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: Lofland Park **DATE SURVEY COMPLETED: May 28, 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 annual and complaint survey was conducted at this facility from May 12, 2021 through May 28, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 97. The survey sample totaled fifty (50). During this period, an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.		
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:		

Provider's Signature Tawnya Glenn, BSN, LNHA Title Regional Executive Director Date 6/18/2021

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	Cross Refer to the CMS 2567-L survey completed May 28, 2021: F641, F656, F695, and F812.	Cross Refer to the CMS 2567-L for F641, F656, F695 and F812.	07/11/2021

Provider's Signature Thurgood Dennis, BSN, CNHA Title Regional Executive Director Date 6/18/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085040	A. BUILDING _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFLAND PARK CENTER	715 E. KING STREET SEAFORD, DE 19973

(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
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from May 12, 2021 through May 28, 2021. The facility census on the first day of the survey was 97. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from May 12, 2021 through May 28, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 97. The survey sample totaled fifty (50). ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; ICP - Infection Control Practitioner; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SE - Staff Educator; UM - Unit Manager;	F 000		

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

Electronically Signed | 06/18/2021

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 000	Continued From page 1	F 000		

ADL - activities of daily living;
Aspiration Pneumonia - a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15.
13-15 Cognitively Intact
8-12 Moderately Impaired
0-7 Severe Impairment;
cc - is the same as milliliter (mL) - metric unit of liquid volume, 5 cc equals 1 teaspoon;
CDC - Centers for Disease Control and Prevention;
CHF (Congestive Heart Failure) - heart cannot pump enough blood to meet the body's needs and can lead to fluid retention and edema;
CMS - Centers for Medicare & Medicaid Services;
COPD (Chronic Obstructive Pulmonary Disease) - a group of diseases that cause airflow blockage and breathing-related problems;
COVID-19/Coronavirus -a respiratory illness that can be spread person to person;
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 person's daily functioning;
Dycem - an anti-slip material used to prevent slipping or falling;
Edema - build-up of fluid causing swelling;
e.g. - for example;
eMAR (electronic Medication Administration Record) - list of resident medications that are signed off when given;
eTAR (electronic Treatment Administration Record) - list of resident treatments that are signed off when completed;

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F 000	Continued From page 2 etc. - and so on; EMR - Electronic Medical Record; htn (hypertension) - high blood pressure; MDS (Minimum Data Set) - standardized assessment used in nursing homes; Pulse Oximetry/Pulse Oximeter - a test used to measure the oxygen level (oxygen saturation) of the blood; SARS-Cov-2 - Coronavirus.	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 the facility failed to have a MDS assessment that accurately reflected the residents' status for one (R49) out of 27 sampled residents for stage two investigations. Findings include: The following was reviewed in R49's clinical record: 3/24/21 - R49 was admitted to the facility. 3/24/21 - The Admission Oral Health Evaluation stated R49's gums and oral tissues appeared red with one ulcer/sore spot on the floor of his mouth, had very worn down teeth, and R49 had no verbal or non-verbal signs of dental pain. 3/30/21 - The Admission MDS Assessment stated that R49 had no broken or loose fitting dentures and no problems with his gums or oral tissue.	F 641	A. R49 MDS was corrected on 5/25/2021. B. Oral Health Evaluations were reviewed by 6/18/2021 for current residents and the MDS reflects accurate information. C. A Root Cause Analysis (RCA) was completed on 6/11/2021 which determined the underlying cause was the nurse completing the Oral Health Evaluation is not the nurse completing the MDS & the Oral Health Evaluation information does not pull into the MDS through the PointClickCare documentation system. As a result of the RCA it was determined that the Clinical Reimbursement Coordinators (CRCs) completing the MDS required additional education on the policy for accuracy of documentation in the clinical record. The Nurse Practice Educator (NPE) or	7/11/21

