of abuse as R9 frequently had such markings on R9's body due to behaviors, therefore, the facility was sure that abuse did not occur. E2 stated that since this "occurred outside the facility" and "was already being reported to the State" E2 was unaware that the facility was still required to report to the state agency as well.</p> <p>The facility failed to identify and immediately report R9's possible allegation of abuse after</p>	F 609		
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 609	Continued From page 15 being notified by the hospital of suspicious bruising and the concerns noted twice in the hospital's discharge documentation regarding possible strangulation.	F 609		
F 625 SS=D	<p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.</p> <p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§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-</p> <ul style="list-style-type: none"> (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. <p>§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</p>	F 625		6/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 625	<p>Continued From page 16 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that, for three (R70, R96 and R9) out of four residents reviewed for hospitalization, the facility failed to provide written bed hold information to the resident/responsible party when the residents were transferred to the hospital. Findings include:</p> <p>1. Review of R70's clinical record revealed:</p> <p>R70 was hospitalized 12/4/18, 1/23/19 and 4/24/19.</p> <p>12/4/18 - There was no evidence that the responsible party (RP) was notified of the bed hold as the RP copy of the notice remained in the chart.</p> <p>4/24/19 - There was no evidence of bed hold notification to the resident and RP since the resident and RP copies remained in the chart.</p> <p>4/30/19 (9:30 AM) - An interview with E30 (Unit Clerk) confirmed the resident and/or RP copies of the bed hold notice were in the chart.</p> <p>5/1/19 (8:10 AM) - During an interview with E15 (Billing) about the process for bed hold notification to the family, E15 stated "my assistant does it." After the surveyor explained about the copies in the chart, E15 added, "If we did not get the copies, then they were not mailed."</p> <p>2. Review of R96's clinical record revealed:</p> <p>R96 was hospitalized on 6/29/18. There was no</p>	F 625	<p>A. R96 is no longer in the facility. R70 and R9 did not exhaust their 7-day bed hold during admission and no private funds were necessary to return to their bed. All residents transferred out at this time have received information regarding bedholds and the RP has also been made aware.</p> <p>B. All residents who transfer from the center have the potential to be affected. All residents who transfer to an acute care facility will receive a copy of the bed hold policy.</p> <p>C. Review of the Accounts Receivable Bed Hold Policy (AR102) and an RCA was completed. The form is not user-friendly and confusing. A new transfer/bed hold policy form was adopted for use 6/3/19. Education for the new form was completed for nursing and managers (Attachment B & H). An audit of current transfers was completed and an audit tool developed to ensure that bed hold information was communicated to the resident and responsible party.</p> <p>D. The Center Nurse Executive or designee will audit all transfers for compliance with the bed hold policy (Attachment I). Audits will occur daily until 100% compliance is achieved 3 consecutive days, then 3 times a week for 3 weeks, weekly for 3 weeks and monthly for 3 months. Results of the audits will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	---	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 625	<p>Continued From page 17</p> <p>evidence in the chart that the responsible party (RP) was provided a bed hold notice.</p> <p>5/2/19 (3:20 PM) - During an interview with E1 (NHA) it was confirmed that the "bed hold (notice) was not able to be located."</p> <p>3. Review of R9's clinical record revealed:</p> <p>11/10/18 7:19 AM - A progress note revealed that R9 was sent via ambulance to the hospital.</p> <p>5/1/19 3:30 PM - E2 (DON) revealed that the notice of bed hold policy would have been handled by an employee whom is no longer with the facility.</p> <p>5/2/19 at 12:10 PM - E1 (NHA) was asked for the bed hold notice for R9's November 2018 hospitalization.</p> <p>There was no evidence that R9 received a bed hold notice when hospitalized on 11/10/18.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.</p>	F 625		
F 641 SS=E	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the MDS assessment's accurately reflected the</p>	F 641	<p>A. The MDS was corrected for R41, R60, R13, R85, R196 and R6. B. All patients at the facility are at risk for</p>	6/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 641	<p>Continued From page 18</p> <p>resident's status for six (R6, R13, R41, R60, R85 and R196) out of 23 sampled residents. Findings include:</p> <p>Cross refer F791</p> <p>1. Review of R41's clinical records revealed:</p> <p>11/18/16 - R41 was admitted to the facility.</p> <p>2/24/19 - A Nutrition Assessment documented that R41 had both upper and lower dentures. R41 reported that the lower denture fit poorly and R41 was selective of meats he/she consumed.</p> <p>2/27/19 - The Quarterly MDS assessment incorrectly documented that R41 did not have any issues with broken or loose fitting dentures.</p> <p>5/2/19 at approximately 12:45 PM - During a meal observation, R41 verbalized to the surveyor that R41 had problems chewing due to a poor fitting lower denture.</p> <p>5/2/19 at approximately 2:15 PM - An interview with E6 (RNAC) confirmed that the facility failed to accurately document the poor fitting denture in the 2/27/19 MDS assessment.</p> <p>2. Review of R60's clinical record revealed:</p> <p>3/12/19 - R60 was admitted to the facility from another nursing facility to be closer to family.</p> <p>3/15/19 - Physicians' orders discontinued the antipsychotic medication scheduled to be given at bedtime.</p> <p>3/19/19 - The Admission MDS Assessment documented that R60 received the antipsychotic</p>	F 641	<p>an inaccurate assessment related to incomplete chart reviews, medication administration count errors and missed diagnoses. All residents had a new Oral Health Evaluation completed and all abnormalities addressed as indicated. A full-house audit of patient weights was conducted, comparing PCC weight to the weight on the most current MDS. Reweights were obtained as indicated for confirmation. MDS s were modified as needed to reflect the correct patient weights.</p> <p>C. A RCA was completed to determine a course of correction. The data from the Oral Health Evaluation, in conjunction with the nursing assessment and nutrition assessment, will be used to accurately complete the dental section of the MDS. The number of times medication is administered within the MDS look-back period will be double-checked by the CRC or designee prior to MDS submission for accuracy and corrected as necessary prior to MDS transmission. New orders and consults will be reviewed by CRC or designee each business day for new diagnoses and added or removed appropriately from the diagnosis list of the patient. Diagnosis codes will also be reviewed quarterly on all patients for accuracy. Resolved diagnoses will be removed at quarterly review. During review if a discrepancy exists between the weight in PCC and the weight that auto-populates the MDS, the CRC or designee will investigate the discrepancy prior to MDS submission. CRC or designee will compare POC</p>	
-------	--	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 641	<p>Continued From page 19 every day during the seven-day look back period.</p> <p>March, 2018 - Review of the eMAR revealed that R60 received the antipsychotic medication only three days before it was discontinued.</p> <p>5/1/19 (11:13 AM) - An interview with E5 (RNAC) confirmed that he/she corrected the error.</p> <p>3. Review of R6's clinical record revealed:</p> <p>10/27/16 - R6 was admitted to the facility with multiple diagnoses including hemiplegia (weakness on one side of the body) after a stroke.</p> <p>9/1/16 - The physicians' orders included iron to be given by mouth for iron deficient anemia.</p> <p>12/5/18 - R6's weight was documented as 202.6 pounds.</p> <p>1/18/19 - The Annual MDS Assessment included paraplegia (weakness from the waist down) among the diagnoses, but did not include anemia. R6's weight was recorded as 130 pounds. R6 did not have paraplegia and weighed over 70 pounds more than what was coded.</p> <p>5/1/19 (11:13 AM) - An interview with E5 (RNAC) confirmed the errors. E5 stated the diagnosis of paraplegia was removed, anemia was added and the weight was changed in the modification of the assessment.</p> <p>4. Review of R13's clinical record revealed:</p> <p>10/26/18 - The Quarterly MDS Assessment included that R13 was continent of urine.</p>	F 641	<p>documentation with auto-populated responses within the MDS to determine accuracy of the individual's documentation. CRC or designee will compare vaccination documents located in the paper chart with the documentation found in the electronic chart for accuracy. Unit managers or designees will be notified of discrepancies and any need for correction so that the two charts match. Education for MDS accuracy was provided to Nurse Managers and the Center Reimbursement Coordinators (Attachment J).</p> <p>D. The Center Reimbursement Coordinator (CRC) or designee will perform audits to ensure MDS accuracy prior to transmission. The CRC or designee will audit for accuracy on weight, medication administration, dental, vaccinations, and diagnosis (Attachment K). The CRC will also audit new or returning admissions for new or resolved diagnosis (Attachment L). Audits will be completed weekly x 8 then monthly x 4 until 100% compliance is achieved. Results of audits will be reported to the Quality Assurance Performance Improvement for review and recommendations.</p>	
-------	--	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 641	<p>Continued From page 20</p> <p>October 2018 - Review of CNA documentation showed that R13 experienced an incontinent episode on the night shift on October 26.</p> <p>5/1/19 (11:13 AM) - An interview with E5 (RNAC) confirmed the incontinent episode. E5 stated that "it did not auto-populate" into the MDS, and made the correction.</p> <p>5. Review of R196's clinical record revealed:</p> <p>4/13/19 - The admission nursing assessment did not include any information about R196's pneumonia or influenza vaccination status.</p> <p>4/20/19 - The Admission MDS Assessment documented that the "historical administration of pneumonia and influenza vaccines" was coded as "not assessed."</p> <p>4/29/19 (approximately 4:10 PM) - During an interview with E1 (DON) it was discovered that the consent forms were completed in the chart showing that R196 received the influenza vaccine in October 2018 and historically (undated) received the pneumonia vaccination.</p> <p>5/1/19 (11:13 AM) - During an interview with E5 (RNAC), E5 confirmed the error and stated he/she "made the modification."</p> <p>6. Review of R85's clinical records revealed:</p> <p>3/29/19 - R85 was admitted to the facility.</p> <p>3/29/19 - A Care Plan was initiated for "Resident/patient exhibits or is at risk for distressed / fluctuating mood symptoms related</p>	F 641		
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 641	<p>Continued From page 21 to: Anxiety."</p> <p>The following medication orders were written for R85: 3/29/19 - 4/5/19 - Amitriptyline at bedtime for depression. 3/29/19 - 4/2/19 - Alprazolam three times a day for anxiety. 4/2/19 - 4/5/19 - Alprazolam every 8 hours as needed for anxiety. 4/4/19 - Clonazepam two times a day for anxiety.</p> <p>4/5/19 - The Admission MDS Assessment did not include anxiety or depression as active diagnoses.</p> <p>4/12/19 - A Change of Therapy MDS Assessment also did not include the diagnoses of anxiety or depression.</p> <p>5/1/19 11:13 AM - During an interview E5 (RN) confirmed that R85 had both diagnoses and stated that corrections were made to both MDS Assessments.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.</p>	F 641		
F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§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</p>	F 656		6/10/19

