DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: April 22, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Follow-up and Complaint Survey to the Complaint Survey ending February 27th, 2024, was conducted by the State of Delaware Division of Heath Care Quality, Office of Long-Term Care Residents Protection from April 18th through April 22, 2024. The deficiencies in this report are based on observations, interviews, record reviews and other facility documentation as indicated. The facility census on the first day of the survey was one hundred and fifteen (115). The survey sample totaled eighteen (18) residents.	F641 Resident 16 MDS 3/08/2024 was modified to reflect the correct documentation in section J1800 and resubmitted on 4/22/2024
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	Current residents have the potential to be affected by the deficient practice. MDS documentation submitted within the last 30 days was audited on 4/29/2024 to ensure section J1800 was coded correctly, no further errors noted.
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.**	Root cause analysis determined the need for re-education to current MDS coordinators related to where to locate most recent fall documentation in PCC to ensure accurate MDS coding in section J1800. Regional MDS coordinator will provide re-education to current MDS staff at the Milford center and to regional staff who assist the Milford Center with MDS coding on how to obtain the information to correctly code section J1800 in the MDS.
	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed April 22, 2024: cross refer: F641 and F677.	Regional MDS Director/designee will audit MDS section J1800 monthly x 3 months or until 100% compliant to ensure correct coding of section J1800. Results of the audits will be presented at the center's monthly QAPI meeting for review.

Provider's Signature Karen Hurst Title ADMINISTRATOR Date 5/31/24

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		F677 Resident R17 was immediately assessed and provided care Current dependent residents in E18 assignment have the potential to be affected by the deficient practice. Residents in E18 assignment were immediately assessed to ensure care was provided no further identified areas of concern as a result of this audit. Root Cause analysis determined E18 did not provide care because she assumed that because the resident had an indwelling catheter that he did not require frequent changing. NPE/designee will re-educate current nursing aides on Quality of Care with focus on providing ADL care timely to current residents including those who require indwelling catheters. Director of Nursing/designee will perform random observations and interviews of those residents who are dependent for care including those with indwelling catheter to ensure timely care is being provided these audits will be conducted 3 times a week x 2 weeks or until 100% compliant then weekly x 2 weeks or until 100% compliant then Monthly x 2 months or until 100% compliant. Results of the audits will be presented at the monthly QAPI meeting for review

Provider's Signature Karen Mum Title ADMINISTRATOR Date 5/3/24

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 _____	R-C 04/22/2024

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 Follow-up and Complaint Survey to the Complaint Survey ending February 27th, 2024, was conducted by the State of Delaware Division of Heath Care Quality, Office of Long Term Care Residents Protection from April 18th through April 22th, 2024. The deficiencies in this report are based on observations, interviews, record reviews and other facility documentation as indicated. The facility census on the first day of the survey was one hundred and fifteen (115). The survey sample totaled eighteen (18) residents. Abbreviations/definitions used in the report are as follows: ADL - Activity of Daily Living; DON - Director of Nursing; FNP - Family Nurse Practitioner; MDS - Minimum Data Set; NHA - Nursing Home Administrator; OBRA - Omnibus budget reconciliation act; PPS - Prospective Payment System; RT - Respiratory Therapist. Diarrhea - liquid or semi-liquid stool; Emesis - vomit; Febrile - having a fever; KUB - kidney, ureter, and bladder X-ray(s); Lethargic - abnormal drowsiness; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Omnibus budget reconciliation act (OBRA): A law made by the government that has many different rules in it. It helps to make sure that the government spends money the way it said it would;	{F 000}		

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

Electronically Signed | 05/02/2024

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

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{F 000}	Continued From page 1 Prospective Payment System (PPS) - MDS assessment used in Long Term Care facilities which sets payment levels based on services being provided; Pulse oximetry - measures amount of oxygen in the blood; Vital signs - clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure that indicate the state of a patient's essential body functions; X-ray - pictures taken of bones or organs.	{F 000}		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R16) out of three residents reviewed for falls, the facility failed to ensure accuracy of the MDS assessment. Findings include: Review of R16's clinical record revealed: 3/25/21 - R16 was admitted to the facility. 2/15/24 - A nursing progress note documented that R16 had a fall without any injury. 3/8/24 - An annual MDS assessment for R16 documented, "Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent?" The facility answered "No."	F 641	Resident 16 MDS 3/08/2024 was modified to reflect the correct documentation in section J1800 and resubmitted on 4/22/2024 Current residents have the potential to be affected by the deficient practice. MDS documentation submitted within the last 30 days was audited on 4/29/2024 to ensure section J1800 was coded correctly, no further errors noted. Root cause analysis determined the need for re-education to current MDS coordinators related to where to locate most recent fall documentation in PCC to ensure accurate MDS coding in section J1800. Regional MDS coordinator will provide	5/6/24

