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

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

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: April 26, 2023

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 on April 21, 2023 through April 26, 2023. The deficiencies contained in this report are based on interviews, review of residents' clinical records, and review of other facility documentation records as indicated. The facility census the first day of the survey was 123. The survey sample size was fourteen (14) residents.	F609 A. Residents R7 and R8 remain in the facility. Due to cognitive impairment, the residents are unable to be interviewed, however staff have not reported any other allegations of abuse. The facility was unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 4/26/2023 determined the need for education for all staff on the Abuse Prohibition policy. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on reporting abuse immediately to protect other residents by 5/26/2023. D. Director of Nursing/Designee will audit (Attachment A) 100% of reported abuse allegations weekly for 3 weeks until 100% compliance achieved, then monthly for 3 months until 100% compliance achieved, and then quarterly for 2 quarters until 100% compliance is achieved to determine if OPS 300 policy has been followed and the event was reported within the 2 hour timeframe per regulation. Results of audits will be presented to the QAPI committee for review.	06/26/2023
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 April 26, 2023: F609, F610, F868.		

Provider's Signature Patricia Baker Title LNHA Date 5/31/23

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		F610 A. Residents R1, R2, R7 and R8 remain in the facility. R1 was interviewed on 4/26/2023 and has not reported any other allegations of abuse. Due to cognitive impairment, R7 & R8 are unable to be interviewed, however staff have not reported any other allegations of abuse The facility was unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 4/26/2023 determined the facility requires additional education for all staff on the Abuse Prohibition policy and for all management staff on completing investigations. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on accurately identifying abuse and placing immediate appropriate interventions, as well as, educating management on the significance of thorough investigation by 5/26/2023. D. Director of Nursing/Designee will audit (Attachment B) 100% of reported abuse allegations weekly for 3 weeks until 100% compliance achieved, then monthly for 3 months until 100% compliance achieved, and then quarterly for 2 quarters until 100% compliance is achieved to determine if OPS 300 policy has been followed, appropriate interventions put in place, and allegations inves-	

Provider's Signature Patrick Baker Title LNHA Date 5/3/23

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: April 26, 2023

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		tigated thoroughly. Results of audits will be presented to the QAPI committee for review. **F868** A. E1 nor appointed representative was present during the 8/25/2022 QAPI meeting. The facility is unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of QAPI meeting attendance logs to ensure all required members were in attendance. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 4/26/2023 determined the facility management staff need additional education on the requirements of QAPI attendance. The Nurse Practice Educator/Designee will re-educate all current members of management on OPS103 Center Quality Assurance Performance Improvement Process policy, as well as ensure if the NHA or other required member cannot be present an appropriate designee/representative is identified on the sign in sheet. D. Director of Nursing/Designee will audit (Attachment C) 100% of QAPI attendance logs monthly for 3 months until 100% compliance achieved, then quarterly for 3 quarters until 100% compliance achieved. Results of audits will be presented to the QAPI committee for review.	

Provider's Signature Patrick Baker Title LNHA Date 5/31/23

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 04/26/2023

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 beginning April 21, 2023 and ending April 26, 2023. 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 on the entrance day of the survey was 123 residents. The investigative sample totaled 14. Abbreviations/definitions used in this report are as follows: ADON- Assistant Director of Nursing; CNA - Certified Nurse's Aide; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; 1:1 Supervision - one staff person assigned direct supervision of a resident Abrasion - wearing away of the skin through some mechanical process (friction or trauma) OR superficial wound caused by rubbing or scraping the skin; Bruise - injury causing rupture of underlying blood vessels with resultant discoloration SBAR (Situation Background Assessment Recommendation) - tool used to communicate between members of the health care team.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		7/26/23

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

Electronically Signed | 05/16/2023

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

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F 609	Continued From page 1 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 interview and review of other facility documentation, it was determined that for one (R8) out of six residents reviewed for abuse, the facility failed to identify an allegation of physical abuse for a resident to resident and immediately report within two hours. Findings include: Cross refer: F610 10/14/22 - R8 was admitted to the facility. 3/14/23 10:17 AM - A progress note documented that R8 received a skin check and the following areas were identified: a bruise to the posterior left	F 609	A. Residents R7 and R8 remain in the facility. Due to cognitive impairment, the residents are unable to be interviewed, however staff have not reported any other allegations of abuse. The facility was unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an	