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F 641	Continued From page 3 5/25/21 10:33 AM - An interview with E8 (RNAC) confirmed that the 3/30/21 MDS assessment incorrectly documented that R49 had no oral health issues as the Admission Oral Health Evaluation documented that R49 had gum and oral tissues. E8 stated that she does not conduct the oral assessment, thus, she relied on the oral health evaluation. 5/26/21 4:15 PM - These findings were reviewed during a meeting held with E1 (NHA - via telephone conference), E2 (DON), E3 (ADON), and E6 (SE). 5/28/21 11:00 AM - Findings were reviewed with E1 and E2 during the Exit Conference.	F 641	designee will complete education (see attachment A) with the CRCs by 6/22/2021. D. The Center Nurse Executive (CNE) or designee will complete weekly audits (attachment B) of 10% of the MDS assessments until 3 consecutive weeks with 100% accuracy occurs. Then audits will occur monthly until 100% accuracy occurs for 3 consecutive months. The results of audits will be presented to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		7/11/21

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F 656	Continued From page 4 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, it was determined that for one (R7) out of 27 sampled residents for stage two investigations, the facility failed to develop a comprehensive person-centered care plan to address R7's frequent complaints of thirst. Findings include: Review of R7's clinical record revealed the following: 11/8/19 - R7 was admitted to the facility. 11/6/20 (discontinued 12/21/20) - New order from E7 (NP) stated: "Lasix (a pill to remove excess	F 656	A. R7 care plan was revised on 5/28/2021 to reflect behaviors for restlessness/repetitive excessive worry/concern to include something to eat and drink. B. Behavior care plans were reviewed by 6/18/2021 for current residents and all care plans include a comprehensive person-centered approach with appropriate interventions. C. A Root Cause Analysis (RCA) was completed on 6/11/2021. It was determined that since the resident had a	

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F 656	Continued From page 5 fluid from the body)...give 20 mg by mouth one time a day for edema (swelling) /htn (high blood pressure)." 11/10/20 - New orders from E7 (NP) stated: "fluid restriction 1,500 cc for chf (congestive heart failure)" and "fluid restriction 1,500 cc total 350 breakfast 350 lunch 350 dinner 450 cc snack time." 12/20/20 - New order from E7 (NP) stated: "Lasix...give 20 mg by mouth one time a day on odd days for edema /htn." 2/14/21 and 5/17/21 - The quarterly MDS assessments revealed that R7 was severely cognitively impaired. 5/12/21 1:30 PM - R7 was observed walking from his room to the multipurpose area holding a cup and asking staff for cold water. E15 (CNA) told him he can not have water because he is on a fluid restriction. R7 responded by saying that he is thirsty. 5/12/21 2:00 PM - During an interview, E15 (CNA) and E16 (LPN) confirmed that R7 frequently complains of thirst and asks for water. 5/24/21 - Review of the current care plan revealed: - 11/11/19 - A care plan was initiated for "Resident exhibits or is at risk for fluid volume excess as evidenced by Edema." - 11/29/19 (last revised 7/8/20) - R7 had a care plan for "Resident exhibits or has the potential to exhibit physical behaviors related to: Cognitive Loss/Dementia, Poor impulse control - touching/grabbing others in personal/private	F 656	behavior care plan already in place for restlessness/repetitive worry/concern that was not specific to food or drink due to multiple other behaviors. As a result of the RCA, it was identified that licensed nursing staff need additional education about individualizing and revising resident care plans. The NPE/designee will complete education (see attachment A) with licensed nurses by 7/4/2021. D. The Center Nurse Executive (CNE) or designee will complete audits (attachment C) for 10% of resident population to verify care plans are comprehensive and person-centered. Audits will occur daily until 3 consecutive days of 100% compliance. Then audits will occur weekly until 3 consecutive weeks with compliance, then monthly until 3 consecutive months with compliance. Results of audits will be presented to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	