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F 641	Continued From page 2 4/22/24 3:26 PM - During an interview E17 (MDS coordinator) confirmed that the MDS should have documented "yes" for the question related to any falls since admission because the resident has a history of falls and she fell on 2/15/24. E17 stated we can go in and fix that. These findings were reviewed during the exit conference on 4/22/24 at 3:40 PM with E1 (NHA), E2 (DON) and E16 (Regional Nurse Consultant).	F 641	re-education to current MDS staff at the Milford center and to regional staff who assist the Milford Center with MDS coding on how to obtain the information to correctly code section J1800 in the MDS. Regional MDS Director/designee will audit MDS section J1800 monthly x 3 months or until 100% compliant to ensure correct coding of section J1800. Results of the audits will be presented at the center's monthly QAPI meeting for review.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R17) out of one resident reviewed for ADLs, the facility failed to ensure ADLs were provided to dependent residents. Findings include: Review of R17's record revealed: 3/7/24 - R17 was admitted to the facility. 3/13/24 - An admission MDS revealed that R17 is cognitively intact. R17 required substantial or maximum assist by one person for toileting, shower/bath, hygiene, and rolling side to side. The MDS revealed that R17 had an indwelling catheter in place and was always incontinent of bowel.	F 677	Resident R17 was immediately assessed and provided care Current dependent residents in E18 assignment have the potential to be affected by the deficient practice. Residents in E18 assignment were immediately assessed to ensure care was provided no further identified areas of concern as a result of this audit. Root Cause analysis determined E18 did not provide care because she assumed that because the resident had an indwelling catheter that he did not require frequent changing. NPE/designee will re-educate current nursing aides on	5/6/24

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F 677	Continued From page 3 4/16/24 7:00 AM to 3:00 PM - A review of R17's CNA task flow sheet revealed that E15 (CNA) documented R17 as dependent "response not required for bowel continence." The task sheet also revealed that R17 did not receive assistance with dressing, hygiene, or toileting. 4/16/24 - A facility incident report revealed that R17 reported he was not provided care on 4/16/24 during the day shift. 4/16/24 5:14 PM - A facility investigative packet revealed that E15 confirmed that care was not completed for R17 on 4/16/24 due to "[R17] stated he was ok and gets agitated when we bother him for care." 4/16/24 5:48 PM - A facility investigative packet revealed that E18 (UM) answered the call bell approximately 1 or 1:30 pm for R17 and was informed that R17 "... was waiting to be cleaned up." During the evening shift (3-11) staff reported to E18 that R17 "... did not receive care and had a large bowel movement." 4/19/24 9:15 AM - An interview with R17 confirmed he did not receive care on 4/16/24 and confirmed he did not refuse care. 4/19/24 10:00 AM - An interview with E18 confirmed that E15 was told that R17 needed care on 4/16/24 and documentation lacked evidence care was completed. 4/19/24 10:36 AM - An interview with E2 (DON) confirmed that E15 did not provide care to R17 on 4/16/24. E2 confirmed that E15 was on administrative leave pending investigation.	F 677	Quality of Care with focus on providing ADL care timely to current residents including those who require indwelling catheters. Director of Nursing/designee will perform random observations and interviews of those residents who are dependent for care including those with indwelling catheter to ensure timely care is being provided these audits will be conducted 3 times a week x 2 weeks or until 100% compliant then weekly x 2 weeks or until 100% compliant then Monthly x 2 months or until 100% compliant. Results of the audits will be presented at the monthly QAPI meeting for review	

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F 677	Continued From page 4 The facility failed to ensure ADLs were provided to a dependent resident. 4/19/24 2:30 PM - Findings reviewed with E1 (NHA), E2 (DON) and E13 (Corporate) during the exit conference.	F 677		