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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center
February 27, 2024

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	An unannounced Complaint and Extended survey was conducted at this facility from February 22, 2024 through February 27, 2024. 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 first day of the survey was 125. The sample totaled 3 residents. **Regulations for Skilled and Intermediate Care Facilities** Scope **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 February 27, 2024: cross refer: F578, F692, F711, F730, F756, F760, F941, F942, F943, F944, F945, F946, and F947.	Cross reference plan of correction to the CMS 2567-L survey completed February 27, 2024 for F578, F692, F711, F730, F756, F760, F941, F942, F943, F944, F945, F946, and F947.	4/4/2024

Provider's Signature Lucy L Halligan Title Administrator Date 3/22/24

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 _____	C 02/27/2024

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 Complaint and Extended survey was conducted at this facility from February 22, 2024 through February 27, 2024. 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 first day of the survey was 125. The sample totaled 3 residents. Abbreviations/definitions used in this report are as follows: Advance Directive - a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor; Agitation - emotional state of restlessness; 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; CNA - Certified Nursing Assistant; DON - Director of Nursing; Diuretics - medicines that help reduce the amount of water/excess fluid in the body; EMR - Electronic Medical Record; Family Member - FM; Hypotensive - abnormally low blood pressure; LPN - Licensed Practicle Nurse; Medication Administration Record (MAR) - list of daily medications to be administered; mL (milliliters) -unit of liquid volume, 5 ml equals 1 teaspoon;	F 000		

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

Electronically Signed | 03/14/2024

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 Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; NP - Nurse Practitioner; UM - Unit Manager.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		4/4/24

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F 578	Continued From page 2 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R1, R2, and R3) out of three residents reviewed for Advance Directives, the facility failed to provide evidence that R1, R2 and R3 were offered an opportunity to formulate an Advance Directive. Findings include: A facility policy dated 6/1/96, revised 1/8/24, and titled, "Health Care Decision Making", documented, " ...It is the right of all patients/residents to participate in their own health care decision-making including the right to decide whether they wish to request, accept, refuse or discontinue treatment, and to formulate or not and advance directive". 1. Review of R1's clinical records revealed: 2/14/24 - R1 was admitted to the facility with diagnoses including but not limited to insulin dependent diabetes and hyperglycemia. 2/23/24 1:04 PM - A review of R1's clinical lacked evidence that R1 was offered or provided an	F 578	A. R1 has been discharged from the facility on 2/19/24 unable to correct. R2 and R3 were both discharged on 2/23/24 unable to correct. B. All current residents have the potential to be affected by the deficient practice. Social services/Designee will audit all current residents to ensure each resident has been offered an opportunity to formulate an advanced directive. All discrepant findings will be addressed. C. Root cause analysis determined the social services department needs to be re-educated regarding documentation procedures for advanced directives. Nurse Practice Educator/Designee will reeducate all current social services staff on the procedures for offering the opportunity to formulate an advanced directive and documentation of the offering	

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F 578	Continued From page 3 opportunity to formulate an Advance Directive. 2/23/24 1:15 PM - During a phone interview with F1 (Family) it was stated, "Advance Directive or Code Status was not discussed during the care plan meeting". 2. Review of R2's clinical records revealed: 2/15/24 - R2 was admitted to the facility with diagnoses including but not limited to diabetes. 2/16/24 2:14 PM - R2's clinical document titled, "Social Services Assessment and Documentation", documented that R2 had an Advance Document in place. 2/23/24 1:30 PM - A review of R2's clinical record lacked evidence that R2 was offered an opportunity to formulate an Advance Directive. 3. Review of R3's clinical records revealed: R3 was admitted the facility on 1/22/24 with diagnoses including but not limited to Acute and Chronic Respiratory Failure. 1/30/24 - R3's clinical document titled, "Social Services Assessment and Documentation", documented that R3 was not offered the opportunity to complete an Advance Directive. 2/23/24 1:30 PM - During a telephone interview, E5 (NP) stated, "I did not discuss Advance Directives with this resident". 2/23/24 2:00 PM - During a telephone interview, E7 (SS) stated, "I usually discuss Advance Directives, but I don't always document the	F 578	D. The Director of Social Services/Designee will audit (Attachment A) all new admissions and those residents on the MDS assessment schedule to ensure those residents were offered the opportunity to formulate an advanced directive and document such offering for a period of 3 months or until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 578	Continued From page 4 conversation". 2/23/24 1:45 PM - The facility was unable to provide the Advance Directive documents when requested from E7 (SW) for R1, R2 and R3. The facility failed to offer R1, R2, and R3 the opportunity to formulate an Advance Directive.	F 578		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R1) out of three residents reviewed for hydration, the facility failed to ensure a resident at risk for dehydration R1	F 692	A. R1 has been discharged from the facility on 2/19/24 unable to correct. B. All current residents have the	4/4/24

