STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 3, 2020 through March 5, 2020. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 117. The survey sample totaled seven (7). Abbreviations/Definitions used in this report are as following: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; CNA - Certified Nurse Aide; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 -15. 13-15: Cognitively Intact 08-12 Moderately Impaired 00-07 Severe Impairment; MDS (Minimum Data Set) assessment - standardized assessment form used in nursing homes; Alzheimers disease- brain disorder causing loss of memory, thinking abilities and memory; dementia- brain disorder with memory loss, poor judgement, personality changes, and disorientation or loss of mental functions such as memory and reasoning that interferes with a persons daily functioning, may or may not be Alzheimers related;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/27/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 2 or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 3 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure information was provided to the receiving provider for four (R1, R2, R3, and R5) out of four sampled residents investigated for hospitalizations. The facility failed to include resident care plan goals in the transfer/discharge information. Findings include: 1. Review of R1's clinical record revealed the following: 1/9/20 and 2/22/2020 - R1 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R1. 2. Review of R2's clinical record revealed the following: 11/17/2019 and 12/9/2019 - R2 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R2. 3. Review of R3's clinical record revealed the	F 622	A. Residents R1 and R5 have been readmitted to facility and have had no further hospital transfers since the survey on 3/5/2020. Care plans reviewed and remain appropriate. R2 unable to correct resident discharged on 12/9/19 from facility; R3 unable to correct resident discharged on 2/28/2020 from facility. B. Current residents with hospital transfers have the potential to be affected. Residents who transfers to an acute care facility, care plan goals will be sent with transfer. C. Root Cause Analysis (RCA) was completed on 3/19/2020. It was determined licensed nursing staff failed to follow the process of completing the pre-transfer checklist and documenting in Point Click Care that the Care Plan goals were sent with discharge information. Review of transfers was not being completed by Manager to verify that process was being followed. The pre-transfer checklist will be included in the admission paperwork packet and placed in the chart so it is readily available in the event of a discharge/transfer. All discharges will be reviewed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 4 following: 1/16/20 - R3 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R3. 4. Review of R5's clinical record revealed the following: 10/19/2019 - R5 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R5. During an interview on 3/5/2020 at approximately 1:30 PM, E1 (ED) confirmed the facility documentation lacked evidence that the required care plan goals accompanied the residents when transferring R1, R2, R3, and R5 to another provider. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/5/2020 during the exit conference beginning at 2:50 PM.	F 622	following shift and/or the Unit Manager to ensure the pre-transfer checklist was completed and the care plan goals were sent to the hospital. As a result of the RCA, the NPE/Designee will provide re-education on or before 4/14/2020 to all current licensed Nurses related to policy OPS404 (Attachment 1) and the pre-transfer checklist (Attachment 2) is completed and all required information is sent with transfer to the hospital. D. The Center Nurse Executive (CNE) or designee will complete audits (Attachment 3) on all discharges to hospital daily for 3 days until 100% compliance on three consecutive reviews, then weekly until 100% compliance on three consecutive reviews, then monthly until 100% compliance achieved for 3 consecutive reviews. Results of the audits will be presented to the QAPI Committee for review and recommendations.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 6 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 7 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for three (R1, R2, and R3) out of four sampled residents reviewed for hospitalization, the facility failed to provide written notice to the resident and/or the resident's representative of the resident's transfer or discharge to another facility. Findings include: 1. Review of R1's clinical record revealed: 2/22/2020 - R1 was transferred to the hospital. There was no evidence in the clinical record to indicate that a written notice was given to the resident or resident representative for R1. 2. Review of R2's clinical record revealed: 11/17/2019 and 12/9/2019 - R2 was transferred to the hospital. There was no evidence in the clinical record to indicate that a written notice was given to the resident or resident representative for R2. 