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F 609	Continued From page 2 hand, a bruise to the right side of bottom lip, and an abrasion noted to tip of nose. 3/14/23 11:24 AM - An incident report was submitted to the State Agency for an allegation of resident to resident abuse. 3/14/23 1:45 PM - A progress note documented that R8 got into a physical altercation with another resident. They were separated by staff and staff would continue to monitor. 3/14/23 2:35 PM - A progress note documented that R8's family was notified of the incident with R7 and the injuries sustained. 4/26/23 11:45 AM - An interview with E12 (Dementia Program Director) revealed that she was trying to separate R7 from R8 and to encourage R7 to come out of R8's room. Additionally, E12 confirmed that R7 and R8 had a resident to resident Physical altercation on 3/13/23 and recognized that to be an allegation of resident to resident abuse. 4/26/23 3:15 PM - E2 (ADON) confirmed that the facility failed to report the incident within the two-hour time frame and stated that the facility was at fault. The facility failed to report an allegation of resident to resident abuse to the State Agency within two hours. Findings were reviewed with E1 (NHA) and E2 during the Exit Conference on 4/26/23 beginning at approximately 3:15 PM.	F 609	interdisciplinary team on 4/26/2023 determined the need for education for all staff on the Abuse Prohibition policy. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on reporting abuse immediately to protect other residents by 5/26/2023. D. Director of Nursing/Designee will audit (Attachment A) 100% of reported abuse allegations weekly for 3 weeks until 100% compliance achieved, then monthly for 3 months until 100% compliance achieved, and then quarterly for 2 quarters until 100% compliance is achieved to determine if OPS 300 policy has been followed and the event was reported within the 2 hour timeframe per regulation. Results of audits will be presented to the QAPI committee for review.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		7/26/23

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F 610	Continued From page 3 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 interview, record review, and review of other facility documentation as indicated, it was determined that for one (R2) out of six residents reviewed for abuse, the facility failed to have evidence of thorough investigation. In addition, for one (R8) out of six residents reviewed for abuse, the facility failed to immediately put measures in place to prevent further potential abuse. Findings include: Review of the facility's Policy and Procedure titled OPS 300 Abuse Prohibition with a revision date of 10/24/22 stated, "...7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: ...7.7.1 whether abuse or neglect occurred and to what extent;...7.8 The investigation will be thoroughly	F 610	A. Residents R1, R2, R7 and R8 remain in the facility. R1 was interviewed on 4/26/2023 and has not reported any other allegations of abuse. Due to cognitive impairment, R7 & R8 are unable to be interviewed, however staff have not reported any other allegations of abuse The facility was unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of abuse allegations. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 4/26/2023	

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F 610	Continued From page 4 documented...Ensure that documentation of witnessed interviews is (sic) included...9. The Administrator or designee will...9.2 Report findings of all completed investigations withine five (5) working days to the Department of Health [State Agency]...". Cross refer: F609 1. Review of R8's clinical records revealed the following: 10/14/22 - R8 was admitted to the facility. 3/14/23 11:24 AM - An incident report was submitted to the State Agency for physical altercation that occurred on 3/13/23. 3/14/23 11:30 AM - A review of the clinical record revealed that R7 was placed on continuous one-on-one monitoring for behaviors. 3/14/23 1:45 PM - A progress note documented that R8 got into a physical altercation with R7. They were separated by staff and staff would continue to monitor. 4/26/23 11:45 AM - An interview with E12 (Dementia Program Director) revealed that she was trying to separate R7 from R8 and to encourage R7 to come out of R8's room. Additionally, E12 confirmed that R7 and R8 had a resident to resident Physical altercation on 3/13/23 and recognized that to be an allegation of resident to resident abuse. The facility failed to protect R8 from R7 for approximately 20.5 hours until the one on one (1:1) continuous supervision was initiated for R7.	F 610	determined the facility requires additional education for all staff on the Abuse Prohibition policy and for all management staff on completing investigations. The Nurse Practice Educator/Designee will re-educate all current staff in all departments on OPS 300 Abuse Prohibition with a focus on accurately identifying abuse and placing immediate appropriate interventions, as well as, educating management on the significance of thorough investigation by 5/26/2023. D. Director of Nursing/Designee will audit (Attachment B) 100% of reported abuse allegations weekly for 3 weeks until 100% compliance achieved, then monthly for 3 months until 100% compliance achieved, and then quarterly for 2 quarters until 100% compliance is achieved to determine if OPS 300 policy has been followed, appropriate interventions put in place, and allegations investigated thoroughly. Results of audits will be presented to the QAPI committee for review.	