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F 692	Continued From page 5 was monitored for hydration. Findings include: A facility policy dated 1/1/04, revised 2/1/23, and titled, "Nutrition/Hydration Care and Services", documented, "Maintain fluid and hydration balance ....at risk for dehydration ..." Review of R1's clinical records revealed: 2/14/24 9:11 PM - R1 was admitted to the facility with diagnoses including insulin dependent diabetes mellitus with hyperglycemia, obstructive uropathy, and acute kidney injury. R1 had a urinary catheter. R1's medications included Lasix (diuretic) daily for fluid management, and Keflex (antibiotic) four times a day for seven days for sepsis. R1's clinical record documented, " ...is a brittle diabetic ..." 2/15/24 6:51 AM - R1's laboratory results in the facility revealed a potassium level of 4.7 (normal range 3.6 - 5.2), BUN level of 39 (normal level 6-24), and Creatinine level of 1 (normal level 0.7-1.3). 2/15/24 10:38 AM - R1's nutritional assessment completed by E9 (RD) documented a daily "fluid needs of 1860 cc. [R1] refused admission weight, clinical records failed to show evidence of any other attempt to obtain weights or [R1's] refusal to be weighed. [R1's] baseline nutritional care plan documented, ...at nutritional risk due to recent surgery, history of diabetes ..." 2/16/24 - R1's nutritional base line care plan failed to include needs related to diabetes and use of diuretic medication, 2/16/24 - R1's sepsis baseline care plan included,	F 692	potential to be affected by the deficient practice. Director of Nursing/designee will conduct an audit of all current residents to identify those residents who are at increased risk for dehydration C. Root cause analysis determined the need for re-education to all current nursing staff regarding what puts residents at risk for dehydration, the importance of hydration monitoring, signs and symptoms of dehydration and for those residents determined to be at an increased risk for dehydration the significance of accurate reporting of fluids consumed during meal time, the need to encourage fluid intake, and the provisions of sufficient intake between meals to maintain adequate hydration. D. The Nursing Management Team/Designee will complete an audit (Attachment B) of all residents identified as an increased risk for dehydration to ensure appropriate interventions are implemented and an updated plan of care is completed three times weekly for 3 months or until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 692	Continued From page 6 " ...Monitor for changes in... hydration status ..." 2/16/24 1:46 PM - R1' clinical record revealed a skin check assessment that documented, "Mucous membranes moist, catheter patent ...skin warm and dry, skin color within normal limits, and turgor normal." 2/19/24 at 6:40 AM - R1's next nursing clinical assessment was completed on for change in mental status. A review of R1's clinical records lacked evidence of monitoring of fluid intake despite the use of the diuretic and the urinary catheter. 2/23/24 2:10 PM - During an interview, E9 (RD) revealed that (R1) was assessed for fluid needs on admission. The fluid intake is not recorded but labs and weights are checked to see if they are getting adequate hydration. The facility lacked evidence of a weight on R1 at the time of admission due to refusal to be weighed. When the surveyor asked how the facility would monitor hydration on a resident that refused weights E9 replied, "We check labs and weights." 2/26/24 9:45 AM - During an interview, E11 (LPN) stated, "The aides give the residents their food. I don't do anything with the aides charting". 2/26/24 10:00 AM - During an interview E13 (agency CNA) stated, "There is nowhere to record how much the residents drink or how much is emptied from the foley bag." The surveyor asked E13 if the nurse is informed of how much urine is emptied from the foley bag. E13 stated, "No."	F 692		

