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: Millcroft **DATE SURVEY COMPLETED: September 13, 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 COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from September 8, 2021 through September 13, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was sixty three (63). The survey sample totaled eleven (11).	F880 A. At the time the deficiency was observed on 9/9/2021, E10 was instructed to put a gown on by E11 before performing personal care for the resident. After providing care to the resident, E10 was immediately re-educated on the appropriate PPE usage for contact precautions. B. All residents have the potential to be affected by this deficient practice. R2's contact precautions were discontinued on 9/10/2021, and there have been no new cases of C-Diff in the facility. All healthcare personnel, including agency staff, responsible for providing direct care to residents will be re-educated on the transmission based precautions required for residents with C-Diff by the Staff Development Coordinator by 11/1/2021. C. After a root cause analysis was conducted the cause was determined to be that E10 was an agency staff worker new to the facility. She may not have received proper edu-	11/01/2021
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 requirements for skilled and regulatory 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:		

Provider's Signature [signature] Title Executive Director Date 10/01/2021

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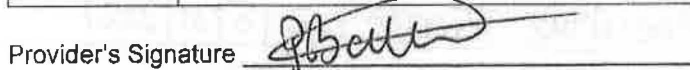
	Cross Refer to the CMS 2567-L survey completed September 13, 2021: F880 and F886.	cation on Infection Prevention, or transmission based precautions from her employer. All agency staff workers will receive an orientation packet that contains education on Infection Prevention, transmission based precautions, and other protocols and policies as appropriate. In addition to daily surveillance, the Infection Preventionist will be attending the facility's clinical meetings once a week to ensure residents are on transmission based precautions appropriately. Nursing Supervisors will have huddles with staff members at the start of the shift that will include an update on which residents are on transmission based precautions and to educate staff on the appropriate PPE use as necessary. D. Nursing supervisor or designee will observe staff members entering the rooms of residents on transmission based precautions to ensure appropriate PPE is being worn every shift x 3 shifts, then daily x 3 days, then weekly x 5 weeks until 100% compliance is met. Observation will be done one month	

Provider's Signature  Title Executive Director Date 10/01/2021

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		later ton ensure 100% compliance is being maintained. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	

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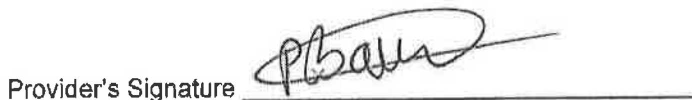
	Cross Refer to the CMS 2567-L survey completed September 13, 2021: F880 and F886.	testing. All testing, regardless of location tested, will be logged appropriately. D. Executive Director/Infection Preventionist or designee will audit unvaccinated staff members COVID-19 testing to ensure compliance with current Delaware Public Health testing guidelines. Audits will be performed weekly x 5 weeks until 100% compliance is achieved. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING ______ B. WING ______	C 09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT LIVING	**255 POSSUM PARK ROAD NEWARK, DE 19711**

(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	F 000		

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Abbreviations and definitions used in the report are as follows:

CNA - Certified Nurse's Aide;
DA - Dietary Aide;
DON - Director of Nursing;
IP- Infection Control Preventionist;
LPN - Licensed Practical Nurse;
NHA - Nursing Home Administrator;
RN - Registered Nurse;

CDC - Center for Disease Control and Prevention;
Clostridium Difficile (C-diff) - a bacterial infection found in the bowels that can cause diarrhea;
Contact Precautions - transmission based precautions used for patients with known or suspected infections that represent an increased risk for contact transmission;
COVID-19 (Coronavirus) - a respiratory illness that can be spread person to person;
PPE (personal protective equipment) - equipment, including mask, gloves, gown, etcetera, worn to minimize exposure to infection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/01/2021

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.

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

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F 000	Continued From page 1 in the workplace; Transmission Based Precautions - special measures that are put in place to prevent the spread of infection.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		11/1/21

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F 880	Continued From page 2 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to correctly implement transmission-based precautions for one (R2) out of two residents on transmission-based precautions. Findings	F 880	A. At the time the deficiency was observed on 9/9/2021, E10 was instructed to put a gown on by E11 before performing personal care for the resident. After providing care to the resident, E10	

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F 880	Continued From page 3 include: The facility policy for C-diff, last updated 10/1/17, indicated in the Prevention section that employees "Wear gowns when potential soiling of clothing with feces is likely." Review of the CDC webpage guidance for C-diff indicated for employees to "Use contact precautions for patients with known or suspected CDI (C-diff infection): Place these patients in private rooms. If private rooms are not available, they can be placed in rooms (cohorted) with other CDI patients. Wear gloves and a gown when entering CDI patient rooms and during their care." https://www.cdc.gov/cdiff/clinicians/faq.html. Review of R2's clinical record revealed; 12/22/20 - A care plan for C-difficile was initiated and updated on 7/31/21 that included the intervention to place R2 in a private room with contact isolation precautions if room available and/or to cohort. Review of R2's record of bowel movements revealed loose stools on 9/2 and 9/3/21. 9/4/21 - An order was written for R2 to receive antibiotics four times a day for C-difficile. 9/8/21 12:01 PM - During a random observation, E10 (CNA) was observed in R2's room, which was marked with signage as requiring a gown, eye protection and gloves for entry and drawers outside of the room contained PPE. E10 was standing at the bedside wearing a face mask, eye protection and gloves, no gown. There were incontinence cleansing wipes on the overbed	F 880	was immediately re-educated on the appropriate PPE usage for contact precautions. B. All residents have the potential to be affected by this deficient practice. R2's contact precautions were discontinued on 9/10/2021, and there have been no new cases of C-Diff in the facility. All healthcare personnel, including agency staff, responsible for providing direct care to residents will be re-educated on the transmission based precautions required for residents with C-Diff by the Staff Development Coordinator by 11/1/2021. C. After a root cause analysis was conducted the cause was determined to be that E10 was an agency staff worker new to the facility. She may not have received proper education on Infection Prevention, or transmission based precautions from her employer. All agency staff workers will receive an orientation packet that contains education on Infection Prevention, transmission based precautions, and other protocols and policies as appropriate. In addition to daily surveillance, the Infection Preventionist will be attending the facility's clinical meetings once a week to ensure residents are on transmission based precautions appropriately. Nursing Supervisors will have huddles with staff members at the start of the shift that will include an update on which residents are on transmission based precautions and to educate staff on the appropriate PPE use	