3. Review of R3's clinical record revealed: 1/16/2020 - R3 was transferred to the hospital. There was no evidence in the clinical record to indicate that a written notice was given to the	F 623	A. R1 remains in the facility and has had no further hospital transfers since the survey on 3/5/2020. R2 unable to correct the resident discharged on 12/9/19 from facility; R3 unable to correct resident discharged on 2/28/2020 from facility. B. Current residents with hospital transfers have the potential to be affected. For any residents who transfers to an acute care facility, notice of hospital transfer will be documented and a copy of the notice sent with the transfer. C. A Root Cause Analysis (RCA) was completed on 3/19/2020. It was determined that the licensed nurses failed to utilize pre-transfer checklist resulting in omission of evidence in the record to indicate that the facility provided the resident/resident representative notification of discharge or discharge to another facility. The Notice of Transfer or Discharge was also being sent with patient and not given to appropriate departments at the center. The pre-transfer checklist (Attachment 2) will be included in the admission paperwork packet and placed in the chart so it is readily available in the event of a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 8 resident or resident representative for R3. During an interview on 3/5/2020 at approximately 1:30 PM, E1 (ED) confirmed the facility documentation lacked evidence that the facility provided written notice to the residents and/or the resident's representatives of the resident's transfer or discharge to another facility for R1, R2, and R3. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/5/2020 during the exit conference beginning at 2:50 PM.	F 623	discharge/transfer to the hospital. Discharges will be reviewed by the following shift and/or the Unit Manager to ensure the pre-transfer checklist was completed and written notice was provided to the resident/resident representative of the residents transfer or discharge to the hospital. As a result of the RCA the NPE/designee will provide re-education on or before 4/14/2020 to current licensed nurses related to policy OPS404 (Attachment 1) and the process to ensure pre-transfer checklist (Attachment 2) is completed and all required information is sent to hospital. D. The Center Nurse Executive (CNE) or designee will complete audits (Attachment 3) of all discharges to hospital daily for 3 days until 100% compliance on three consecutive reviews, then weekly until 100% compliance on three consecutive reviews, then monthly until 100% compliance achieved for 3 consecutive reviews. Results of the audits will be presented to the QAPI Committee for review and recommendations.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 9 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R1, R2 and R3) out of four sampled residents reviewed for hospitalization, the facility failed to provide written bed-hold notice to the resident and/or the resident's representative when R1, R2 and R3 were transferred to the hospital. Findings include: 1. Review of R1's clinical record revealed: 2/22/2020 - R1 was transferred to the hospital. There was no evidence in the record to indicate that the bed-hold notice was given to the resident or resident representative. 2. Review of R2's clinical record revealed:	F 625	A. R1 is a current resident of facility and has had no further hospital transfers since survey on 3/5/2020. R2 unable correct the resident discharged on 12/9/19 from facility; R3 unable to correct resident discharged on 2/28/2020 from facility. B. Current residents with hospital transfers have the potential to be affected. For any residents who transfer to an acute care facility, a copy of the Bed Hold Policy & Authorization form (Attachment 4) will be sent with transfer. C. A Root Cause Analysis (RCA) was completed on 3/19/2020. It was identified that licensed nursing staff failed to utilize discharge checklist resulting in omission of evidence in the record to indicate that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 10 11/17/2019 and 12/9/2019 - R2 was transferred to the hospital. There was no evidence in the record to indicate that the bed-hold notice was given to the resident or resident representative. 3. Review of R3's clinical record revealed: 1/16/20 - R3 was transferred to the hospital. There was no evidence in the record to indicate that the bed-hold notice was given to the resident or resident representative. During an interview on 3/5/2020 at approximately 1:30 PM, E1 (ED) confirmed that the bed-hold notice was not provided to the residents or the resident's representatives when R1, R2, and R3 were transferred to the hospital. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/5/2020 during the exit conference beginning at 2:50 PM.	F 625	the bed-hold policy was given to the resident/resident representative. The pre-transfer checklist (Attachment 2) will be included in the admission paperwork packet and placed in the chart so it is readily available in the event of a discharge/transfer to the hospital. Discharges will be reviewed by the following shift to ensure the checklist was completed and written notice was provided to the resident/resident representative of the residents transfer or discharge to another facility. The Business Office will make sure information is sent to Resident/Representative if not signed by the Resident at time of transfer. As a result of the RCA, the NPE/designee will re-educate on or before 4/14/2020 to all current licensed nurses and Business Office staff related to policy AR102 (Attachment 5) and Bed Hold Notice of Policy & Authorization form (Attachment 4) the updated process to ensure pre-transfer checklist (Attachment 2) is completed and all required information is sent to hospital. D. The Center Nurse Executive (CNE) or designee will complete audits (Attachment 3) on all discharges daily for 3 days until 100% compliance on three consecutive reviews, then weekly until 100% compliance on four consecutive reviews, then monthly until 100% compliance achieved for 3 consecutive reviews. Results of the audits will be presented to the QAPI Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for one (R1) out of three sampled residents reviewed for falls, the facility failed to complete neurological evaluations after a fall. Findings include: Review of R1's clinical record revealed: A Facility policy entitled Neurological Evaluation (last revised 1/31/2020) included: "Neurological evaluation will be performed as indicated or ordered. When a patient sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: - Every 15 minutes x two hours, then - Every 30 minutes x two hours, then - Every 60 minutes x four hours, then - Every eight (8) hours until at least 72 hours has elapsed." The standard of care in nursing home facilities includes: "A fall that is unwitnessed, or in which the head is struck, requires neurological checks. Any change	F 684	A. R1 has not had any falls since survey on 3/5/2020. B. Falls for current residents reviewed to determine appropriate neurological assessments are being completed per policy. C. A Root Cause Analysis was completed on 3/19/2020. It was identified that the licensed nursing staff continued to utilize the neurological assessment evaluation form from Policy NSG 204 prior to the update of policy on 1/31/2020. Center Nurse Executive removed all existing retired neurological assessment forms on 3/6/2020 and replace with the current form per policy NSG204 (Attachment 6). As a result of the RCA, the NPE/designee will re-educate on or before 4/14/2020 all current license Nurses related to updated policy NSG204 (Attachment 6) to ensure the correct neurological assessment form is being utilized after a fall. D. Center Nurse Executive or designee	4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 in resident condition requires a phone call to the primary care physician. (The assessments should include): Initial assessment (baseline); followed by q15 min x 4; q30 min x 2; every hour x 2; once per shift for 72 hours." (https://healthinsight.org/Internal/assets/Nursing Home/FALLS-PR - Post fall 72 hour...) 2/16/2020 6:55 PM - A facility event summary for an unwitnessed fall included: "This nurse and his (R1's) primary nurse were notified patient found on floor. Patient sitting up with back against bed, legs in front of him, abductor pillow was in place. Patient removed from the floor via Hoyer (hydraulic) lift per facility policy. Vital signs obtained. MD called." 2/16/2020 7:00 PM - R1's neurological evaluations were initiated. For the following dates and times R1's neurological evaluation flowsheet lacked evidence of a neurological assessment: 2/16/2020 11:05 PM; 2/17/2020 11:05 AM; 2/17/2020 7:00 PM; 2/18/2020 3:00 AM; 2/18/2020 11:00 AM; 2/18/2020 7:00PM; 2/19/2020 3:00 AM; 2/19/2020 11:00 AM; and 2/19/2020 7:00 PM. During an interview on 3/4/2020 at approximately 1:00 PM E3 (ADON) confirmed that R1's neurological assessments from the 2/16/2020 fall were incomplete, and that R1's clinical record (including nursing progress notes) lacked evidence that every 8-hour neurological assessments were completed for 72 hours after R1 sustained a fall.	F 684	will complete an audit (Attachment 7) on falls to ensure all indicated or ordered neurological assessments are complete daily for 3 days until 100% compliance on three consecutive reviews, then weekly until 100% compliance on three consecutive reviews, then monthly until 100% compliance achieved for 3 consecutive reviews. Results of the audits will be presented to the QAPI Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/5/2020 during the exit conference beginning at 2:50 PM.	F 684		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726		4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 14 Based on interview and review of other facility documentation it was determined that the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through the facility assessment. The facility failed to ensure that training was conducted with licensed nursing staff on post-transfusion assessment of potential complications and the facility's policy on blood transfusions. Findings include: 1/4/16 (effective date) and 8/27/19 (effective date) - The facility's contracts with the vendor that administers the transfusions in the facility included that the vendor will provide any necessary in-servicing and/or training to facility staff prior to the first transfusion. 11/1/19 (revision from the effective date 5/1/19) - The facility's policy entitled "Blood/Blood Product Transfusion Provided by [vendor]" included that: - "[Vendor] RN will verify blood product to be transfused against the patient's identification band and the Center RN will verify identification of patient with patient identification band to verify dual nurse verification and document on the "Dual Nurse Verification form." (This form includes visual inspection of the blood product/bag and expiration date.) - Post-Transfusion the Center licensed nurse will: "Receives the 'Post Transfusion Vital Signs Form' and signs as understanding of the instructions; Observes the patient hourly for an additional five hours; Documents vital signs on the 'Post Transfusion Vital Signs Form'; Submits completed 'Post Transfusion Vital Signs Form' to [vendor]." - In the event of a transfusion related incident during or within one-hour post-transfusion the,	F 726	A. Facility has not had a resident receiving blood transfusion since last day of survey 3/5/2020. B. Current residents have the potential to be affected. No blood transfusions have been conducted at the facility since survey 3/5/2020. C. A Root Cause Analysis (RCA) was completed on 3/19/2020. It was identified that there was no documentation that training was conducted with the licensed nurses on post-transfusion assessment of potential complications and facility policy on blood transfusions. As a result of the RCA, the NPE/ designee will educate on or before 4/14/2020 on NSG267 Blood/Blood Product Transfusion Provided by Advanced PICC Specialists, Inc. APS (Attachment 8). D. Center Nurse Executive or designee will complete audits (Attachment 9) on all Blood transfusion events for the next three months. Results of the audits will be presented to the QAPI Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 15	F 726		

Center licensed nurse will: "Document emergency protocol and/or additional physician orders; Communicate updates with patient representative."