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F 692	Continued From page 7 2/26/24 1:00 PM - During the interview E3 (Regional Resource Management RN) it was confirmed the facility lacked evidence on how they monitor residents who used medications for fluid management and are risk for dehydration. The facility failed to provide evidence that R1's hydration status was monitored. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 692		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R1) out of three residents reviewed for physician's services, the facility failed to ensure that R1's order for insulin was accurately reviewed and documented to	F 711	A. R1 was discharged from the facility on 2/19/24 unable to correct. B. All newly admitted residents with a diagnosis of diabetes have the potential to	4/4/24

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F 711	Continued From page 8 ensure that R1 received the insulin as ordered. Findings include: Cross refer F760. Review of R1's records revealed: 2/14/24 9:11 PM - R1 was admitted to the facility with diagnoses including but not limited to insulin dependent diabetes mellitus with hyperglycemia. 2/14/24 - R1's hospital physician's discharge orders included, "insulin lispro (insulin lispro 100 units/ml injectable solution) via continuous insulin pump per current pump settings". 2/15/24 - E5's (NP) documentation included, " ...Patient (R1) to continue on insulin ...I reviewed external hospital notes/discharge summary ..." 2/16/24 - E5's (NP) documentation included, "...Patient (R1) to continue insulin ..." 2/19/24 6:40 AM - R1's clinical records documented that R1 was observed with medical status changes including respiratory distress. R1's blood sugar, "was greater than 500, and the glucometer read HI". R1 was sent to the emergency room. 2/19/24 7:35 AM - R1's emergency room records documented blood sugars at 580 and 980. 2/22/24 12:10 PM - A review of R1's MAR (medication administration record) from 2/14/24 - 2/19/24 lacked evidence that insulin was ordered and administered. 2/22/24 1:30 PM - During a phone interview, E5	F 711	be affected by the deficient practice. All admissions from the last 7 days were audited on 2/20/24 and daily thereafter to ensure all orders from the hospital transfer paperwork were transcribed properly and communicated to the provider as well as the diagnosis. C. Root cause analysis determined all current medical providers need for reeducation on the process for reviewing hospital transfer paperwork to ensure those residents with diagnosis of diabetes are being monitored and have the appropriate diabetic medications in place as needed. Nurse Practice Educator/Designee will re-educate all current providers on policy OPS401 Admission Process with intense focus on reviewing the hospital records thoroughly with a focus on diabetic medications. D. The Director of Nursing/Designee will complete an audit (Attachment C) of all newly admitted residents with a diagnosis of diabetes to ensure they are being monitored and have the appropriate diabetic medications in place as needed daily x 3 months or until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 711	Continued From page 9 (NP) stated, "I saw that the resident (R1) had an episode of low blood on 2/15/23 at 6:00 AM, and I wanted to wait to see if she needed insulin". E5 confirmed that blood sugar checks were not ordered to monitor R1's blood sugar status for further evaluation and insulin administration. E5 also confirmed that the documentation in R1's medical records included "resident (R1) continues on insulin". 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 711		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that a performance review was completed at least every 12 months for five (E16, E17, E18, E19 and E20) out of five sampled employees. Findings include: 2/27/24 9:30 AM - Review of the staff training hours documentation revealed the following: 1. E16 (CNA) had a hire date of 9/24/13. A record review revealed that the last annual performance was completed on 3/11/21. There was a lack of	F 730	A. E16, 17, 18, 19, 20 unable to correct as it is no longer 2023. B. All current employees have the potential to be affected by this deficient practice. The Administrator/Designee conducted an audit of nursing aides that are due for performance reviews in January, February, and March of 2024 to ensure that performance reviews have been completed. C. Root cause analysis determined that	4/4/24