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 656	<p>Continued From page 22</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to develop and develop a comprehensive person-centered care plan for three (R41, R63 and R70) out of 23</p>	F 656	<p>A. R70, R63 and R41 have updated care plans to include infection, pain and dental.</p> <p>B. All residents have the potential to be affected by lack of personalized care</p>	
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 656	<p>Continued From page 23 sampled residents. Findings include:</p> <p>Cross refer F641, example #1 Cross refer F791</p> <p>1. Review of R41's clinical records revealed:</p> <p>11/18/16 - R41 was admitted to the facility.</p> <p>2/24/19 - A Nutrition Assessment documented that R41 had both upper and lower dentures. R41 reported that the lower denture fit poorly and R41 was selective of meats she/he consumed.</p> <p>2/27/19 - The Quarterly MDS assessment incorrectly documented that R41 did not have any issues with a broken or loose fitting denture.</p> <p>5/2/19 At approximately 2:15 PM - an interview with E6 (RNAC) confirmed that the facility failed to develop and implement a care plan for poor fitting lower denture and subsequently that R41 required her/his meat to be ground.</p> <p>The facility policy entitled "Pain Management", last updated on 8/21/18, indicated the following: "An individualized interdisciplinary care plan will be developed and include: addressing and treating underlying causes of pain to the extent possible; non pharm (pharmacological) and pharm approaches using specific strategies for preventing or minimizing different levels or sources of pain or pain related symptoms."</p> <p>2. Review of R63's clinical records revealed:</p> <p>3/16/19 - A quarterly MDS Assessment documented that R63 received PRN pain medication and non-pharmalogical interventions</p>	F 656	<p>plans and appropriate revisions.</p> <p>C. An RCA was completed regarding lack of comprehensive care plans. Lack of education was identified as the cause of the deficiency. This knowledge gap was for both the nurse managers and frontline staff. Staff identify problems but do not follow all steps to initiate or update the care plan. The nurse managers do not know how to generate a report to check for care plan items. General care plan education was provided to the staff (Attachment A) to ensure he/she knows how to initiate a new care plan focus and update interventions. Nurse Managers received education regarding how to run reports to determine which items are needed and a reference page for Care Plan Basics to include medication and diagnosis driven items was provided. (Attachment F).</p> <p>D. The Center Nurse Executive or designee will audit all care plans on their review schedule for accuracy and completeness (Baseline, Comprehensive and Quarterly) (Attachment M). The audits will occur 3 time a week for 3 weeks, then weekly x 3 weeks and monthly x 3 months until 100% compliance is achieved. Results of the audits will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 656	<p>Continued From page 24 for frequent pain.</p> <p>Review of R63's care plans revealed the absence of a care plan for pain management.</p> <p>During an interview on 5/2/19 at 11:18 AM, E4 (RN, UM) confirmed that R63 did not have a care plan for pain management.</p> <p>Cross Refer F695, Example 2</p> <p>3. Review of R70's clinical record revealed:</p> <p>3/22/18 - R70 was admitted to the facility with hemiplegia, dysphagia, aphasia and tube feeding from multiple strokes, as well as diabetes.</p> <p>3/23/18 - R70's care plan for enteral tube feeding included the intervention to provide mouth care every shift and PRN.</p> <p>6/26/18 - R70 had a physicians' order for a mouth rinse that destroys germs to be used twice a day and spit out.</p> <p>December 2018 - April 2019 - Nursing progress and eMAR notes revealed multiple factors placing R70 at increased risk for infection from aspiration (fluid / food entering lungs):</p> <ul style="list-style-type: none"> - Diagnosis of dysphagia (when swallowing something in the mouth, a portion enters lungs). - Dependent on staff for oral care to keep mouth clean. - Received PRN medication to reduce oral secretions (Levsin): December 20 times; January 6 times; February 20 times; March 19 times; and April 6 times. - Vomiting: 2/1/19 and 4/14/19. - Hospitalization for increased oral secretions/respiratory distress: 12/4/18, 1/23/19 	F 656		
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 656	Continued From page 25 and 4/24/19. Two of these admissions to the hospital (1/23/19 and 4/24/19) were to treat sepsis from suspected / probable aspiration pneumonia. There was no care plan for the risk of infection due to aspiration. 5/1/19 (approximately 4:10 PM) - During an interview E2 (DON) confirmed that R70 did not have a care plan for the being at risk for infection due to aspiration. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.	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	F 657		6/10/19

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 657	<p>Continued From page 26</p> <p>resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview it was determined that the facility failed to revise the care plan for one (R13) out of 23 sampled residents. Findings include:</p> <p>Review of R13's clinical record revealed:</p> <p>3/3/17 - R13's care plan for fall risk related to placing self on floor (last revised 2/13/19) had a goal that R13 would have no falls with injury. Interventions included: Encourage non skid socks; Dycem (anti-slip material) in wheelchair; Low bed; Call light in reach; Remind to use the call light; Personal items in reach; Monitor /assist with toileting; and Chair/bed alarm.</p> <p>6/15/17 - The care plan for "Behaviors safety hazard - throwing self on the floor..." included the interventions: Psychiatric evaluation; Provide calm, quiet well-lit environment; and Approach resident in calm, unhurried manner.</p> <p>February - April, 2019 - Review of facility fall investigations revealed that R13 had 17 "falls" without injury including one fall occurring outside the resident's room in the front lobby.</p> <p>4/24/19 (9:10 AM) - R13 was observed in bed and a large wooden piece of furniture resembling</p>	F 657	<p>A. R13 has had revisions to her preferences care plan to include use of a prayer bench. On 8/28/18 a care plan intervention was placed stating "Resident able to transfer herself from the bed to the floor and back again with non skid socks". This intervention was placed after evaluation by therapy for safety. A care plan progress noted on 8/29/18 indicates the same. Chair/bed alarms were discontinued as an intervention 10/24/17 as the facility became alarm-free.</p> <p>B. All residents have the potential to be affected by lack of personalized care plans and appropriate revisions. All fall care plans were reviewed and personalized interventions are in place 6/3/19.</p> <p>C. A RCA was completed regarding lack of care plans revisions. Lack of education was identified as the cause of the deficiency. This knowledge gap was for both the nurse managers and frontline staff. Staff identify problems but do not follow all steps to initiate or update the care plan. The nurse managers do not understand all items that require a care plan. General care plan education was provided to the staff (Attachment A) to</p>	
-------	---	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 657	Continued From page 27 a podium (lecture stand) with a place to kneel was sitting in the resident's room. 4/25/19 (approximately 3:55 PM) - During an interview E2 (DON) stated that R13 had "fallen so many times." E2 added that "there have been times when (R13) fell 15 times a month and other times when (R13) had not fallen for several months." 5/1/19 (approximately 1:00 PM) - An interview with E3 (RN, UM) revealed that R13 had been "approved by PT to get on and off the floor." E3 added that R13 "scoots a lot on the floor instead of walking" and explained that in the past R13 would say he/she was "praying on the floor, so we got (R13) a kneeling bench." E3 added that every time R13 "gets on the floor, we need to treat it as a fall." There was nothing in R13's care plan about praying on the floor, the kneeling bench or PT's clearance for getting on/off floor. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.	F 657	ensure he/she knows how to initiate a new care plan focus and update interventions. Nurse Managers received direction on revising interventions based on Fall RCA's and other incidents (Attachment F). D. The Center Nurse Executive or designee will also audit all resident care plans for revision of interventions determined during the weekly Customers At Risk (CAR) meeting (Attachment N). Those audits will occur weekly x 8 weeks then monthly x 4 months. Results of the audits will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		6/10/19

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 688	<p>Continued From page 28</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to follow the plan of care to promote range of motion (ROM) for one (R16) out of two sampled residents reviewed for ROM. Findings include:</p> <p>Review of R16's clinical record revealed:</p> <p>11/18/16 - E16's care plan for the prevention of deformities had the goal to prevent further contractions. Interventions included passive ROM (straightening / moving arms and legs to prevent contractures) twice a day for 15 minutes each to all extremities (arms and legs); and teach family to perform the ROM exercises. Interventions added on 1/7/19 included knee splints two hours a day on 7-3 and 3-11 (day and evening shifts), and bilateral (both sides) hand splints 2-3 hours on per (each) shift as tolerated.</p> <p>12/6/18 - R16's contracture measurements documented a severe contracture in the left knee and a moderate contracture in the right knee.</p> <p>April 2019 - Current CNA tasks: - Splint / palm guard application #2, knee splints to prevent contractures, to wear 4 hours every</p>	F 688	<p>R16 has new arm splints and a second set of knee splints has been ordered to ensure splints are available daily. R16 also has appropriate ROM tasks present with clear directions for 15 minutes of passive range of motion two times daily.</p> <p>B. All residents with limited range of motion or the potential to have a decrease in range of motion may be affected. All residents with splints and passive range of motion tasks were reviewed to ensure complete directions 5/31/19.</p> <p>C. An RCA was completed to evaluate the current process for splint application, accurate documentation of splint application and competent performance of passive ROM. A lack of education was identified in all areas of the RCA. Education regarding the importance of splints to prevent contractures, competent performance of passive range of motion exercises and factual documentation was provided (Attachment A). Certified nurses aides showed competency in performance of passive range of motion (Attachment O).</p> <p>D. The Center Nurse Executive or</p>	
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 688	<p>Continued From page 29</p> <p>day, 2 hours per shift (7-3 and 3-11). This task was listed twice with one scheduled for day shift and one scheduled for evening shift.</p> <ul style="list-style-type: none"> - Splint / palm guard application #1: place on bilateral hands and legs, place at 2 PM. This task was scheduled for 10 AM and 2 PM although it was to be completed at 2 PM. - Splint / palm guard removal #1 off at 6 PM. - Passive ROM twice a day for a total of 15 minutes each time to all extremities. <p>March - April 2019 - Review of CNA documentation revealed numerous times when there was no evidence that ROM and splint application was performed:</p> <ul style="list-style-type: none"> - March - 10 out of 31 days; - April- 17 out of 30 days. <p>April 2019 - Review of nursing progress / eMAR notes revealed 9 out of 30 days when the day-shift nurse documented that the facility failed to implement physician orders for splint application: April 1, 2, 6, 7, 11, 15, 20, 21 and 27.</p> <p>5/1/19 - The Occupational Therapy (OT) note documented that R16 was screened "due to report of L (left) hand contracture." R16 had no change in contractures, which were documented in the OT evaluation on 1/3/19. PT recommendation was made to continue splints or rolled wash cloth to both hands to promote good skin integrity.</p> <p>5/2/19 (1:35 PM) - Knee measurements revealed that both knees had moderate contractures. The left knee improved from the December 2018 assessment. It was noted that R16's muscle tone and spasticity (tightness of muscles) can lead to varying degrees of contracture measurements.</p>	F 688	<p>designee will complete audits to determine compliance with splint application orders and accurate documentation of the application (Attachment P). The Center Nurse Executive or designee will also audit the performance of passive range of motion (Attachment Q). Audits will occur daily for 3 consecutive days, then 3 times a week for 3 week, weekly for 3 weeks and monthly for three months. The results of the audit will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 688	<p>Continued From page 30</p> <p>5/3/19 (approximately 9:00 AM) - An interview with E9 (LPN) revealed the facility had "no restorative aide (CNA dedicated to performing ROM) now" and that the unit CNAs were to complete the ROM. E9 added, "We just need the staff" to do the range of motion and that the assignment that R16 was in lost the regular aide. E9 clarified that R16 had not been having a consistent aide assigned during the day.</p> <p>5/3/19 (9:10 AM) - An interview with E10 (CNA) revealed that the facility had no restorative aide for 4-6 weeks.</p> <p>5/3/19 (approximately 9:14 AM) - E17 (CNA) stated that he/she performed R16's ROM during bathing and E17 lifted his/he own arms to mimic putting on clothing. When asked how R16 tolerated ROM and splints, E17 stated, "I think he/she likes it but, (R16) tenses up." E17 explained that R16's splints get removed around 6:00 PM, but was "not sure about the day time" since E17 did not usually work during the day.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.</p>	F 688		
F 690 SS=D	<p>Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§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.</p>	F 690		6/10/19