- In the event of a transfusion related incident after the vendor nurse has left the Center, the Center licensed nurse will: "Immediately notify the patient's physician/[nurse practitioner] ...and the [vendor] RN ...; Notify the patient representative; Document notifications and orders."
- "For ten days post-transfusion, Center licensed nurse monitors patient for signs of transfusion associated graft vs host disease (TA-GVHD) and notifies patient's physician, patient representative and [vendor] upon suspicion of TA-GVHD; Document signs of TA-GVHD, treatment, effectiveness and notifications in the patient's medical record."

12/19/19 - The Facility Assessment contained a section entitled "Special Treatments and Conditions" included that the facility provides an average of one transfusion a month. The section entitled "Staff Training/Education and Competencies" did not include training on transfusions.

3/4/2020 2:20 PM - During an interview, E4 (Nurse Educator) stated that the facility has no record of education being provided to their nurses on transfusions. E4 added that the contracted vendor's nurse administers the transfusions and monitors the resident for one hour after the transfusion; then, the facility nurses only take the resident's vital signs once an hour for the next five hours.

3/5/2020 8:30 AM - During an interview, E1 (NHA) stated that since 1/16/19 residents have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 16 received seven transfusions in the facility, but is not aware of any education provided to the nurses except on the spot report from the vendor's nurse after the transfusion is complete. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/5/2020 during the exit conference beginning at 2:50 PM.	F 726		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, review of cited deficiencies from the facility's annual survey of 6/25/19 and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. Findings include: During the QAPI interview on 3/5/2020 at 2:40 PM with E1 (NHA), E2 (DON) and E3 (ADON) it was confirmed that the team meets at least quarterly and meetings include the required meeting members. During the same interview, E1 was made aware that the survey team identified deficiencies in the following areas: Transfer and Discharge Requirements, Notice Requirements Before Transfer/Discharge and Notice of Bed Hold Policy Before/Upon Transfer.	F 867	A. Cross refer to F622, F623, F625 for resolution and residents affected. B. Cross refer to F622, F623, F625 for resolution on other residents affected. C. A QAPI Committee completed a Root Cause Analysis on 3/23/2020 to identify underlying causes for audits not being completed for identified areas of concern in the monthly QAPI meetings. If data from audits determines issues or concerns then the process will need re-evaluated and new action plan to be developed. As a result of the RCA, a form was developed to use at QAPI meetings to track audits for areas of concern identified (Attachment 10). Education will be completed on or before 4/14/2020 by the Center Executive	4/14/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 17 Review of the facility's 6/25/19 annual survey identified deficiencies were cited for: Transfer and Discharge Requirements, Notice Requirements Before Transfer/Discharge and Notice of Bed Hold Policy Before/Upon Transfer. 1. Transfer and Discharge Requirements - The facility's plan of correction for a deficiency regarding Transfer and Discharge Requirements cited during the 6/25/19 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability. The results of the current survey cited under F622 revealed that the QAPI committee was ineffective in correcting this deficient practice. 2. Notice Requirements Before Transfer/Discharge - The facility's plan of correction for a deficiency regarding Notice Requirements Before Transfer/Discharge cited during the 6/25/19 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability. The results of the current survey cited under F623 revealed that the QAPI committee was ineffective in correcting this deficient practice. 3. Notice of Bed Hold Policy Before/Upon Transfer - The facility's plan of correction for a deficiency regarding Notice of Bed Hold Policy Before/Upon Transfer cited during the 6/25/19 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability.	F 867	Director or designee with QAPI Committee members regarding the policy for QAPI in the center and the importance of monitoring quality assessment and assurance activities to ascertain compliance, which includes use of audit tools. The Committee will identify and prioritize areas that need improvement, assign improvement teams, audit and track progress, and make recommendations as needed for sustained improvement. D. The Center Executive Director/designee will meet weekly with QAPI committee for 4 weeks to discuss the survey plan of correction action plans, review audits, and determine if revisions are needed to the action plans. The QAPI Committee will then meet monthly to review and monitor ongoing quality improvement activities, which includes discussion of audit results, as well as continued changes in action plans to achieve sustainable improvement. The QAPI Improvement Activities audit Tool (attachment 11) will be utilized for the next 6 months for compliance with monitoring quality assessment and assurance. Results of all audit tools will be presented to the QAPI Committee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 03/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 18 The results of the current survey cited under F625 revealed that the QAPI committee was ineffective in correcting this deficient practice. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/5/2020 during the exit conference beginning at 2:50 PM.	F 867		

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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: March 5, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from March 3, 2020through March 5, 2020. 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).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 5, 2020: F697.	Cross Refer CMS 2567-L F622, F623, F625, F684, F726, and F867	4/14/2020

Provider's Signature Shirley M Shafer Title CED Date 3/27/2020