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F 730	Continued From page 10 evidence of a performance evaluation from the past year. 2. E17 (CNA) had a hire date of 8/20/18. A record review revealed a lack of evidence of a performance evaluation from the past year. 3. E18 (CNA) had a hire dated of 9/2/20. A record review revealed a lack of evidence of a performance evaluation from the past year. 4. E19 (CNA) had a hire date of 8/19/19. A record review revealed that the last annual performance was completed on 3/5/21. There was a lack of evidence of a performance evaluation from the past year. 5. E20 (CNA) had a hire date of 9/8/21. A record review revealed a lack of evidence of a performance evaluation from the past year. 2/27/24 1:345 PM - Findings were comfirmed by E1 (NHA) in an interview. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 730	there is not a process in place for conducting nursing aide performance reviews annually. The center will implement a new process of utilizing a spreadsheet of all current employees hire dates. Monthly the Administrator will inform each department head of performance reviews due for that month from the spreadsheet and provide a deadline date to complete each review to the respected supervisor. Administrator will re-educate the Director of Nursing/Designee on the requirements for regulation 483.95 and the new process in regards to management of performance reviews to ensure they are performed yearly for all current nursing aides D. The Administrator/Designee will complete an audit (Attachment D) of all current nursing aides that are due for their annual performance review to ensure that it has been completed monthly x 3 months or until 100% compliance is achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		4/4/24

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F 756	Continued From page 11 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R1) out of three residents reviewed for pharmacy services, the facility failed to ensure that R1's order for insulin was accurately and comprehensively reviewed to ensure that R1 received the insulin as ordered. A facility document dated 10/1/17, revised on	F 756	A. R1 has been discharged from the facility on 2/19/24 unable to correct. B. All newly admitted residents with a diagnosis of diabetes have the potential to be affected by the deficient practice. All admissions from the last 7 days were audited on 2/20/24 and daily thereafter to	

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F 756	Continued From page 12 2/13/18, 10/1/18, and 11/8/23, and titled, "Admission Medication Regimen Review", documented, " .... The Consultant Pharmacist will conduct a comprehensive review of each patient's medication therapy ...this will include but not limited to .... current medication regimen, medication history, admission, and discharge information ..." Review of R1's records revealed: 2/14/24 9:11 PM - R1 was admitted to the facility with diagnoses including insulin dependent diabetes mellitus with hyperglycemia. R1's hospital physician's discharge orders included, "insulin lispro (insulin lispro 100 units/ml injectable solution) via continuous insulin pump per current pump settings". 2/16/24 9:41 AM - R1's Pharmacist Medication Regimen Review documented, "No irregularities". 2/19/24 6:40 AM - R1's clinical records documented that R1 was observed with medical status changes including respiratory distress. R1's blood sugar was, "was greater than 500, and the glucometer read HI". 2/19/23 7:35 AM - R1's emergency room records documented blood sugars of 580 and 980. 2/22/24 12:10 PM - A review of R1's MAR from 2/14 - 2/19/24 failed to show evidence that insulin was administered. 2/23/24 10:25 AM - During a telephone interview E6 (PC) stated, "I review the resident's (R1) admission orders, but I missed the order for insulin".	F 756	ensure all orders from the hospital transfer paperwork were transcribed properly. C. Root cause analysis determined the need for reeducation to the Consultant Pharmacist on the process for reviewing hospital transfer paperwork to ensure those residents with diagnosis of diabetes are being monitored and have the appropriate diabetic medications in place. Nurse Practice Educator/Designee will re-educate Consultant Pharmacist on policy OPS401 Admission Process with intense focus on reviewing the hospital records thoroughly with a focus on diabetic medications. D. The Director of Nursing/Designee will complete an audit (Attachment E) of all newly admitted residents with a diagnosis of diabetes to ensure they are being monitored and have the appropriate diabetic medications in place as needed daily x 3 months or until 100% compliance is achieved. Results of audits will be presented to the QAPI committee for review.	

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F 756	Continued From page 13 The facility failed to ensure that R1's medication orders were accurately reviewed and reconciled by the consultant pharmacist, and the order for insulin administration was implemented. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 756		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R1) out of three residents reviewed for medications, the facility failed to ensure that R1 was ordered and received necessary insulin for a diagnosis of insulin dependent diabetes upon her admission to the facility from 2/14/24 to 2/19/24. The facility's failure placed R1 in a severe adverse outcome, hyperglycemia, and diabetic ketoacidosis. Due to this significant medication error R1 became unresponsive and was emergently transferred to a hospital and received emergent treatment for hyperglycemia, diabetic ketoacidosis, and acute kidney injury resulting in harm to the resident. Based on interviews and review of the facility documentation and other sources, an Immediate Jeopardy (IJ) was called on 2/23/24 at 1:14 PM. The IJ was abated on 2/23/24 at 3:50 PM. Findings include: A facility nursing policy dated 12/8/14, and revised	F 760	A. Unable to correct for R1 affected by deficient practice related to the resident discharging on 2/19/2024. B. All current residents with diagnosis of diabetes have the potential to be affected by the deficient practice. All current residents with diagnosis of diabetes identified on 2/20/2024 and audited to ensure insulin orders are in place, accuchecks orders have been put in place if needed or recent HGA1C, diabetes care plan, hypoglycemic protocols C. Root Cause analysis determined there needs to be re-education to multiple disciplines on the process for thoroughly reviewing hospital transfer paperwork at the time of admission from acute care hospital to the Milford Center to ensure all areas of the residents plan of care is	4/4/24