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 690	<p>Continued From page 31</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(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;</p> <p>(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</p> <p>(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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that, for one (R43) out of one sampled resident reviewed for Catheter or UTI (urinary tract infection), the facility failed to provide care and services in a manner to minimize the risk of infection from an indwelling urinary catheter (tube held in the bladder by a small balloon to drain urine). Findings include:</p> <p>2009 Guidelines for Prevention of</p>	F 690	<p>A. R43 no longer has a foley catheter.</p> <p>B. All residents who require Foley catheter management and incontinence care are at risk. All residents with foley catheters were reviewed for corrects tasks and orders 5/31/19.</p> <p>C. A RCA was completed and lack of education was identified as the primary cause of the deficiency related to the Foley catheter. Education for Foley</p>	
-------	---	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 690	<p>Continued From page 32</p> <p>Catheter-Associated Urinary Tract Infections (CAUTIs) from the Healthcare Infection Control Practices Advisory Committee provided recommendations to minimize the risk of developing a UTI. One category 1B recommendation (strong recommendation supported by low quality evidence) for catheter maintenance included "Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor...The source of microorganisms (bacteria / germs) causing CAUTI...can enter the urinary tract" on the outside of the catheter (contamination during catheter or incontinence care) or by movement along the inside of the catheter "from a contaminated collection bag." https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines.pdf</p> <p>Review of R43's clinical record revealed:</p> <p>8/29/18 - The Admission MDS Assessment documented that R43 had a Stage 4 pressure ulcer and severe cognitive impairment.</p> <p>4/7/19 - A care plan problem for requiring a foley (brand of urinary catheter) due to a pressure ulcer included the following interventions: provide catheter care twice a day and PRN; keep catheter off the floor; and assess continued need of catheter.</p> <p>4/25/19 (2:02 PM) - During an observation of incontinence care to remove bowel movement (BM) from R43, E31 (CNA) first used a wet paper towel, then changed to a wet bath towel. While R43 was on his/her right side, E31 wiped R43 from front to back while standing behind the resident. E31 rearranged the bath towel so the</p>	F 690	<p>catheter management to include movement of the urine collection bag was provided to staff (Attachment A). The RCA identified several factors for the contaminated incontinence care - availability of supplies, preparing for incontinence care, knowledge to avoid wounds and potentially contaminating a clean area. Education was provided to keep clean areas clean (wipe front to back, avoid wounds/dressings, use clean areas of the towel) (Attachment A).</p> <p>D. The Center Nurse or designee will audit management of Foley catheters and incontinence care (Attachment R). Audits will occur daily for 3 consecutive days, then 3 times a week for 3 week, weekly for 3 weeks and monthly for three months. The results of the audit will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 690	Continued From page 33 contaminated section with BM was inside the towel before E31 wiped the resident a second time with the bath towel. E31 did not rearrange the towel and used the contaminated section of the bath towel to wipe R43 a third time. The contaminated towel can transfer bowel organisms onto the area around the urinary catheter. 4/25/19 (approximately 2:20 PM) - An observation was made of E7 (LPN) assisting E31 (CNA) with repositioning R43 onto his/her left side. The urinary catheter drainage bag had not been emptied for the shift. The urine bag was raised above the resident and passed to the far side of the bed. Raising the bag higher than the resident's bladder could lead to urine flowing from the tubing and back into R43's bladder, increasing the risk for developing a CAUTI. 4/26/19 (12:30 PM) - During an interview with E2 (DON) to review the aforementioned observations, no additional information was offered. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.	F 690			
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		6/10/19	