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F 656	Continued From page 6 areas." The facility failed to include R7's frequent complaints of thirst and frequent attempts to seek cold water to drink in his behavior care plan. - 10/9/20 - A care plan was initiated for "Resident or is at risk for dehydration as evidenced by medications (diuretics- remove excess fluid). Interventions included to monitor for signs/symptoms of dehydration (may include: dry mouth, dark yellow urine, thirst, headache, cool, dry skin, and/or decreased urine output). 5/27/21 9:00 AM - During an interview, when asked why she ordered a fluid restriction in November 2020, E7 (NP) stated, "I put him on a fluid restriction to help staff so he doesn't urinate so much." E7 later added that he is medically stable, the fluid restriction was for congestive heart failure, he has limited verbal skills and his complaint of thirst is attention seeking behavior." 5/28/21 8:30 AM - During an interview, E2 (DON) confirmed that the current care plan did not address R7's frequent complaints of thirst and frequent attempts to seek cold water to drink. 5/28/21 9:30 AM - During an interview, E5 (Dementia Program Director) confirmed that staff have not discussed with R7's representative party (his son) his frequent complaints of thirst and frequent attempts to seek cold water to drink or options to evaluate if allowing R7 to drink more fluids may decrease his complaints of thirst. E5 added that the staff feel that complaining of thirst is a behavior and that they redirect R7 to try to maintain the fluid restriction. 5/28/21 11:00 AM - Findings were reviewed with	F 656		

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F 656	Continued From page 7 E1 (NHA) and E2 (DON) during the Exit Conference.	F 656		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for two (2) out of three (3) sampled residents (R49 and R186) reviewed for respiratory services, the facility failed to provide appropriate respiratory care as per the physician's orders. In addition, for R186, the facility failed to change the resident's oxygen tubing and humidifier bottle weekly. Findings include: 1. Review of R49's clinical records revealed the following: 4/26/21 - R49 was re-admitted to the facility from the hospital with diagnoses including COPD. 4/26/21 - A review of R49's care plan revealed that starting on 4/26/21 and revised on 4/30/21, R49 was at risk for respiratory complications related to COPD and histories of tobacco use and aspiration pneumonia. Approaches included to monitor and report oxygen (O2) saturation (sat)	F 695	A. R49 was discharged on 5/15/2021. R186 oxygen tubing and humidifier bottle were replaced on 5/12/2021. R186 physician orders were corrected on 5/25/2021 to reflect documentation needed for titration, use of prn oxygen and resident response to treatment. B. All current residents requiring prn oxygen and titration orders were reviewed and corrected on 5/25/2021 to reflect documentation required. C. A Root Cause Analysis (RCA) was completed on 5/24/2021 for lack of nursing documentation for oxygen titration. As a result of the RCA it was determined that licensed nurses needed education (attachment D) on documentation requirements for oxygen saturation, liter flow and response in the clinical record. An action plan was	7/11/21

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F 695	Continued From page 8 levels using a pulse oximeter as ordered and as needed, observe for respiratory rate, as well as any signs/symptoms of respiratory distress and to report to physician as needed. 5/3/21 6:05 PM - A physician's order was written for "Oxygen 2 L (liters)/ (per) min (minute) via nasal cannula (NC) continuously every shift for increased wob (work of breathing), copd. Post tx (treatment) evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds." 5/3/21 3 PM to 11 PM shift and 11 PM to 7 AM shift - There was lack of evidence that R49's O2 sat was monitored for these two consecutive shifts as ordered. 5/4/21 8:18 AM - O2 sat of 94% on oxygen via NC. There was lack of evidence of the O2 sat level prior to initiating the O2 and lack of evidence of post treatment evaluation of R49's heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds as ordered. 5/4/21 11:26 AM - A physician's order stated, "Oxygen at 2L/min via nasal cannula. Titrate (adjust) for O2 sat > (greater than) 92% every shift for increased wob, copd." 5/6/21 10:03 AM - O2 sat of 92% on room air (RA). 5/6/21 11 AM - A Progress Note documented R49 with poor oral intake, the NP was notified and R49's O2 sat was 92% on oxygen. There was lack of evidence that the facility titrated the O2 as ordered when R49's O2 sat was 92% and there was lack of evidence of an assessment of R49's respiratory system.	F 695	developed and education was initiated by the Center Nurse Executive on 5/25/2021. The Nurse Practice Educator (NPE) is completing additional education (attachment A) with licensed nurses by 7/4/2021. Another RCA was completed on 6/11/2021 for failure to change oxygen tubing and humidifier bottle weekly per policy and for the lack of documentation of the oxygen status, especially when titrating per order. As a result of the RCA, the vital signs worksheet was revised to include a column for documenting oxygen number of liters versus room air (attachment E). It was also determined that licensed nurses needed education on the policy for changing and labelling oxygen tubing and humidifier bottles. The NPE or designee will provide education to licensed nurses by 7/4/2021. D. The Center Nurse Executive (CNE) or designee will complete audits (attachment F) of all residents with orders for oxygen titration or as needed oxygen daily until 100% compliance occurs with documentation requirements on 3 consecutive reviews. Then audits will occur weekly until 100% compliance on 3 consecutive reviews, then monthly until 100% compliance on 3 consecutive reviews. The CNE or designee will complete audits (attachment G) for proper labelling and changing of oxygen tubing and humidifier bottles weekly for all residents on oxygen until 100% compliance is achieved on 4 consecutive weeks. Then audits will be completed monthly until 100% compliance is	