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F 760	Continued From page 14 6/1/21, titled, "24 Hour Chart Check", documented " ...The licensed nurse completing the 24 Hours Chart Check identifies and corrects improper orders in the medical record ...the purpose is to validate the correctness of orders, proper transcription, and to prevent improper treatment or omission of treatment, medication, ancillary orders, or documentation ..." R1's records revealed: 2/14/24 9:11 PM - R1 was admitted to the facility with diagnoses including but not limited to insulin dependent diabetes mellitus with hyperglycemia. R1's hospital physician's discharge orders included, "insulin lispro (insulin lispro 100 units/ml injectable solution) via continuous insulin pump per current pump settings". 2/15/24 - R1's baseline care plan documented, "Non-insulin dependent diabetic". 2/15/24 - E5's (NP) progress notes documentation included, " ...Patient (R1) to continue on insulin ...I reviewed external hospital notes/discharge summary ..." 2/15/24 - The MAR lacked evidence of an order or an administration of insulin. 2/16/24 - E5's (NP) progress notes documentation included, " ...Patient (R1) to continue insulin ..." 2/16/24 - The MAR lacked evidence of an order or an administration of insulin. 2/19/24 6:40 AM - R1's clinical records documented that R1 was observed with medical	F 760	addressed and carried out at the center. Nurse Practice Educator/ Designee will provide re-education to all current licensed nursing staff on the following policies NSG251 24 hour chart checks, OPS401 Admission Process with intense focus on reviewing the hospital records thoroughly with focus on diabetes medications and residents admitted with insulin pumps, NSG117 Transcription of Orders with a focus on reviewing diagnosis and orders with the physician and documenting in the residents chart the provider who approved the orders and NSG122 change in condition notification with a focus on initiating a change in condition post acute event. Nursing leadership including the DON will also be re-educated on thoroughly reviewing new admission paperwork to ensure all noted plan of care documentation from the hospital paperwork has been addressed. Clinical Reimbursement will be re-educated to ensure the diagnosis for each resident is addressed in the POC. Unit Clerks will also be re-educated on uploading the hospital transfer paperwork timely in the residents electronic chart. NPE/Designee will provide re-education to all current Providers related to thoroughly reviewing hospital records to ensure all areas of the patient's plan of care have been addressed upon admission NPE/designee will provide re-education to the centers Consultant Pharmacist to ensure they thoroughly review the after visit summary. All listed education was initiated on 2/20/2024 and will be completed by 2/24/2024 the remaining	

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F 760	Continued From page 15 status changes including respiratory distress. R1's blood sugar was, "was greater than 500, and the glucometer read HI". Normal blood sugar ranged between 70-120 (World Health Organization). 2/19/23 7:35 AM - R1's electronic emergency room records documented blood sugars of 580 and 980. 2/22/24 12:10 PM - A review of R1's MAR from 2/14/24 through 2/19/24 lacked evidence that the facility administered any insulin. 2/22/24 1:30 PM - During a telephone interview, E5 (NP) stated, "I saw that the resident (R1) had an episode of low blood on 2/15/23 at 6:00 AM, and I wanted to wait to see if she needed insulin". E5 confirmed that she did not order blood sugar checks to monitor R1's blood sugar status for further evaluation. E5 also confirmed that her documentation in R1's medical records included "resident (R1) continues on insulin". 2/22/24 2:00 PM - During a telephone interview, E4 (RN) stated, "The hospital nurse told me that the resident (R1) was diabetic when she called report". A review of R1's medical records lacked evidence that the doctor was notified of the admission orders. E4 (RN) stated, "I don't remember which doctor I spoke to. I did not know I had to write that information down." 2/23/24 10:25 AM - During a telephone interview with E6 (Consultant Pharmacist) stated, "I reviewed R1's records on 2/15/24, but I missed the order for the insulin". E6 confirmed that R1's order for insulin dated 2/14/24 was missed from	F 760	employees who are PRN or have not worked since 2/20/2024 will not work in the facility prior to receiving said education. D. The Nursing Leadership team will audit all new admissions daily. Audits will occur daily x 3 months or until 100% compliant. Results of the audits will be reviewed at the monthly QAPI meeting	