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 692	<p>Continued From page 34</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to maintain fluid and electrolyte balance in one (R70) out of three sampled residents receiving enteral feeding.(Total of 6 residents with enteral feeding in the facility.) The facility failed to provide the calculated minimal amount of fluid in the presence of diarrhea, excessive oral secretions and sweating. This failure resulted in harm when R70 required treatment in the hospital for fluid and electrolyte imbalance on 12/4/18 and 1/23/19. Findings include: Facility policy entitled Fluid Balance (last revised 7/24/18) included the facility "will provide patients with sufficient amounts of fluids based on individual needs...Patient's hydration status will be determined through routine nursing evaluation. Patients identified as being at risk for dehydration or needing acute rehydration will be monitored to identify appropriate care plan interventions for promoting adequate hydration."</p>	F 692	<p>Requesting Informal Dispute Resolution (IDR) for this deficiency. Information sent to state licensing director (Attachment LL). A. R70 returned from the hospital and enteral feed and flush orders were verified by dietitian and adjusted for caloric and fluid needs. B. Current residents who do not take anything by mouth and rely on enteral feedings and flush orders to meet fluid needs have the potential to be affected. A whole house audit was completed to ensure that all residents with tube feedings have enteral feeding and flush orders that meet documented fluid needs 1/31/19. The nutritional assessment includes documentation of nurse interview and/or medical record review to identify insensible fluid loss, i.e. excessive oral secretions, to include in fluid need calculations. This information is located in the Summary and/or Evaluation and Plan sections of the assessment and included in the calculations for fluid needs.</p>	
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 692	<p>Continued From page 35</p> <p>Review of R70's clinical record revealed:</p> <p>3/22/18 - Admission to the facility with multiple diagnoses including diabetes, multiple strokes resulting in aphasia, dysphagia and hemiplegia.</p> <p>3/23/18 - A care plan for enteral feeding tube to meet nutritional needs included the goal that R70 would display no signs of aspiration (fluids from mouth entering the lungs). Interventions included: Aspiration precautions; Check patency and placement of tube daily and before administering feedings and meds; Dietary evaluation and monitoring; Free water; Monitor for nausea, vomiting, diarrhea, cramping, fatigue, weakness and vital sign changes and report; and Mouth care every shift and PRN.</p> <p>3/27/18 - A care plan for nutritional risk included interventions: Glucerna 1.5 (tube feeding formula) with flush (water) as ordered; and Monitor for signs of aspiration.</p> <p>Manufacturer (Abbott Laboratories) nutritional information revealed that each 1,000 mL of Glucerna 1.5 contained 759 mL of free water.</p> <p>4/4/18 - A care plan for being at risk for dehydration had the goal that R70 will not exhibit signs of dehydration as evidence by moist mucous membranes. Interventions included: Monitor for signs of dehydration (increased temperature, decrease output, mental status changes, dry mucous membranes, orthostatic hypotension, tachycardia); and Obtain dietitian consult as needed/ordered.</p> <p>6/29/18 - A Significant Change MDS Assessment included that R70 had received nutrition by tube</p>	F 692	<p>Dietitians also attend IDT or CAR meetings for involvement in discussions about at-risk or high-risk patients. The nutrition assessment documents IDT, wound care and others involved in the coordination of nutritional care.</p> <p>C. A RCA of enteral feedings and fluid needs was completed 1/30/19. Identified patient factors include amount of insensible fluid loss from diaphoresis or secretions. Process factors include staff reliance on dietitian for calculations and orders and non-standard laboratory monitoring for patients upon return from admission.</p> <p>The nutritional assessment includes documentation of nurse interview and/or medical record review to identify insensible fluid loss, i.e. excessive oral secretions, to include in fluid need calculations. This information is located in the Summary and/or Evaluation and Plan sections of the assessment and included in the calculations for fluid needs. Dietitians also attend IDT or CAR meetings for involvement in discussions about at-risk or high-risk patients. The nutrition assessment documents IDT, wound care and others involved in the coordination of nutritional care.</p> <p>Education for nurse managers to appropriately review enteral feeding and fluid orders was completed 1/30/19. On 1/30/19 nurse managers also received an enteral feeding policy and procedure review to ensure additional orders related to enteral feeding were complete,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 692	<p>Continued From page 36 feeding.</p> <p>11/7/18 (3:23 AM) - Nursing progress note documented "Increased secretions noted around mouth. Tick, white sputum which was difficult to suction. Feeding held for one hour as a nursing measure and patient sitting up with HOB (head of bed) elevated. Staff has noted an increase in secretions and the need to be suctioned. Not written in NP's book to make aware of problem."</p> <p>11/13/18 - NP note acknowledged the increased oral secretions.</p> <p>11/21/18 (2:20 AM) - Nursing progress note documented R70 "had a coughing spell" and had "a large amount of flatulence (gas). Abdomen was very distended. Feeding held from 1:15 AM - 2:45 AM."</p> <p>11/24/18 (8:17 AM) - Nutrition note included "spoke with nursing regarding explosive bowel movements with reports of 3 movements daily. Reviewed MAR and noted orders for (name of stool softener)...if holding stool softener does not correct loose stools will review adding fiber to firm stools..."</p> <p>11/24/18 - A Nutritional Assessment showed the fluid factor used by E12 (RD) was 30 mL per kilogram (kg) of weight. E12 (RD) used 114 pounds (from 11/12/18) to calculate calorie and fluid needs. E12 documented that R70 was "having some diarrhea (noted today)" and that "RD unsure of diarrheal frequency." Nutrition plan included if R70's "diarrhea continues, (R70) may need a formula which contains less dietary fiber."</p>	F 692	<p>including a basic metabolic panel (BMP) 2 weeks after an admission (Attachment S). The dietitians received education about feeding and fluid need calculations (Attachment T) 2/5/19. Education regarding reportable observations (vomiting, fever, nausea, diarrhea, sweating) which need inclusion in fluid needs completed by nursing staff 6/10/19. D. The Center Nurse Executive or designee will audit all enteral feedings to ensure fluid needs are met based on the most recent nutritional assessment (Attachment U). The Center Nurse Executive or designee will audit all admissions with enteral feeding orders to ensure a BMP was ordered and completed 2 weeks after admission (Attachment V). Audits will occur daily until 100% compliance is achieved for three consecutive days, then three times a week until 100% compliance is achieved for three weeks, then weekly until 100% compliance is achieved for three weeks, then monthly for three months until 100% compliance is achieved. For the enteral feeding and fluid needs audits 100% compliance was achieved for daily audits on 2/3/19, 2/4/19, 2/5/19, and 2/6/19. 100% compliance was achieved for audits 3 x weekly on 2/11/19, 2/12/19, 2/13/19, 2/14/19, 2/19/19, 2/23/19, 2/24/19, 2/25/19, and 2/26/19. 100% compliance was achieved on weekly audits for weeks 3/4/19, 3/11/19, and 3/18/19. 100% compliance has been achieved for 2 of the 3 monthly audits on 4/24/19 and 5/24/19. For the BMP after admission order 100% compliance was achieved for</p>	
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 692	<p>Continued From page 37</p> <ul style="list-style-type: none"> - Fluid needs determined to be 1,554 mLs daily. - Nutrition plan for Glucerna 1.5 at 85 mL per hour for 14 hours (provided 903 mL water); -150 mL water flush every 6 hours (provided 600 mL water); - Totaled 1,503 mL water daily which did not meet R70's calculated fluid needs of 1,554 mL. <p>November, 2018 - eMAR review discovered that R70 received one dose of PRN medication for increased oral secretions (Levsin).</p> <p>November, 2018 - Review of CNA documentation showed that R70 had frequent diarrhea:</p> <ul style="list-style-type: none"> - 39 medium / large loose bowel movements (BMs); and - 5 medium / large watery BMs. <p>12/3/18 - A change of condition note revealed E8 (NP) was notified of shortness of breath and ordered nebulizer (breathing) treatments, blood tests and chest x-ray.</p> <p>12/3/18 (10:06 PM) - A nursing progress note documented crackles (abnormal sounds indicating fluid, mucus, secretions) over trachea (upper breathing tube in neck area) and suctioned thick, bloody mucus secretions. Chest x-ray was negative for pneumonia.</p> <p>12/4/18 (6:30 AM) - A late entry nursing progress note documented "resident's pulse was 130 and respirations were reading at 40.... physician was notified at 6:30 AM...911 was notified... Resident had secretions coming from mouth while ambulance were preparing (R70) for transport."</p> <p>12/4/18 - Emergency Department physician documentation included that R70 was</p>	F 692	<p>daily audits on 2/3/19, 2/4/19, 2/5/19. 100% compliance was achieved for audits 3 x a week the weeks of 2/10/19, 2/17/19, and 2/24/19. 100% compliance was achieved weekly for weeks 3/4/19, 3/11/19, and 3/18/19. 100% compliance has been achieved for 2 of the 3 monthly audits 4/24/19 and 5/27/19. Results of all audits were/will be presented at the Quality Assurance Performance Improvement meeting for review and recommendations.</p>	
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 692	<p>Continued From page 38</p> <p>unresponsive, had a fever (102.2 F), low blood pressure (82 / 40) and high heart rate (150s). Elevated blood tests revealed fluid and electrolyte imbalance and acute renal failure (kidney injury) [sodium 155, BUN 91, creatinine 1.73, potassium 5.6, hematocrit 46.2, urine specific gravity 1.026]. R70's condition improved with IV fluids.</p> <p>12/4/18 - Hospital History and Physical included the following diagnoses: "Acute renal failure...Acute hypotension (low blood pressure) and sinus tachycardia (high heart rate)...sec (secondary) to dehydration...Acute hypernatremia (high sodium) and hyperkalemia (high potassium), and (sic) due to dehydration and AKI (acute kidney injury)..."</p> <p>Hypernatremia is most often the result of unreplaced water that is lost from the gastrointestinal tract (diarrhea), skin (sweat) or urine (increased urine production with high blood glucose). https://www.uptodate.com/contents/treatment-of-hypernatremia-in-adults</p> <p>12/11/18 - R70 returned to the facility with the continuation of hospital tube feeding orders: - Glucerna 1.5 at 55 mL per hour for 14 hours (provided 583 mL water); and - 150 mL water flush every 6 hours (provided 600 mL); - Totaled 1,183 mL water daily which was even less than prior to hospitalization.</p> <p>12/12/18 - A NP progress note documented that "during the hospital stay, (R70) had shown improvement in clinical status and blood pressure is now stable. (R70's) tube feed rate has advanced and R70 tolerated it well. R70 finished</p>	F 692		
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 692	<p>Continued From page 39</p> <p>a seven-day course of antibiotics for a urinary tract infection (UTI). R70's mental status is at baseline."</p> <p>12/12/18 (1:39 PM) - A nursing progress note documented that R70 had some diaphoresis (sweating) once this morning.</p> <p>12/12/18 (10:55 PM) - A nursing progress note documented that R70 was given a PRN (as needed) Levsin after a coughing episode and saliva draining out the sides of R70's mouth.</p> <p>12/16/18 (4:52 AM) - A nursing progress note documented R70 had moderate amount of foamy white sputum (secretions) draining from his/her mouth. Mouth suctioned and PRN Levsin was effective.</p> <p>12/16/18 - The Nutritional Assessment used R70's weight of 117.4 pounds (from 12/11/18) for calculating calorie and fluid needs. 117.4 pounds divided by 2.2 kg equals 53.6 kg. E25 (RD) kept the fluid factor at 30 mL per kg of resident weight to equal 1,600 mL of water even though the resident was recently re-admitted to the facility after being hospitalized for fluid and electrolyte imbalance. Nutrition plan included:</p> <ul style="list-style-type: none"> - Glucerna 1.5 increased to 65 mL per hour for 14 hours (provided 692 mL water); - 150 mL water flush every 6 hours (provided 600 mL water); - R70's weight increased by seven pounds in the past 14 days, "which may be related to fluids delivered in the hospital. - E25 did not calculate R70's daily water (totaled 1,292 mL which did not meet R70's calculated minimal fluid needs of 1,600 mL). The facility failed to ensure fluids provided met the 1,600 ml 	F 692		
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 692	<p>Continued From page 40 minimum.</p> <p>12/23/18 - A Nutritional Assessment used R70's weight of 117 pounds (from 12/19/18) for calculating calorie and fluid needs (117 pounds divided by 2.2 equals 53.18 kg). - E25 (RD) still used the fluid factor of 30 mL per kg which equaled 1,595 mL. - Nutrition plan included tube feeding at 65 mL per hour for 14 hours (provided 692 mL water). - E25 requested weekly weights and did not calculate the daily amount of water provided (including the flushes) that totaled 1,292 mL which did not meet R70's 1,600 mL calculated minimal fluid needs.</p> <p>December, 2018 - January, 2019 - Review of eMARs, nursing progress notes and CNA documentation revealed that R70 received many doses of PRN medication for increased oral secretions and had frequent diarrhea: - Levsin PRN for increased secretions (20 doses in December, after 12/11/18; and 6 doses in January, until 1/23/19); - December: 33 medium / large loose BMs and 6 medium / large watery BMs; and - January: 34 medium / large loose BMs and 3 medium / large watery BMs.</p> <p>1/23/19 (4:24 PM) - A nursing progress note documented that R70 was sent to the hospital for shortness of breath, facial swelling, increased oral secretions, and heart rate in 130s.</p> <p>1/23/19 - The hospital History and Physical included that R70 was sent to the hospital from the nursing home with gurgling sounds from his/her throat. Lab tests showed elevated sodium 157, BUN 63 (indicating dehydration - low fluid</p>	F 692		
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 692	<p>Continued From page 41</p> <p>volume) and WBC 16.4 (indicating infection). Chest x-ray did not show pneumonia. Admitting diagnoses included sepsis from suspected aspiration pneumonia and hyperosmolar hyponatremia (elevated sodium level from a decrease in total body water) caused by insensible losses from sepsis.</p> <p>The hospital did not identify that the amount of free water in R70's nutrition plan in the nursing home was not meeting the resident's 1,600 mL minimal calculated needs.</p> <p>1/26/19 - R70 was readmitted to the facility with tube feeding orders(continued from the hospital): - Glucerna 1.5 at 40 mL per hour (provided 728 mL water); and - 200 mL water every 4 hours (provided 1,200 mL water). - Daily water totaled 1,928 mL.</p> <p>1/27/19 - A nutrition note by E25 (RD) documented that R70 had increased need for hydration and that R70 "sweats profusely."</p> <p>1/29/19 - A Nutritional Assessment revealed that E12 (RD) calculated calorie and fluid needs based on R70's weight of 117.4 (from 1/27/19). - Fluid factor was increased to 35 mL per kg (1,855 mL daily) - surveyor calculation: 117.4 divided by 2.2 equals 53.36 then times 35 equals 1,867 mL calculated fluid need; - Glucerna 1.5 at 65 mL per hour for 16 hours (provided 789 mL water); and - 200 mL water every 4 hours (provided 1,200 mL). - Daily water totaled 1,989 mL which was the first nutritional plan that met R70's calculated fluid needs.</p>	F 692			