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F 695	Continued From page 9 5/6/21 7 PM - A Progress Note documented that R49 continued with poor oral intake and intravenous fluids were started. R49's O2 sat was 92% on RA. Despite R49's O2 sat at 92%, the facility failed to adhere to the physician's order to administer O2. In addition, there was lack of evidence of an assessment of R49's respiratory system. 5/6/21 11:58 PM - O2 sat was 96% on oxygen via NC. There was lack of evidence of the O2 sat level prior to initiating the O2, including an assessment of R49's respiratory system. 5/7/21 7 PM - A Progress Note documented R49 had pneumonia and IV antibiotic's were started. R49's O2 sat was 100% with O2 via NC. 5/7/21 11 PM to 7 AM shift - There was lack of evidence that R49's O2 sat was monitored. 5/8/21 11:17 AM - O2 sat was 92% on oxygen via NC. There was lack of evidence that the facility titrated the O2 to maintain the O2 sat > 92% as ordered. In addition, there was lack of evidence of an assessment of R49's respiratory system. 5/8/21 11 PM to 7 AM shift - There was lack of evidence that R49's O2 sat was monitored as ordered. 5/9/21 11 PM to 7 AM shift and 5/10/21 7 AM to 3 PM shift - There was lack of evidence that R49's O2 sat was monitored as ordered. 5/11/21 12:00 AM - A Progress Note by E7 (NP) documented that due to R49's declining physical status, R49's Power of Attorney (PA1) elected for	F 695	achieved on 4 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee (QAPI) for review and recommendations.	

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(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 695	Continued From page 10 end of life comfort care. 5/11/21 7 PM - A Progress Note documented that R49's lungs sounds were diminished with an O2 sat of 95% on O2 via NC. 5/12/21 3 PM to 11 PM shift and 11 PM to 7 AM shift - There was lack of evidence that R49's O2 sat was monitored as ordered for the above shifts. 5/14/21 10:33 AM - O2 sat of 92% on RA. There was lack of evidence that the facility initiated oxygen to maintain R49's O2 sat > 92% as ordered. 5/14/21 2 PM - A Progress Note documented that R49 was administered medication for air hunger (difficulty breathing) and anxiety. 5/14/21 7 PM - A Progress Note documented that R49 was not arousable with periods of no breathing and his O2 was increased to 4 L via NC for R49's comfort. 5/26/21 3:45 PM - An interview with E10 (RN UM) was conducted and confirmed that the facility failed to consistently have evidence of monitoring R49's O2 sat and failed to have evidence of initiating oxygen when R49's O2 sat was 92% or less. 2a. Review of R186's clinical records revealed the following: 5/7/21 - R186 was admitted to the facility from the hospital following treatment for pneumonia. R186 had additional diagnoses including COPD and Congestive Heart Failure (CHF).	F 695		

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	085040	A. BUILDING _____ B. WING _____	C 05/28/2021