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F 760	Continued From page 16 the hospital records. The facility failed to order and administer R1 with necessary insulin to treat her diabetes per her hospital discharge orders dated 2/14/24. R1 was sent to the hospital and was diagnosed with hyperglycemia, diabetic ketoacidosis, and acute kidney injury. 2/23/24 1:14 PM - Based on interviews and review of the facility documentation and other sources, an Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA), E2 (DON), E3 (RRM). 2/23/24 3:50 PM - E1 (NHA) submitted an acceptable abatement plan with documentation that all current residents with diagnosis of diabetes were audited to ensure that insulin orders, blood sugar checks, labs needed, diabetes care plan and hypoglycemic protocols were in place. All current licensed nursing staff and personnel involved in the admission process including providers, and consultant pharmacist, were and will be provided with re-education on 24 hours chart checks, admission process with intense focus on reviewing the hospital records thoroughly for focus on diabetes medications, and residents admitted with insulin pumps, transcription of orders with focus on reviewing diagnosis and orders with physician and documenting the name of the provider who approved the orders. The facility's Immediate Jeopardy was abated at this time. 2/23/24 3:55 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM).	F 760		
F 941 SS=D	Communication Training	F 941		4/4/24

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F 941	Continued From page 17 CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training on effective communications for direct care staff was completed for two (E10 and E21) out of four sampled employees. Findings include: 2/27/24 10:00 AM - Review of the employee training records revealed a lack of evidence of effective communications for direct care staff training of the following staff: 4/24/23 - E10's first day in the facility assigned as Agency LPN. 9/20/21 - E23's first day in the facility hired for the RN (Registered Nurse) position. 2/27/24 2:00 - Findings were comfirmed by E1 (NHA) during an interview. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 941	A. All current direct care staff, including agency direct care staff, will be educated on effective communication. B. All direct care staff, including agency direct care staff, have the potential to be affected by the deficient practice. The Nurse Practice Educator/designee will conduct an audit of all current direct care staff, including agency direct care staff, to identify staff who have not completed the mandatory effective communication training. All deficient findings will be corrected. C. Root cause analysis determined that there is not a process in place for ensuring that all direct care staff have completed the mandatory effective communication training. The center will implement a new process where monthly the Nurse Practice Educator will audit the quarterly mandatory in-services in healthstream to ensure all current direct care employees complete the requirement by each quarterly deadline date to ensure that all direct care staff will complete mandatory effective communication training yearly. Director of Nursing/Designee will educate Nurse Practice Educator on the new process to monitor the completion of the mandatory	

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F 941	Continued From page 18	F 941	effective communication training by all direct care staff. D. The Nurse Practice Educator/Designee will complete an audit (Attachment F) of all new direct care staff, including agency direct care staff, to ensure mandatory training for effective communication has been completed. Audits will occur monthly x 3 months, or until 100% compliance has been achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	
F 942 SS=D	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training on resident rights was completed for three (E10, E21 and E22) out of four sampled employees. Findings include: 2/27/24 10:00 AM - Review of the employee training records revealed a lack of evidence of resident rights training of the following staff: 4/24/23 - E10's first day in the facility assigned as Agency LPN.	F 942	A. All current direct care staff, including agency direct care staff, will be educated on Resident's Rights. B. All direct care staff, including agency direct care staff, have the potential to be affected by the deficient practice. The Nurse Practice Educator/designee will conduct an audit of all current direct care staff, including agency direct care staff, to identify staff who have not completed the mandatory Resident's Rights training. All deficient findings will be corrected.	4/4/24