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	<p>Continued From page 42</p> <p>The amount of free water ordered was doubled from 150 mL four times a day (600 mL) to 200 mL every 4 hours (1,200 mL).</p> <p>5/1/19 (around 1030 AM) - During an interview with E8 (NP) to discuss prior hydration needs in relation to number of loose and watery stools, E8 said "I increased the free water since then."</p> <p>5/1/19 (10:55 AM) - During an interview with E2 (DON) to review hydration needs in relation to number of loose and watery stools monthly, E2 explained that dietitians received education to consider insensible fluid loss (secretions, diaphoresis, diarrhea) when calculating nutrition / hydration needs.</p> <p>5/1/19 (12:55 PM) - During an interview with E12 (RD) to find out how the amount of free water is determined for a resident receiving tube feeding, E12 said the "gold standard for normal folks is 25-35 mL per kg." When asked how insensible fluid loss gets determined, E12 said it's "anecdotal, talk with nurses and aides. They don't do I & O (intake and output measuring) here which makes it hard." After the surveyor showed R70's tallies of medium and large loose / watery stools by month, E12 stated that staff mentioned that R70 had some explosive watery diarrhea. After discussion about review of the facility's root cause analysis findings, E12 added that R70 "is in a better place now."</p> <p>The facility failed to provide R70 with the calculated minimal amount of fluid in the presence of diarrhea, excessive oral secretions and sweating. This failure resulted in harm when R70 required treatment in the hospital for fluid</p>	F 692		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 692	Continued From page 43 and electrolyte imbalance / dehydration on 12/4/18 and 1/23/19	F 692		
F 693 SS=D	<p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.</p> <p>Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)</p> <p>§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to administer medications through an enteral tube according to standards of practice for two (R16 and R43) out of two sampled residents receiving</p>	F 693	<p>A. R40 and R16 have had no adverse effects from enteral medication and flush administration noted by surveyor.</p> <p>B. All residents with enteral medication and flush administration have the potential</p>	6/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 693	<p>Continued From page 44</p> <p>medications by enteral feeding tube during medication administration observation. Findings include:</p> <p>Facility policy entitled Medication Administration: Enteral (last revised 10/17/18) included the process: "Administer medications individually. Pour medication into syringe so entire dose is administered. Allow medication to flow down the syringe via gravity (pour into the syringe and allow to flow in slowly). Do not push medication through the tube (with the syringe)...Flush with at least 15 mL tap or sterile water in between each medication. After administering all medications, flush with at least 15 mL tap or sterile water or per physician order."</p> <p>Facility policy entitled Enteral Feeding: Administration by Syringe Bolus (last revised 10/1/18) included to "avoid letting the syringe empty completely."</p> <p>1. Review of R16's clinical record revealed:</p> <p>Physicians' orders included several medications to be given by enteral tube as scheduled: 1/26/19: Cough medicine every 4 hours. 2/1/19: Tylenol every 8 hours for pain. 2/18/19: Reglan (promote tube feeding to move through the stomach) every 6 hours.</p> <p>4/23/19 (5:00 AM) - During a medication administration observation, after pouring the medications, measuring the gastrostomy tube length and checking for gastric residual (30 mL), E11 (RN) pulled up a liquid medication into the syringe and pushed the liquid into R16's feeding tube. This was repeated for all three liquid medications without flushing the tube in between</p>	F 693	<p>to be affected. All residents with enteral medication and flush administration were reviewed and no adverse effects noted 5/31/19.</p> <p>C. The enteral medication administration policy/procedure was reviewed by the management team. A RCA was completed to determine factors in the deficient practice. Education was identified as the primary need. The use of stopcocks is also important to reduce air instillation. All enteral tubes have stock cocks in place. Measurement of tube length is documented on MAR for comparison prior to medication or fluid administration. Education was provided to nurses regarding best practice enteral medication and flush administration (Attachment A).</p> <p>D. The Center Nurse Executive or designee will audit enteral medication and flush administration on varied shifts and residents(Attachment W). Audits will occur daily for 3 consecutive days, then 3 times a week for 3 weeks, weekly for 3 weeks and monthly for 3 months. The results of the audit will be presented to the Quality Assurance Performance Improvement Committee for review and recommendation.</p>	
-------	--	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 693	<p>Continued From page 45</p> <p>each medication. The water flush administered after all three medications were given was done by gravity. E11 failed to administer the medications by gravity and flush between each medication as stated in the facility policy.</p> <p>Cross Refer F695, Example 1</p> <p>2. Review of R43's clinical record revealed:</p> <p>Physicians' orders included medications to be administered to R43 by enteral feeding tube as scheduled:</p> <p>2/1/19: Blood pressure medication twice a day; and seizure medication three times a day.</p> <p>2/2/19: Different blood pressure medication daily; iron twice a day; folic acid daily; probiotic daily; blood thinner daily; potassium daily; protein supplement twice a day; and vitamin B6 daily.</p> <p>4/22/19: antibiotic daily for pneumonia.</p> <p>4/25/19 (9:10 AM - 10:00 AM) - During a medication administration observation, E7 (LPN) crushed tablets, opened capsules and poured liquid medications, each medication was placed in an individual medicine cup. E7 verified tube placement and checked for residual. E7 was next to R43's bed and the bedside table containing all of the medicine cups were positioned to the nurse's right side.</p> <p>- E7 turned away from R43 and toward the table to pour water into the crushed medication in the first cup. E7 then poured the mixture into the syringe and gave it by gravity. Once the syringe was empty, a small amount of air entered the feeding tube.</p> <p>- E7 turned toward the table then poured more water into the medicine cup to ensure all of the medication was mixed with the water. As E7 poured the mixture in the syringe, the air that was</p>	F 693		
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 693	Continued From page 46 in the feeding tube entered R43's stomach. - When E7 turned to pour water into the empty medicine cup (for water flush between medications) more air entered the feeding tube as the syringe emptied. When the water was poured in the syringe, more air entered R43's stomach. - This process of several administrations of water mixed with crushed medication followed by plain water flush continued for 10 more medications. Air entered R43's feeding tube when each medication cup with water/mixture was poured into the syringe. The syringe was allowed to empty between each administration of medication cup of liquid.	F 693			
F 695 SS=D	Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to ensure that respiratory care was provided in a manner consistent with professional standards for two (R43 and R60) out of three sampled	F 695	A. Suction canisters, tubing and Yankhauer suction devices for R70 and R43 have been replaced and labeled with date. B. All residents who require suction	6/10/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 695	<p>Continued From page 47</p> <p>residents reviewed for respiratory care. Findings include:</p> <p>Cross Refer F693, Eaxmple 2</p> <p>1. Review of R43's clinical record revealed:</p> <p>8/22/18 - R43 was admitted to the facility with multiple diagnoses including stroke resulting in weakness, contractures, dysphagia (inability to swallow safely - fluids enter lungs instead of stomach), and the need for tube feeding (liquid nutrition given through a tube inserted in the stomach).</p> <p>12/9/18 - A care plan for being at risk for respiratory failure due to a history of respiratory failure included that R43 received continuous oxygen by nasal cannula (soft prongs in the nose with tubing wrapped behind the ears to hold in place).</p> <p>4/24/19 (9:00 AM) - Observed approximately 200 mL liquid and sputum was in the suction canister and the suction machine tubing was undated. The Yankauer (hard plastic device to suction secretions from the mouth) was in an undated open paper wrapper. It was not clear how long the Yankauer and suction machine tubing had been in place, increasing the risk for contamination. The nasal cannula tubing did not have any cushions to protect R43's ears from irritation since the oxygen was used continuously.</p> <p>April 2019 - Review of R43's eMAR revealed an intervention for suctioning excess oral secretions. There were no instances when the nurse signed off that this task was performed from April 1-24 although there was evidence in the suction canister that R43 had been suctioned.</p>	F 695	<p>equipment or suctioning are at risk. All suction equipment has been dated per policy 5/31/19.</p> <p>C. A RCA identified lack of education as the primary factor in this deficiency. Education was provided regarding replacement of suction equipment (Attachment A). Orders to replace suction equipment per schedule were placed on the MAR. All yankheur suction catheters are stored appropriately. Education for documentation when suctioning and replacement/storage of suction equipment was provided to nursing staff (Attachment H).</p> <p>D. The Center Nurse Executive or designee will audit all suction equipment for compliance with replacement (Attachment X). Audits for those patients who require suctioning will also occur to ensure complete documentation is present (Attachment Y). Audits will occur daily for 3 consecutive days, then 3 times a week for 3 weeks, weekly for 3 weeks and monthly for three months. The results of the audit will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	--	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 695	<p>Continued From page 48</p> <p>4/25/19 (9:10 AM) - An observation of the undated Yankauer tucked between the motor and suction canister with the Yankauer tip (part that goes in the resident's mouth) was uncovered and contaminated. The suction machine tubing remained undated, however, there was now 250 mL of liquid and sputum in the canister, indicating it had been used since the previous day. R43's nasal cannula tubing did not have cushions attached for ear protection.</p> <p>4/25/19 (approximately 2:00 PM) - The surveyor observed R43's ears for irritation from the nasal cannula tubing in the presence of E7 (LPN) and E31 (CNA).</p> <p>4/25/19 (2:11 PM) - A nursing progress note documented "foam pads applied to nasal cannula tubing to prevent irritation to top of ears."</p> <p>4/26/19 (8:30 AM) - An observation found the suction machine tubing remained undated and now had approximately 300 mL of liquid/sputum in the canister, showing that R43 had been suctioned in the previous 24 hours. The Yankauer tip was sitting inside a disposable glove laying on top of the suction machine. It was not clear if the glove was clean or used (dirty). Ear cushions were now visible on R43's nasal cannula tubing.</p> <p>4/26/19 (945 AM) - Observed that R43 had vomited a small amount while lying on his/her right side and wearing the nasal cannula. E32 (CNA) put the tube feeding machine on hold before lowering the head of the bed flat to clean R43's face. E32 stated he/she would get someone to help change R43 as E32 raised the</p>	F 695		
-------	---	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 695	<p>Continued From page 49</p> <p>head of the bed and restarted the feeding pump.</p> <p>4/26/19 (10:30 AM) - R43 was receiving care with the door closed.</p> <p>4/26/19 (11:30 AM - 12:00 PM) - Observed R43 with a towel across his/her chest with light brown / tan vomit on the towel and breathing at an increased rate. An interview with E33 (LPN) revealed that R43 was suctioned first thing in the morning and that R43 was not retaining tube feeding formula in his/her stomach. E33 added that he/she made a written entry in the NP communication book for the NP to see R43 today. After the surveyor informed E8 (NP) at the nursing station of R43's current status, E8 and E33 entered R43's room. E33 discovered that R43 was not wearing the nasal cannula / continuous oxygen (O2) as ordered. After E33 picked up the nasal cannula from the bedside table and placed it on R43, E8 requested the amount of O2 be increased. R43's blood oxygen level (O2 saturation) was low at 83% and R43 was breathing fast at 28-30 breaths a minute. Since R43 was not able to follow the command to breathe through his/her nose, E8 ordered that oxygen be given by face mask.</p> <p>4/26/19 (12:20 PM) - An interview with E8 (NP) revealed that R43's blood oxygen level was up to 91% with the face mask in place.</p> <p>4/26/19 (untimed, after lunch) - E2 (DON) provided a copy of the facility policy entitled Respiratory Equipment / Supply Cleaning / Disinfection (last revised 12/1/18) which included that the suction machine canister and connecting tubing should be changed weekly and PRN. The policy did not address the frequency that the</p>	F 695			