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F 695	Continued From page 11 5/9/21 7:57 PM - R186's O2 sat was 97% on room air (RA). 5/10/21 - A review of R186's care plan stated R186 was at risk for respiratory complications related to COPD, CHF, and had histories of respiratory failure and pneumonia. Approaches included to monitor and report oxygen saturation (sat) levels using pulse oximetry as ordered and as needed, O2 as ordered via nasal cannula (NC), and observe respiratory rate, signs/symptoms of respiratory distress and to report to physician as needed. 5/10/21 4:24 PM - A Progress Note documented R186 with O2 via NC and shortness of breath with exertion. Vital signs and a respiratory assessment were completed with an O2 sat of 94%. 5/10/21 9:57 AM - A physician's order was written for "Oxygen via Nasal Cannula to maintain O2 saturation > (greater than) 92%." 5/10/21 and 5/12/2021 11 PM to 7 AM shifts - There was lack of evidence that R186's O2 sat was monitored for these shifts. 5/12/21 12:58 AM - R186's O2 sat of was 97% with O2 via NC. There was lack of evidence of the O2 sat level prior to initiating oxygen. 5/12/21 2:31 PM - A physician's order for "Oxygen via Nasal Cannula to maintain O2 saturation > 92%. up to 4 L (Liter) for indications of acute and chronic hypoxia (low oxygen level in the bloodstream)."	F 695		

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F 695	Continued From page 12 5/15/21 5:53 PM to 5/20/21 8:47 AM - R186's O2 sat was above 92%. 5/20/21 7:52 PM - R186's O2 sat was 92% on RA. There was lack of evidence that the facility administered the O2 as ordered when R186's O2 sat was 92% and there was lack of evidence of an assessment of R186's respiratory system. 5/26/21 3:45 PM - An interview with E10 (RN UM) was conducted and confirmed that the facility failed to consistently have evidence of monitoring R186's O2 sat and failed to have evidence of initiating oxygen when R186's O2 sat was 92% or less. 5/26/21 4:15 PM - Findings were reviewed during a meeting held with E1 (NHA - via telephone conference), E2 (DON), E3 (ADON), and E6 (SE). 2b. 5/12/21 10:00 AM - A random observation of R186's oxygen concentrator tubing and the humidifier bottle lacked evidence of a date. A joint observation was immediately done with E9 (RN) who confirmed the findings. E9 stated the facility's process was to change both the tubing and the humidifier bottle weekly. 5/13/21 10:00 AM - During an interview E6 (SE), confirmed the facility's policy was to change the oxygen tubing and humidifier bottle weekly. 5/28/21 11:00 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		7/11/21

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F 812	Continued From page 13 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to consistently monitor food temperatures in accordance with professional standards for food safety for cooking/reheating food items, ensure sanitary storage of food, protect quality of food, maintain consistent food temperature logs, provide timely disposal of pest remains, provide a required waste disposal receptacle at or near a hand washing sink, ensure staff were practicing appropriate hand hygiene, maintain labels and dates for refrigerated food, and dispose of expired food. Findings include: 1. 5/12/21 - During the initial kitchen tour the following observations were made:	F 812	A. On 5/13/2021 the following were done: the three compartment sink was filled per policy; the walk-in refrigerator ceiling and jelly jar were cleaned; the Jello dessert exposed were disposed of & lids were corrected, as well as new containers ordered that would fit with the lids; the trash can lid was placed on the trash can and facility is ordering new trash cans with attached lids; the adhesive insect trap has pictures of flies to attract but was replaced and has since been removed from the kitchen as new fly lights were installed; an appropriate trash can was placed by the second hand washing station near the walk-in; the soiled rag along the stove was removed; the debris on side of stove was	