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F 610	Continued From page 5 4/26/23 1:45 PM - An interview with E1 (NHA) and E2 (ADON) confirmed that E7 was started on 1:1 continuous supervision on 3/14/23 at 11:30 AM, which was approximately 20.5 hours after the incident. 2. Review of R2's clinical records revealed the following: 1/10/23 - R2 was admitted to the facility. 4/18/23 3:00 PM - The facility reported an allegation of sexual abuse to the State Agency. 4/18/23 - Review of the facility's incident report revealed that R2 alledged that R1 touched R2 inappropriately three times since 2/14/23 and there were no staff present at the time of stated allegations. 4/24/23 - Review of the 5 day follow-up from the facility sent to the State Agency stated "...Root Cause Analysis:...The resident is alleging that another resident touched her inappropriately three times in her room since February 14, 2023. No staff present in the resident room at the time of stated allegation...Result of Investigation: Upon thorough investigation which included review of the medical record, observations, record reviews, and statements from other residents, the allegation of physical abuse has been unsubstantiated related to lack of evidence and lack of witnesses...". 4/24/23 - Review of the facility's incident investigation lacked evidence of statements from staff that provided care to R1 and R2 on 2/14/23. The date that R1 reported she was	F 610		

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F 610	Continued From page 6 inappropriately touched. 4/25/23 1:00 PM - An interview with E2 (ADON), with the presence of E1 (NHA) and E4 (SA) that E2 confirmed that while investigating the above allegation, staff who were assigned to R1 and R2 on 2/14/23 were not interviewed and/or statements obtained, thus, not incorporated into the investigation despite the fact on 4/24/23 the facility reported to the State Agency that allegation was unsubstantiated. 4/25/23 3:20 PM - The Surveyor was provided three written interview statements from E1 (NHA), one dated 4/24/23 and two were dated 4/25/23. There was lack of evidence that the facility thoroughly investigated the allegation of sexual abuse verbalized by R2. Findings were reviewed with E1 (NHA), E2 (ADON), and E4 (SA) during the Exit Conference on 4/26/23 beginning at approximately 3:15 PM.	F 610		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist.	F 868		7/26/23

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F 868	Continued From page 7 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure attendance of required members at the Quality Assurance Performance Improvement (QAPI) quarterly meetings. Findings include: The facility QAPI plan, last updated 10/24/22, indicated,"...Meeting at a minimum on a quarterly basis... E1 (NHA) administrator, owner/board member other leader." 4/25/23 - Review of the facility quarterly QAPI meeting sign in sheets revealed that during the	F 868	A. E1 nor appointed representative was present during the 8/25/2022 QAPI meeting. The facility is unable to correct action. B. The Director of Nursing completed the initial audit of the last 6 months of QAPI meeting attendance logs to ensure all required members were in attendance. All current residents have the potential to be affected by alleged deficient practice. C. Root Cause Analysis completed by an interdisciplinary team on 4/26/2023	

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F 868	Continued From page 8 8/25/22 meeting all required members were not present. The facility administrator, an owner or a board member was not present. 4/26/23 - 1:45 PM - An interview with E1 and E2 (ADON) confirmed that the NHA was not present and nor was another representative present on his/her behalf at the 8/25/22 quarterly QAPI meeting. Findings were reviewed with E1 and E2 during the the Exit Conference on 4/26/23 beginning at approximately 3:15 PM.	F 868	determined the facility management staff need additional education on the requirements of QAPI attendance. The Nurse Practice Educator/Designee will re-educate all current members of management on OPS103 Center Quality Assurance Performance Improvement Process policy, as well as ensure if the NHA or other required member cannot be present an appropriate designee/representative is identified on the sign in sheet. D. Director of Nursing/Designee will audit (Attachment C) 100% of QAPI attendance logs monthly for 3 months until 100% compliance achieved, then quarterly for 3 quarters until 100% compliance achieved. Results of audits will be presented to the QAPI committee for review.	