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 695	<p>Continued From page 50</p> <p>Yankauer should be replaced to minimize the risk for contaminants to enter a resident's mouth and flowing into the lungs due to dysphagia, causing an infection.</p> <p>4/27/19 (2:00 PM) - A change of condition nursing note documented "notified (E8, NP) of declining respiratory condition, abnormal vital signs (high BP 213/92, fast heart rate 100), decreased O2 saturation (82%) and fever (100.3 axillary). R43 was sent to the hospital.</p> <p>4/27/19 (10:25 PM) - A nursing note documented that R43 was admitted to the hospital with aspiration pneumonia.</p> <p>4/29/19 (8:35 AM) - An observation of R43's room revealed that the suction machine tubing and canister had been replaced and were dated 4/26/19.</p> <p>For R43, the facility:</p> <ul style="list-style-type: none"> - failed to replace R43's nasal cannula after providing care causing a drop in blood oxygen levels; - failed to document when R43 was suctioned; - failed to ensure equipment used for oral suctioning was clean / replaced to minimize the risk for infection from germs being in the resident's mouth and entering the lungs due to dysphagia; and - failed to apply ear cushions on R43's nasal cannula that was used continuously to minimize skin irritation. <p>Cross Refer F656, Example 3</p> <p>2. Review of R70's clinical record revealed:</p> <p>3/22/18 - R70 admitted to the facility with</p>	F 695		
-------	--	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 695	<p>Continued From page 51</p> <p>weakness, aphasia, dysphagia and received tube feeding after having multiple strokes.</p> <p>4/23/19 (6:32 AM) - R70's Yankauer was observed uncovered, undated and sitting on top the suction machine.</p> <p>4/23/19 (9:30 AM) - An observation of resident sleeping revealed R70 was receiving oxygen by nasal cannula. The suction machine canister contained approximately 200 mL whitish /clear fluid and no components / tubing were dated. The Yankauer still laid uncovered and undated on top of the suction machine. The cleanliness of the Yankauer tip that enters the resident's mouth for suctioning of oral secretions was unknown.</p> <p>April, 2019 - A review of the eMAR / eTAR found no intervention for suctioning excess oral secretions.</p> <p>4/24/19 (2:46 AM) - A nursing note documented that R70 was sent to the hospital at 1:30 AM for increased oral secretions, periods of shortness of breath, fast breathing (22-40 a minute), high heart rate (130-135 a minute) and diarrhea. R70 was admitted to the hospital with the diagnosis of aspiration pneumonia.</p> <p>For R70, the facility:</p> <ul style="list-style-type: none"> - failed to ensure equipment used for oral suctioning was clean / replaced to minimize the risk for infection from germs being in the resident's mouth and entering the lungs due to dysphagia; and - failed to document when R43 was suctioned. <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference</p>	F 695			

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 695	Continued From page 52 beginning at 11:15 AM.	F 695		
F 725 SS=F	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 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 interviews and review of facility documentation it was determined, that for 12 residents who wished to remain anonymous (A1, A2, A3, A4, A5, A6, A7, A8, A9, A10, A11 and A12) and one resident (R16), the facility failed to	F 725	A. The facility has met with and followed up with residents' documented grievances. The facility continues to conduct Resident Council Meetings monthly and is responsive to concerns	6/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 725	<p>Continued From page 53</p> <p>provide sufficient nursing staff on a 24 hour basis to meet resident care needs. Findings include:</p> <p>11/1/18 - An anonymous allegation received by the State Agency documented that "they are short staff and required to care for 18-22 residents on the 3:00 PM to 11:00 PM shifts."</p> <p>2/4/19 - Resident Council meeting minutes documented "we (residents) should not have to come to you (staff) every day about our care, when you are staff challenged; you are fully aware of your staffing. Split shifts are not working."</p> <p>2/8/19 - E1's (NHA) documented response to the 2/4/19 staffing concerns from the Resident Council directed residents to "Inform the charge nurse, supervisor or nurse manager when you have a concern. Timely reporting is required to address your specific care concern."</p> <p>3/11/19 - Resident Council meeting minutes documented "you know, as well as we know, that you are staff challenged, but why do we have to keep writing these things down? What about the residents that can't report these things? We are not always getting proper care."</p> <p>3/14/19 - E1's (NHA) documented response to the 3/11/19 staffing concerns from the Resident Council indicated that "any specific concerns have been addressed."</p> <p>4/9/19 - An anonymous allegation received by the State Agency reported "short staffing at the facility."</p> <p>4/12/19 - An anonymous allegation received by</p>	F 725	<p>when raised.</p> <p>B. Current residents have the potential to be affected. The facility has met with and followed up with residents' documented grievances. The facility continues to conduct Resident Council Meetings monthly and is responsive to concerns when raised.</p> <p>C. The Scheduling manager will staff the facility at or above the minimum staffing requirements. The Nursing Leadership will meet with each member of the Resident Council to determine specifics about sufficient nursing staff and assess staffing needs based upon feedback from the residents.</p> <p>D. The Recreation Director/designee will complete audits (Attachment Z) on 10% of the resident population daily until 100% compliance is achieved on 3 consecutive reviews. Audits will then be completed twice a week until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 725	<p>Continued From page 54</p> <p>the State Agency documented that the "facility is very understaffed. There are only 4 aides on the 3-11 shift and they each have 15/16 residents a piece. There are some nurses and administrators in the building but they aren't doing anything to help the CNA's or care for the residents. They are walking past call bells and ignoring residents requests. CNA cannot handle the amount of work the facility is expecting of them."</p> <p>4/23/19 - The updated Staffing Plan section of the facility's submitted Facility Assessment indicated that based on resident population and their needs for care and support to ensure sufficient staff to meet the needs of residents at any given time direct care staff ratios should be: days CNA 1:8 (1 CNA for every 8 residents), evenings CNA 1:10, and nights CNA 1:16.</p> <p>During an interview on 4/23/19 at 9:25 AM, A1 stated, "CNA's don't answer the call bells, for 45 minutes sometimes. I've seen other resident's call bell on for an hour sometimes only three aides (CNA's) working."</p> <p>During an interview on 4/23/19 at 9:44 AM, when asked was there enough staff for the resident to get the care and assistance needed, A2 responded, "definitely not, 3-11 (shift) is terrible, they must hide. Can't find or see. Terrible on weekends. Less than a skeleton crew."</p> <p>During an interview on 4/24/19 at 10:07 AM when asked was there enough staff for the resident to get the care and assistance needed without having to wait a long time, A3 reported being "unable to determine length of time (to answer a call bell), but it takes too long." When asked if he/she ever had an incontinence episode while</p>	F 725		
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 725	<p>Continued From page 55 waiting, A3 stated, "Yes."</p> <p>During an interview on 4/23/19 at 10:18 AM, A4 stated, "We need more aides (CNA's)".</p> <p>During an interview on 4/23/19 at 10:41 AM, A5 reported he/she often has to wait to use the bathroom.</p> <p>During an interview on 4/23/19 at 11:47 AM A6 stated, "the aides are short staffed and they don't want to wait on you. The other day we waited just about all day, they come in just before the shift change and they say we only got 3 (CNA'S). They need more help. If you ring that bell they walk by they see the light but they will stand across the hall and they will not do a thing."</p> <p>4/24/19 at 9:31 AM - During a Resident Council meeting the following anonymous statements were given:</p> <p>A7 stated, "We do not get help without waiting. Some have waited 1 or 2 hours. They turn call bells off before they go into the room. I have heard residents say that they (staff) turn the call bell off and never come. The call bells go off so long, you can hear at nurse's station, and hear it change sound because it's rang for a certain time. They will have a short attitude when they finally answer you...There are not enough aides, they called more staff in, knowing the survey team would be here soon. There are 6 aides (total) on night shift lately...Also they have split shifts, an aide comes in at 7:00 PM and it is not working... 3-11 shift is a big concern with staffing. They work short all the time; there are not enough aides."</p>	F 725			

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 725	<p>Continued From page 56</p> <p>A8 stated that he/she "has rang the call bell in the bathroom for help with bathing... worries he/she could have fallen and would have to wait the same long time for help." A8 further explained that staff "have left people in the shower while they do another task and it takes a long time to come back. A8 doesn't want to be left alone in shower. "Especially on Unit 2. Even on shower days, it's hard to get a shower. We've been told we can have them whenever we want, but it doesn't work like that cause when we ask they say they can't do it, they're (they are) short of time." A8 reported the CNA assigned today knew about the resident council meeting today and would not give the scheduled shower due to "(he/she) won't have time, other than this morning and didn't offer to give shower early/later."</p> <p>A9 stated his/her roommate "has fallen and didn't get help promptly after using call bell."</p> <p>A10 reported some residents don't get to activities they'd enjoy because they are not helped out of bed and dressed in time. A10 then stated it was "not fair that residents miss activities, or come in their pajama's, because aides haven't helped them get ready."</p> <p>A11 stated a CNA "was short with me one night when I only asked for help twice in one night."</p> <p>During an interview on 4/24/19 at 1:38 PM, A12 stated that wait times for assistance were "half an hour or more. I have peed on the floor trying to get to bathroom."</p> <p>4/30/19 - 6:00 PM An eMAR nursing note documented R16 was not turned and repositioned every two hours because the CNA</p>	F 725			

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 725	Continued From page 57 stated that he/she "can not turn R16 [alone] so he/she did not turn R16." During an interview on 5/3/19 at 8:49 AM with E2 (DON), it was confirmed that the facility had several openings for direct care staff, E2 stated "we have CNA and licensed nurse positions... Two full time and two part/time nurse positions; Eight full time and four part time CNA positions." E2 stated that the vacant positions were primarily on the "evening" shifts. During this same interview, E2 confirmed that the daily direct care staff assignments did not reflect the ratio's of direct care staff to resident's, documented as necessary in the Facility Assessment and stated "those numbers are based on full census and full staff". The facility census the first day of the survey was 108 or 87% full. When asked if the level of assistance required, acuity and any other resident care needs were a factor in the assignment of direct care staff to resident ratios, E2 stated "it does for the Transitional Care Unit." 5/3/19 at 9:07 AM - During an interview with E9 (LPN), it was revealed that the facility did not have a restorative aide and that the aides working on the floor must complete the range of motion (straightening / moving arms and legs to prevent contractures). "We need to have enough staff to do the range of motion." 5/3/19 at 9:10 AM - During an interview with E10 (CNA) it was revealed that the "restorative aide position had been vacant around 4-6 weeks."	F 725			
F 757	Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM. Drug Regimen is Free from Unnecessary Drugs	F 757		6/10/19	