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F 812	Continued From page 14 -9:25 AM - access to a handwashing sink was obstructed by two large trashcans. -9:29 AM - three compartment sink used for dishwashing, middle/rinse compartment was empty, did not have water in it. -9:30 AM - E12 (dietary aide) was observed using the rinse compartment of a three compartment sink (sink used for cleaning dishes) for handwashing. Finding was confirmed by E12 at the time of observation. -9:35 AM - a large pan of green jello was on a shelf in the walk-in refrigerator uncovered and undated. This was confirmed by E12 at time of observation. -9:36 AM - E11 (cook) confirmed the rinse section was empty in the three compartment sink. 2. During a kitchen tour the following observations were made: - 5/13/21- 8:37 AM - A circular stained area of small brownish black dots on the ceiling of the walk-in refrigerator and a jar of jelly with butter and bread crumbs on the outside of the jar were located in the walk-in refrigerator. - 5/13/21- 8:42 AM- A tray of ready to serve gelatin desserts in cups with lids that were only partially covering the gelatin preventing protection from dust and other debris. - 5/13/21- 9:12 AM - A trash can that contained food waste with the lid off for more than fifteen (15) minutes. - 5/13/21 - 9:18 AM - An adhesive type insect trap suspended from the ceiling, which was covered with a significant amount of common House Fly remains. - 5/13/21 - 9:47 AM - A second hand washing station located near the walk-in refrigerator was missing the trash can required for the proper	F 812	cleaned; all outdated items from Garden Unit refrigerator were disposed of. Food temperatures are being completed and monitored by Food Service Director. B. All items identified during survey were corrected immediately. C. Root Cause Analyses (RCA) were completed on 6/11/2021 to address all areas identified in the kitchen. It had already been determined during survey that the fly tape would be removed and replaced with a new insect light, which was in place prior to RCA. The cleaning of the walk-in ceiling and fans had been added as a preventive maintenance task monthly in the electronic work order systems and will be completed monthly by the maintenance staff. It was determined that the size of the 2 large trash cans impeded access to sinks; therefore, the facility is ordering smaller trash cans with lids attached. It was also determined that the Food Service Director needed to revise cleaning assignments for kitchen staff (attachment H). In addition, new assignments for dietary staff will be completed and the Food Service Director or designee will check the Garden Unit refrigerator per new schedule. All other areas identified during survey are being addressed through education. The Food Service Director will provide education (attachment I) for all kitchen staff on sanitation areas by 07/04/2021. D. The Center Executive Director (CED) or designee will complete audits	

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F 812	Continued From page 15 disposal of single use hand drying towels. - 5/13/2021 - 10:10 AM - During a review of the food temperature logs, the surveyor observed numerous meals out of four hundred eighty-nine meals (489) reviewed for temperatures had no temperatures recorded. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. In accordance with State of Delaware Food Code 3-501.16 - Time/Temperature Control for Safety Food, Hot and Cold Holding: Fish, meat, and poultry must be heated to an appropriate specific temperature depending on the type of food and the method used to prepare it and maintained at one hundred thirty-five (135) degrees Fahrenheit (F), vegetables must be heated and maintained at one hundred thirty-five (135) degrees (F), and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. - 5/13/21 - 10:10 AM - During a tour of the kitchen, the surveyor observed a soiled rag under the edge of the stove and dried food debris on the side of the stove. 5/13/21 - 1:12 PM - E14 (Food Service Director) reviewed and confirmed the findings. 3. 5/13/21 11:35 AM - The following observations were made on the Garden Unit, in the refrigerator: -A container of open thickened juice, was dated 2/23/21. Another container of thickened juice was open with no date on the box. Both containers stated, "use within 7 days after opening" on the box. -Opened thickened prune juice labeled 4/13, the container label stated, "product good for 7 days	F 812	(attachment J & K) daily on each shift until 3 consecutive reviews have 100% compliance. Audits will then be done twice a week on each shift until 3 consecutive reviews with 100% compliance, then weekly until 3 consecutive reviews have 100% compliance, then monthly until 3 consecutive reviews have 100% compliance. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 812	Continued From page 16 after opening." -Fresh eggs were dated "sell by 4/20/21." -A tuna salad sandwich was dated 5/5/21. -Peanut butter and jelly sandwiches were labeled 5/8/21 and appeared dry and the wrapping was not intact. These findings were reviewed on 5/28/21 at 11:00 AM with E1 (NHA) and E2 (DON) during the exit conference.	F 812		