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F 942	Continued From page 19 2/25/82 - E21's first day in the facility hired for the CNA (Certified Nurse Assistant) position. 9/26/23 - E22's first day in the facility assigned as Agency LPN. 2/27/24 2:00 - Findings were comfirmed by E1 (NHA) during an interview. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 942	C. Root cause analysis determined that there is not a process in place for ensuring that all direct care staff have completed the mandatory Resident's Rights training. The center will implement a new process where monthly the Nurse Practice Educator will audit the quarterly mandatory in-services in healthstream to ensure all current direct care employees complete the requirement by each quarterly deadline date to ensure that all direct care staff will complete mandatory Resident Rights training yearly. The Director of Nursing/designee will re-educate the NPE on the new process to monitor the completion of the mandatory Resident's Rights training by all direct care staff. D. The Nurse Practice Educator/Designee will complete an audit (Attachment F) of all new direct care staff, including agency direct care staff, to ensure mandatory training for Resident's Rights has been completed. Audits will occur monthly x 3 months, or until 100% compliance has been achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 943		4/4/24

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F 943	Continued From page 20 §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training on abuse, neglect and exploitation was completed for three (E10, E21 and E22) out of four sampled employees. Findings include: 2/27/24 10:00 AM - Review of the employee training records revealed a lack of evidence of Abuse, Neglect and Exploitation training of the following staff: 4/24/23 - E10's first day in the facility assigned as Agency LPN. 2/25/82 - E21's first day in the facility hired for the CNA (Certified Nurse Assistant) position. 9/26/23 - E22's first day in the facility assigned as Agency LPN. 2/27/24 2:00 PM - Findings were comfirmed by E1 (NHA) during an interview. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the	F 943	A. All current direct care staff, including agency direct care staff, will be educated on Abuse, Neglect, and Exploitation. B. All direct care staff, including agency direct care staff, have the potential to be affected by the deficient practice. The Nurse Practice Educator/designee will conduct an audit of all current direct care staff, including agency direct care staff, to identify staff who have not completed the mandatory Abuse, Neglect, and Exploitation training. All deficient findings will be corrected. C. Root cause analysis determined that there is not a process in place for ensuring that all direct care staff have completed the mandatory Abuse, Neglect, and Exploitation training. The center will implement a new process where monthly the Nurse Practice Educator will audit the quarterly mandatory in-services in healthstream to ensure all current employees complete the requirement by each quarterly deadline date to ensure	

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F 943	Continued From page 21 exit conference.	F 943	that all direct care staff will complete mandatory Abuse and Neglect training yearly. Director of Nursing/Designee will educate NPE on the new process to monitor the completion of the mandatory Abuse and Neglect training by all direct care staff. D. The Nurse Practice Educator/Designee will complete an audit (Attachment F) of all new direct care staff, including agency direct care staff, to ensure mandatory training for Abuse, Neglect, and Exploitation has been completed. Audits will occur monthly x 3 months, or until 100% compliance has been achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	
F 944 SS=D	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training on QAPI (quality assurance and performance improvement) was completed for two (E10 and E23) out of four sampled employees. Findings include:	F 944	A. All current direct care staff, including agency direct care staff, will be educated on the QAPI program. B. All direct care staff, including agency direct care staff, have the potential to be affected by the deficient practice. The NPE/designee will conduct an audit of all	4/4/24

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F 944	Continued From page 22 2/27/24 10:00 AM - Review of the employee training records revealed a lack of evidence of QAPI training of the following staff: 4/24/23 - E10's first day in the facility assigned as Agency LPN. 9/20/21 - E23's first day in the facility hired for the Registered Nurse (RN) position. 2/27/24 2:00 PM - Findings were comfirmed by E1 (NHA) during an interview. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 944	current direct care staff, including agency direct care staff, to identify staff who have not completed the mandatory QAPI training. All deficient findings will be corrected. C. Root cause analysis determined that there is not a process in place for ensuring that all direct care staff have completed the mandatory QAPI training. The center will implement a new process where monthly the Nurse Practice Educator will audit the quarterly mandatory in-services in healthstream to ensure all current direct care employees complete the requirement by each quarterly deadline date to ensure that all direct care staff will complete mandatory QAPI training yearly. Director of Nursing/Designee will educate NPE on the new process to monitor the completion of the mandatory QAPI training by all direct care staff. D. The NPE/Designee will complete an audit (Attachment F) of all new direct care staff, including agency direct care staff, to ensure mandatory training for QAPI has been completed. Audits will occur monthly x 3 months, or until 100% compliance has been achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	
F 945 SS=D	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection	F 945		4/4/24