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757 SS=D	Continued From page 58 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 §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 and interview it was determined that the facility failed to perform a blood test to monitor the effectiveness of a medication for one (R6) out of five sampled residents for medication review. Findings include: Review of R6's clinical record revealed: 9/18/17 - Physicians' orders included a Vitamin D blood test to be completed yearly with a start date of 2/1/18.	F 757	A. R6 has a vitamin D level drawn and is ordered annually. Vitamin D level result was 39 with a reference range of 30-100. B. All residents who are readmitted are at risk for an omitted routine laboratory test. A whole house audit was completed for admissions/readmission for the past 30 days on 5/16/19. C. An RCA was completed for the missed lab test. R6's readmission orders were reviewed for prior lab orders and the vitamin D level was not reordered. Nurse managers were educated to include		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 757	Continued From page 59 2/8/18 - A vitamin D test result was 53 (normal range 30-100). 9/18/18 - Physicians' orders included Vitamin D to be given twice a day. April, 2019 - Review of R6's lab results found no evidence that a Vitamin D blood test was completed in February 2019. 4/29/19 (9:52 AM) - An interview with E30 (Unit Clerk) revealed that usually six months of lab results were kept in the chart and older ones were thinned out. E30 said he/she would "check the purged record." 4/29/19 (approximately 10:40 AM) - E30 (Unit Clerk) provided the surveyor with lab test results from R6's purged record. Review of these records lacked a Vitamin D blood test from February 2019. 4/29/19 (1:05 PM) - An interview with E2 (DON) revealed that R6 was hospitalized in February 2019 and the vitamin D blood test was not re-ordered upon return to the facility and was not done. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.	F 757	review of prior lab and diagnostic orders upon readmission to the Center following a hospitalization (Attachment F). D. The Center Nurse Executive or designee will audit readmissions for prior routine or recurring lab orders (Attachment AA). Audits will occur daily for 3 consecutive days, then 3 times a week for 3 week, weekly for 3 weeks and monthly for three months until 100% compliance is achieved. The results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review.		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		6/10/19	

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761	<p>Continued From page 60</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to ensure drugs in one out of two medication carts reviewed were maintained within their expiration date. Findings include:</p> <p>An observation on 5/2/19 at 11:27 AM of an Unit 1 medication cart revealed two expired seizure medication cards for R27 that expired on 11/30/18. One card contained 14 out of 15 capsules and the second card contained 5 out of 15 capsules.</p> <p>E28 (RN) immediately confirmed this finding and E28 stated he/she would dispose of the medications.</p>	F 761	<p>A. Expired medications have been removed from the med carts.</p> <p>B. All residents who receive medications are at risk to receive an expired medication. All medication carts and storage areas were checked for additional expired medications and any expired medications were removed.</p> <p>C. A RCA was completed for the expired medication. Education was an identified need. Education provided to the nurses regarding checking expiration dates prior to administration (Attachment A).</p> <p>D. The Center Nurse Executive or designee will audit medication carts and medication rooms for expired medications</p>		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 761	Continued From page 61 Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.	F 761	(Attachment BB). The audits will occur weekly x 4 weeks, then monthly x 4 months until 100% compliance is achieved. The results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that	F 791		6/10/19	

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 791	<p>Continued From page 62 led to the delay;</p> <p>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and</p> <p>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to provide routine dental services to meet the needs for one (R41) out of one sampled resident reviewed for dental services. Findings include:</p> <p>The facility's policy and procedure entitled, Oral Health, with the most recent revision date of 5/1/19, indicated residents oral health will be evaluated as part of the nursing assessment upon admission, annually, and with a change in oral health.</p> <p>The facility's policy and procedure entitled, Dental Services, with the most recent revision date of 7/24/18, indicated that the facility would provide or obtain routine and emergency dental services to meet the resident's dental care needs. "Routine dental services means an annual inspection of the oral cavity for signs of disease, ... minor partial or full denture adjustments..."</p> <p>Cross refer F641, example #1</p>	F 791	<p>A. Per her responsible party, who was aware of the loose/ill fitting dentures, R41 previously refused a dental consult. R41 continues to refuse dental services at this time. The center will continue to monitor and offer dental services per R41's preferences.</p> <p>B. All residents have the potential to be affected by lack of identification of the need for routine dental services. All residents have a current oral assessment and as indicated, dental consults are in place.</p> <p>C. An RCA was completed for this deficiency. Process problems indicate a lack of knowledge for follow through when dental issues are identified. Education provided to nurses to complete all assessments and notify the unit managers of any identified dental issues (Attachment H).</p> <p>D. The Center Nurse Executive or designee will audit oral health evaluations, nutrition and nursing assessments to</p>		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 791	<p>Continued From page 63 Cross refer F656, example #1 Cross refer F805</p> <p>Review of R41's clinical record revealed:</p> <p>11/18/16 - R41 was admitted to the facility.</p> <p>2/24/19 - A Nutrition Assessment documented that R41 had both upper and lower dentures. R41 reported that the lower denture fit poorly and R41 was selective of meats he/she consumed.</p> <p>2/27/19 - The Quarterly MDS assessment incorrectly documented that R41 did not have any issues with broken or loose fitting dentures.</p> <p>Record review lacked evidence that R41 was offered routine dental services to evaluate R41's poor fitting lower denture.</p> <p>5/2/19 at approximately 12:45 PM - During meal observation, R41 was observed with a sandwich consisting of three pieces of luncheon meat. R41 verbalized to the surveyor that he/she cannot chew the luncheon meat due to the poor fitting lower denture. R41 verbalized he/she was uncertain when the last time was he/she had routine dental services, but was interested in obtaining a new lower denture.</p> <p>5/2/19 at approximately 3:00 PM - An interview with E22 (DSS) revealed he/she was not aware of R41's poor fitting lower denture and R41's desire for a new denture.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.</p>	F 791	<p>identify any dental problems (Attachment CC). Audits will occur daily for 3 consecutive days, then 3 times a week for 3 weeks, weekly for 3 weeks and monthly for three months. The results of the audit will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 805 F 805 SS=D	Continued From page 64 Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, it was determined that the facility failed to provide food prepared in a form designed to meet R41's individual needs. Findings include: Cross refer F791 Review of R41's clinical record revealed: 11/18/16 - R41 was admitted to the facility. 5/2/19 - A physician's order for regular, liberalized diet, chopped meat texture. 5/2/19 at approximately 12:35 PM - Review of R41's meal ticket documented a regular, liberalized, ground meat diet. 5/2/19 at approximately 12:45 PM - During meal observation, R41 was observed with a sandwich consisting of three pieces of luncheon meat. R41 verbalized to the surveyor that he/she cannot chew the luncheon meat due to the poor fitting lower denture. 5/2/19 at approximately 12:51 PM - An interview with E23 (DDS) revealed that nursing staff informs the dietary staff of the prescribed diet for each of the residents. E23 verbalized that R41	F 805 F 805	A. R41 has a diet order which meets her needs. The diet order and the tray tracker ticket have matching information. B. All residents in the facility who need an altered diet have the potential to be affected. A whole house audit matching tray tracker information to diet orders was completed. C. A RCA was completed to determine factors involved in this process. The availability of staff who have access to tray tracker, multiple dietary communication slips and nursing follow through were identified as process problems. In this specific instance nursing did not transcribe the order on the dietary communication slip to PointClickCare. Education was provided to nursing to ensure dietary orders are entered in PCC (Attachments F & H). Dietary communication slips are to be copied and placed in the unit manager's mailbox for verification. Nursing staff to follow meal service procedures to include checking ticket prior to serving food or beverages (Attachment DD). D. The Center Nurse Executive or designee will audit meal service to ensure that tickets are checked prior to service	6/10/19	

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 805	Continued From page 65 was served the diet as requested by nursing staff. 5/3/19 at approximately 10:30 AM - During an interview with E2 (DON), the above observations were reviewed and E2 confirmed that R41 was ordered to have all meats served in a ground form. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.	F 805	(Attachment EE). The Center Nurse Executive or designee will also verify all dietary communication slips are entered into PointClickCare (Attachment FF). Audits will occur until 100% compliance is achieved daily x 3 days, 3 times a week for 3 weeks, weekly x 3 weeks and monthly x 3 months. Results of audits will be presented to the Quality Assurance and Performance Improvement Committee for review and recommendations.		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility 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 store clean	F 812	A. Dietary employees are being educated on the storage of clean serving trays.	6/10/19	

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 812	<p>Continued From page 66</p> <p>serving dishes in a sanitary manner and failed to prepare food in accordance with professional standards. Findings include:</p> <p>1. Storage of clean serving trays.</p> <p>4/23/19 (starting at 6:25 AM) - The initial kitchen tour observation revealed that clean serving dishes were stored upside down: - two small stainless steel serving trays had moisture in between them; and - three medium sized stainless trays had an oily liquid substance along the outer rims.</p> <p>E14 (Cook) immediately confirmed the findings and placed the serving trays in the dishwashing area to be rewashed.</p> <p>2. Contamination during food preparation.</p> <p>4/23/19 (6:35 AM) - Observed E14 (Cook) don (put on) a pair of single-use, disposable gloves and placed 4 pieces of bread on the toaster. E14 then sprayed the grill with a can of oil spray then picked up a large jug of oil, twisted off the lid and poured some on the grill, contaminating his/her gloved hands by touching the two containers. E14 rearranged two pieces of bread on the toaster with his/her contaminated gloved hands. When the toast was done, E14 picked up the 4 pieces of toast and placed several pieces of cheese on them using his/her contaminated gloved hands. E14 did not remove the gloves, perform hand hygiene and don a new pair of gloves prior to touching food items.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.</p>	F 812	<p>Dietary Employees are being educated on proper Handwashing Procedure. The facility has had no foodborne illnesses.</p> <p>B. Current residents have the potential to be affected so current dietary employees educated on the storage of clean serving trays and proper handwashing procedures (Attachment GG). The facility has had no foodborne illnesses.</p> <p>C. A root cause analysis was completed on 4/3/19 to determine that education was needed in the following areas : Handwashing Procedure for Dining Services and Storage of Clean Service Trays.</p> <p>D. The Center Executive Director/designee will complete daily audits of handwashing procedures and storage of clean serving trays for dietary staff (Attachment HH). Audits will occur daily until 100% compliance is achieved on 3 consecutive reviews. Audits will then be completed twice a week until 100% compliance is achieved on 3 consecutive reviews, the weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	---	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 842 SS=D	<p>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted</p>	F 842		6/10/19
---------------	--	-------	--	---------

