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 August 11, 2021

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 August 6, 2021 through August 11, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 109. The survey sample totaled eight (8) residents.		
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 was not met as evidenced by:		
	Cross Refer to the CMS 2567 – L survey completed August 11, 2021: F550 and F657.		

Provider's Signature ______________ Title ______________ Date ______________

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 08/11/2021

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 August 6, 2021 through August 11, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 109. The survey sample totaled eight (8) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; UM - Unit Manager; ADL (activities of daily living) - tasks needed for daily living, such as dressing, hygiene, eating, toileting, bathing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15 13-15: Cognitively intact (able to make own decisions) 8-12: Moderately impaired (decisions poor, cues / supervision required) 0-07: Severe impairment (unable to make own decisions); IDT - interdisciplinary team; MDS (Minimum Data Set) - standardized assessment used in nursing homes.	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		8/31/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/26/2021

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 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550		

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to ensure care was provided in a way that promoted dignity during dining for one (R4) out of five residents sampled for investigations. Findings include: A review of R4's clinical record revealed: 7/1/20 - R4 was admitted to the facility for long term care. 7/1/20 (latest revision 7/2/21) - R4 has a care plan for needing assistance / dependent for ADL (activities of daily living) care, including dressing and eating. 6/12/21 - A quarterly MDS (Minimum Data Set) Assessment documented that R4 needed extensive assistance from one person (staff) for eating. 8/6/2021 1:00 PM - E4 (CNA) was observed taking a lunch tray into R4's room and placing it on his over bed table. E4 opened the milk carton, but there was no drinking cup or glass on the tray to pour the milk into. E4 then left the room. R4 was reclining in bed with the head of the bed up approximately 70 degrees and his hands under the sheet. 8/6/21 1:10 PM - E4 (CNA) came back into R4's room and started feeding him. E4 stated that R4 can feed himself while putting the milk carton in	F 550	A)R4 was provided with a drinking cup to pour milk into from carton B)All residents who receive fluid products in cartons present on meal trays have the potential to be affected by the lack of a drinking cup to pour fluid product into. C)Dietary Director given direction by Center Executive Director to provide drinking cups on trays containing fluid filled cartons. Dietary Director will educate all current dietary staff to provide drinking cups on trays containing fluid filled cartons (Attachment A). All current nursing staff will be provided education by Nurse Practice Educator/Designee that all residents who receive fluid filled products in cartons on meal trays must have a drinking cup and all fluid filled cartons must be poured into drinking cup as resident will allow (Attachment A). D)The Center Executive Director/Designee will audit 10% of meal trays prior to delivery to the unit to ensure placement of drinking cup on meal trays with fluid filled cartons. Center Nurse Executive/Designee will audit 10% of meal trays during meal service to ensure fluid has been poured into provided drinking cup. Audits will occur daily x3 days until 100% compliance achieved, then 3 times per week for 3 weeks until 100%	

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F 550	Continued From page 3 R4's left hand and moving his hand to pour milk from the carton into his mouth. When asked by the surveyor, why there was not a glass to pour the milk in, E4 said "I can go get one if you want." 8/6/21 1:30 PM - During an interview and observation, E5 (RN, Unit Manager) confirmed that R4 was being fed milk directly from a carton. 8/11/21 4:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F 550	compliance achieved, then weekly x 3 weeks until 100% compliance achieved, monthly x 3 until 100% compliance achieved (Attachment B). Results of all audits will be presented at the quality and performance improvement monthly meetings for review and recommendations.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		8/31/21

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F 657	Continued From page 4 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R3 and R4) out of five sampled residents for care plan review, the facility failed to ensure that all required members of the Interdisciplinary Team (IDT) participated in, or provided input into, the formation of resident's care plans. Findings include: 1. The following was reviewed in R3's clinical record: 3/12/19 - R3 was admitted to the facility. 2/17/21 1:26 PM - A care conference note documented that only E13 (Dementia Program Director), E6 (SW), and E5 (RN, UM) were present with two family members on the phone. The facility lacked evidence that the following disciplines provided input into the 2/17/21 care plan: nurse's aide with responsibility for the resident, activities, attending physician or designee, and a member of nutrition services staff. 2. A review of R4's clinical record revealed: 7/1/20 - R4 was admitted to the facility for long term care. 6/17/21 10:23 AM - A care conference note documented that only E14 (Palliative Care NP), E12 (Activities), E7 (SW), and E5 (RN, UM) were	F 657	A)Resident R3 no longer is a resident at the facility. Resident R4 unable to revise documentation of care conference note from 2/17/21 due to time lapse. B) All residents have the potential to be affected by a lack of participation or input from the required members of the interdisciplinary team during the care conference meeting C) Review of current process highlighted lack of documentation to support involvement of all members of the interdisciplinary team. The Center Nurse Executive/Designee will provide education to social services director and social services assistant on the new procedure for proper documentation to evidence the participation and/or input of required members of the interdisciplinary team during care conference meetings. (Attachment C). D) The Center Nurse Executive/Designee will audit all care conference meeting documentation weekly x3 weeks until 100% compliant, monthly x 3 months until 100% compliant (Attachment D). Results of all audits will be presented at the quality and performance improvement monthly meetings for review and	

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F 657	Continued From page 5 present. The facility lacked evidence that the following disciplines provided input into the 6/17/21 care plan: nurse's aide with responsibility for the resident, attending physician or designee, and a member of nutrition services staff. 8/11/21 10:35 AM - During an interview, when asked how the CNA's, nurses and attending physician or designee provide input into the residents' care plan, E7 (SW) replied that E5 (RN, UM) speaks for them in the care plan conference. 8/11/21 12:03 PM - During an interview, E5 (RN, UM) stated that before a care plan conference she checks with the CNA's and nurses for updates, and that usually the CNA's come to her with any changes. In addition, E5 stated he/she reviews the physician orders, skin checks, intakes, weights, and ADL (activities of daily living) documentation for changes in the past quarter, but the dietician does not attend the care plan conferences. 8/11/21 1:30 PM - During an interview, when asked how the CNA's provide input into the residents' care plan, E9 (CNA) said there is a form that the nurse who does the functional assessments asks her to fill out the first page, but she does not go to the care plan meetings and does not remember being asked about residents for the care plans. When specifically asked, E9 stated that she tells the nurses about changes or needs in residents when they occur. 8/11/21 1:35 PM - During an interview, when asked how the CNA's provide input into the residents' care plan, E10 (CNA) said she does	F 657	recommendations.	

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F 657	Continued From page 6 not, but she would really like to be able to attend the care plan meetings. 8/11/21 1:45 PM - During an interview, when asked how the CNA's provide input into the residents' care plan, E11 (CNA) said she is updated with changes after the care plan meetings by E15 (Nurse Educator) and she completes "Stop Cards" when there are changes in a resident. 8/11/21 1:50 PM - During an interview, E8 (Staff RN) stated that she talks to the other disciplines all the time about updates, like the therapists and dietician, but she would like to attend the care plan meetings and provide information about her patients. 8/11/21 4:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F 657		