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F 880	Continued From page 4 table. E10 attempted to shut R2's door and reported to the surveyor that incontinence care was being provided. E10 was asked "Are you aware of any precautions to be worn when caring for R2?" E10 stated, "No, I don't work here." E10 was asked if "she noticed signage outside of R2's room on the left wall beside R2's door?" E10 stated, "I didn't see it." At that time, E11 (RN) walked up to E10 and directed E10 to put on a gown, E11 then confirmed that R2 was on precautions for C-diff and that a gown was required for personal care. During an interview on 9/9/21 at 9:47 AM, E4 (IP) confirmed that for a resident on transmission based precautions for C-diff staff "Should have gloves if there is any chance of contact and for incontinence care they should be gowned as well." 9/10/21 9:22 AM - A progress note documented, "Per conversation with doctor, Resident is no longer being treated for an active/acute C-diff infection, contact precautions no longer needed so can be discontinued." Findings were reviewed during the exit conference on 9/13/21 at 3:35 PM with E1 (NHA) and E2 (DON).	F 880	as necessary. D. Nursing supervisor or designee will observe staff members entering the rooms of residents on transmission based precautions to ensure appropriate PPE is being worn every shift x 3 shifts, then daily x 3 days, then weekly x 5 weeks until 100% compliance is met. Observation will be done one month later ton ensure 100% compliance is being maintained. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement	F 886		11/1/21

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F 886	Continued From page 5 and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms	F 886		

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F 886	Continued From page 6 consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to conduct the required COVID-19 testing every seven days for one (E9) out of three employees sampled. Findings include: 8/26/20 - A CMS memorandum (QSO-20-38-NH) established Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents..."Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the HHS (Health and Human Services) Secretary...The minimum frequency of routine testing of LTC facility staff shall be based on county positivity rates, State and county officials have a right to direct LTC facilities to test at higher frequency based on other factors." 2/25/21 -The Division of Public Health (DPH) Testing Guidance for Long-Term Care Facilities	F 886	A. On 9/10/2021, when the deficient practice was identified, the list of staff unvaccinated for COVID-19 was immediately reviewed for accuracy. An audit was also done of the week□s testing to ensure all staff complied with the outbreak testing and unvaccinated staff testing guidelines for the week of 9/5/2021. B. All residents have the potential to be affected by this alleged deficient practice. Unvaccinated staff members were contacted by their departmental heads on 9/13/2021 and informed of the updated testing guidelines. All staff will be re-educated on the COVID-19 testing guidelines for residents and staff, and reminded where the weekly testing schedules are located by the Staff Development Coordinator by 11/1/2021.	

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F 886	Continued From page 7 required COVID-19 testing of facility staff based on county positivity rates. Review of testing data, work schedules and documentation provided by E1 (NHA) and E4 (IP) revealed the following discrepancy in testing: - E9 (Dietary Aide- DA) worked from 6/16/21 through 8/14/21 without being tested for COVID-19 by the facility. During an interview on 9/9/21 at 2:38 PM, E4 (IP) confirmed that the facility lacked evidence of testing for E9 (DA) from 6/16/21 through 8/14/21. E4 stated, "If it's not there we don't have it." During an interview on 9/10/21 at 11:27 AM, E1 (NHA) stated,"E4 (DA) will come and talk to you. He said he's been testing." 9/13/21- The facility submitted a statement written by E9 (DA) that confirmed E9 was unable to provide evidence of testing. Findings were reviewed during the exit conference on 9/13/21 at 3:35 PM with E1 (NHA) and E2 (DON).	F 886	C. After a root cause analysis was conducted the cause was determined to be that due to the limited hours worked by E9, the facility should have tracked off site COVID-19 testing appropriately. A weekly testing schedule will continue to be posted in highly visible locations, and all staff will be re-educated on this location as mentioned. All departmental heads will receive copies of the each week□s testing schedule to share with staff. Departmental heads will be responsible for ensuring their staff members complete required testing. All staff members will be expected to comply with testing by either testing at the facility or provide evidence of testing outside of the facility in order to be scheduled to work. Staff who have completed off-site testing will provide proof of this testing. All testing, regardless of location tested, will be logged appropriately. D. Executive Director/Infection Preventionist or designee will audit unvaccinated staff members□ COVID-19 testing to ensure compliance with current Delaware Public Health testing guidelines. Audits will be performed weekly x 5 weeks until 100% compliance is achieved. Results of audits will be submitted to the QAPI committee to determine the need for further submissions.	