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 842	<p>Continued From page 68 by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure, that for two (R45 and R16) out of 23 residents sampled for investigations, their records were accurate, in accordance with accepted professional standards and practices. Findings include:</p> <p>1. Review of R45's clinical record review revealed:</p>	F 842	<p>A. E21 no longer works at the facility and is unavailable to correct documentation for R16. No further incorrect documentation for R16 has been identified. The diagnosis list for R45 was updated.</p> <p>B. All residents have the potential to be affected. All residents who have specialty consultations/visits are at risk for incorrect diagnosis. All MDSs completed since 5/26/19 have had all consults reviewed</p>	
-------	--	-------	--	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2019
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 842	<p>Continued From page 69</p> <p>8/24/18 - Admission Record documented diagnoses including ALS.</p> <p>2/26/19 - A Neurological Consultation, documented that R45 did not have ALS and was diagnosed with olivopondrocerebellar degeneration (OPCD). This consultation documentation included the initial of the medical provider, E8 (NP).</p> <p>There was lack of evidence that the facility updated R45's diagnosis by deleting ALS and included OPCD.</p> <p>5/2/19 at approximately 10:42 AM - An interview with E24 (ADON) confirmed that the facility failed to ensure R45's diagnosis list was accurate.</p> <p>Cross Refer F 609, Example 1</p> <p>2. Review of R16's clinical record revealed:</p> <p>10/28/16 - A care plan for potential for skin breakdown included the intervention to "turn and/or reposition and check skin every 2 hours or as specified by the plan of care."</p> <p>4/26/19 - The Annual MDS Assessment identified that R16 was totally dependent and required two staff for repositioning in bed.</p> <p>5/2/19 (8:50 AM) - The surveyor discovered several eMAR nursing notes that R16 was not turned due to lack of a second staff member, but CNA documentation included that R16 was turned.</p> <p>5/2/19 (3:08 PM) - During an interview E2 (DON) provided employee statements from an allegation of neglect investigation. Review of the information</p>	F 842	<p>and diagnosis updated as indicated.</p> <p>C. A RCA was completed. The lack of understanding why and what to document in addition to the implications for falsification of documentation was identified as a contributing factor to the deficiency. Education was provided to nursing staff about the importance of accurate documentation and ramifications for falsifying documentation (Attachment A). The RCA for the missed diagnosis indicated that lack of a comprehensive review of the chart by the CRC was a contributing factor in the error. Education for evaluation of consult information when a patient returns was provided to nursing staff (Attachment A). Nurses managers/CRCs received education regarding review of consults for new diagnosis (Attachment J).</p> <p>D. The Center Nurse Executive or designee will complete audits to assess for accuracy of documentation (Attachment II) and consult reviews to update diagnoses (Attachment JJ). Audits will occur until 100% compliance is achieved daily x 3 consecutive days, 3 x a week for 3 weeks, weekly for 3 weeks and monthly for 3 months. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>		

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 842	Continued From page 70 revealed that E21 (CNA) documented that R16 was turned every 2 hours although the resident was not turned. The CNA record did not accurately reflect the care that R16 received.	F 842		
F 881 SS=D	<p>Antibiotic Stewardship Program CFR(s): 483.80(a)(3)</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the appropriate use of an antibiotic for one (R6) out of five residents sampled for infection control review. Findings include:</p> <p>Review of R6's clinical record revealed:</p> <p>8/14/18 - A NP note documented that R6 had pain with urination, urine testing was ordered and R6 would "follow results."</p> <p>8/15/18 - The urinalysis result was abnormal with "many" bacteria. E8 (NP) initialed and dated the test result on 8/15/19.</p>	F 881	<p>A. R6 had no adverse reactions from unnecessary antibiotic use related to lack of a repeat urine sample for culture.</p> <p>B. All residents taking an antibiotic without indication have the potential to be affected. All urine culture results reviewed for compliance with antibiotic stewardship program and/or no adverse reactions noted on 5/24/19.</p> <p>C. An RCA was completed. Lack of a consistent Nurse Practice Educator (NPE) was identified as a factor in this deficiency. A new NPE started May 20, 2019 and will attend the infection preventionist course offered by Genesis in June 2019 to fully understand the role of</p>	6/10/19

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 881	<p>Continued From page 71</p> <p>8/15/18 - A physicians' order was written for an antibiotic to be given twice a day for seven days.</p> <p>8/16/18 - The urine culture test showed "more than three organisms, indicates contamination. Recommend repeat culture if clinically indicated." E8 (NP) initialed and dated the test result on 8/16/19.</p> <p>Nursing progress notes documented: - 8/16/18 (3:07 AM): had "not complained of any difficulties with urinating. Urine is a little concentrated and is dark yellow in brief and on bedpan." - 8/16/18 (1:59 PM) - "requested to stay in bed today...denies pain or discomfort." - 8/16/18 (6:47 PM): "No c/o (complaint of) painful urination and urine is yellow and non cloudy." - 8/17/18 (12:56 PM): "denies any flank pain / dysuria (pain with urination)."</p> <p>August, 2018 - eMAR revealed that R6 received the full seven day course of the antibiotic based on results from a contaminated urine culture.</p> <p>4/29/19 (after lunch) - E2 (DON) stated that the nursing notes indicated that R6's urine was clear and the resident had no pain with urination on 8/16/18 and was not sure why the antibiotic had continued.</p> <p>5/1/19 (10:35 AM) - During an interview with E8 (NP) to review R6's treatment with an antibiotic, E8 looked at his/her electronic calendar and said, "I not here that day" and added "I want to fix whatever I contributed to."</p> <p>Findings were reviewed with E1 (NHA) and E2</p>	F 881	<p>antibiotic stewardship. Education to correctly collect a urine sample was an identified need. This would prevent contamination of the specimen and allow for appropriate treatment decisions in a timely manner. Education to collect a clean catch urine sample in addition to a review of antibiotic stewardship was provided (Attachment A).</p> <p>D. The Center Nurse Executive or designee will audit all urine cultures for sensitivity results, appropriate antibiotic use and need for a repeat sample (Attachment KK). Audits will occur weekly for 8 weeks then monthly for 4 months until 100% compliance is achieved. Results of audits will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations.</p>	
-------	--	-------	---	--

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

PRINTED: 06/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 881	Continued From page 72 (DON) on 5/3/19 during the exit conference beginning at 11:15 AM.	F 881		
-------	--	-------	--	--



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
Page 1

NAME OF FACILITY: Seaford Center
May 3, 2019

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p> <p>3201.5.6</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from April 23, 2019 through May 3, 2019. The deficiencies contained in this report are based on interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred fourteen (114). The survey sample totaled eleven (11).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 3, 2019: F561, F606, F609, F625, F641, F656, F657, F688, F690, F692, F693, F695, F725, F757, F761, F791, F805, F812, F842,</p>	<p>Please see POC for F561, F606, F609, F625, F641, F656, F657, F688, F690, F692, F693, F695, F725, F757, F761, F791, F805, F812, F842, F881</p>	

Provider's Signature Doris Schumbrunner Title CEO Date 6/4/19



**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
Page 2**

**NAME OF FACILITY: Seaford Center
May 3, 2019**

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201.5.6.1</p> <p>3201.5.6.2</p>	<p>and F881. Dementia Training</p> <p>Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.</p> <p>The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview and review of other facility documentation it was determined that the facility failed to provide dementia specific training in the past year to four (E12, E18, E19 and E20) out of ten randomly selected healthcare providers reviewed. Findings include:</p> <p>4/24/19 (in the afternoon) - E24 (ADON) was provided with the Dementia Training form containing ten randomly selected direct healthcare providers to complete with the latest date of dementia training.</p> <p>4/30/19 (in the morning) - E2 (DON) returned the completed Dementia Training form stating, "It's not good." Review of the</p>	<p>A. All Center staff have dementia training assigned and available for completion in the Vital Learn system. Health Care Services Group and Genesis Rehab Services provide dementia training to their staff. Dementia training is provided to contract/agency staff to complete the first day of assignment. All staff will have the required dementia training by 6/10/19.</p> <p>B. All residents with dementia are at risk.</p> <p>C. A RCA for the deficient practice was completed. An Inconsistent NPE and lack of follow through with Vital Learn deadlines were identified as contributing factors. A new NPE started 5/20/19 and will track and ensure staff completion of assigned Vital Learn topics including dementia training. The NPE will receive web-based education to generate reports and assign topics in Vital Learn.</p> <p>D. The Center Nurse Executive/designee will audit contract/agency staff for completion of dementia training (Attachment A). Audits will occur weekly for 8 weeks, then monthly for 4 months until 100% compliance is achieved. Results of audits will be submitted to the Quality</p>	<p>6/10/19</p>

Provider's Signature Doris Schombrunner Title CED Date 6/4/19



**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
Page 4**

NAME OF FACILITY: Seaford Center
May 3, 2019

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>accordance with state regulations."</p> <p>Review of the Employee Tuberculosis (Mantoux) Screening revealed the following:</p> <p>1. E20 (CNA) was hired on 3/21/18. E20 had the first TST or PPD (Purified Protein Derivative) on 2/27/18 and the second on 4/19/18, more than 7 weeks after the first PPD.</p> <p>2. E21 (LPN) was hired on 2/6/18. E21 had the first PPD on 2/6/18 and the second PPD on 3/6/18, 4 weeks after the first PPD.</p> <p>E15 (Staff Education/Infection Control) was interviewed on 1/14/19 and she confirmed that E20 and E21 were given their second PPD's outside of CDC guidelines. E2 (DON) attended while the findings were reviewed.</p> <p>The facility failed to administer 2 step PPD's for 2 staff members in accordance with CDC guidelines of administering the second step PPD 1-3 weeks after the first PPD.</p>	<p>contracted employees.</p> <p>D. The Center Executive Director/designee will audit all new contract and center staff for completion of a 2-step TST screening or TB symptom surveillance (if history of TB exposure) (Attachment B). Audits will occur weekly for 8 weeks, then monthly for 4 months until 100% compliance is achieved. Results of audits will be reported to the Quality Assurance Performance Improvement Committee for review.</p>	

Provider's Signature Dois Schonbrunner Title CEO Date 6/4/19