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F 945	Continued From page 23 prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training on infection control program was completed for one (E10) out of four sampled employees. Findings include: 4/24/23 - E10's first day in the facility assigned as Agency LPN. 2/27/24 10:00 AM - Review of E10's employee training records revealed a lack of evidence of infection control program training. 2/27/24 2:00 - Findings were comfirmed by E1 (NHA) during an interview. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 945	A. All current direct care staff, including agency direct care staff, will be educated on Infection Control. B. All direct care staff, including agency direct care staff, have the potential to be affected by the deficient practice. The Nurse Practice Educator/designee will conduct an audit of all current direct care staff, including agency direct care staff, to identify staff who have not completed the mandatory Infection Control training. All deficient findings will be corrected. C. Root cause analysis determined that there is not a process in place for ensuring that all direct care staff have completed the mandatory Infection Control training. The center will implement a new process where monthly the Nurse Practice Educator will audit the quarterly mandatory in-services in healthstream to ensure all current direct care staff complete the requirement by each quarterly deadline date to ensure that all direct care staff will complete mandatory Infection Control training yearly. Director of Nursing/Designee will educate Nurse Practice Educator on the new process to monitor the completion of the mandatory Infection Control training by all direct care staff.	

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F 945	Continued From page 24	F 945	D. The Nurse Practice Educator/Designee will complete an audit (Attachment F) of all new direct care staff, including agency direct care staff, to ensure mandatory training for Infection Control has been completed. Audits will occur monthly x 3 months, or until 100% compliance has been achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	
F 946 SS=D	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required yearly training on compliance and ethics program was completed for three (E10, E21 and E22) out of four sampled employees. Findings include: 2/27/24 10:00 AM - Review of the employee training records revealed a lack of evidence of compliance and ethics program training of the	F 946	A. All current direct care staff, including agency direct care staff, will be educated on Compliance and Ethics. B. All direct care staff, including agency direct care staff, have the potential to be affected by the deficient practice. The Nurse Practice Educator/designee will conduct an audit of all current direct care staff, including agency direct care staff, to	4/4/24

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F 946	Continued From page 25 following staff: 4/24/23 - E10's first day in the facility assigned as Agency LPN. 2/25/82 - E21's first day in the facility hired for the CNA (Certified Nurse Assistant) position. 9/26/23 - E22's first day in the facility assigned as Agency LPN. 2/27/24 2:00 - Findings were comfirmed by E1 (NHA) during an interview. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 946	identify staff who have not completed the mandatory Compliance and Ethics. All deficient findings will be corrected. C. Root cause analysis determined that there is not a process in place for ensuring that all direct care staff have completed the mandatory Compliance and Ethics training. The center will implement a new process where monthly the Nurse Practice Educator will audit the quarterly mandatory in-services in healthstream to ensure all current employees complete the requirement by each quarterly deadline date to ensure that all direct care staff will complete mandatory Compliance and Ethics training yearly. Director of Nursing/Designee will educate Nurse Practice Educator on the new process to monitor the completion of the mandatory Compliance and Ethics training by all direct care staff. D. The Nurse Practice Educator/Designee will complete an audit (Attachment F) of all new direct care staff, including agency direct care staff, to ensure mandatory training for Compliance and Ethics has been completed. Audits will occur monthly x 3 months, or until 100% compliance has been achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse	F 947		4/4/24

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F 947	Continued From page 26 aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (E16, E17, E18 and E20) out of five sample Certified Nursing Assistants (CNAs) reviewed, the facility failed to ensure that these employees had the mandatory twelve hours of annual in-service training. Findings include: 2/27/24 9:30 AM - Review of the staff training hours documentation revealed the following: E16 (CNA) with a hire date of 9/24/13 had only 8.4 hours of training; E17 (CNA) with a hire date of 8/20/18 had only 3.10 hours of training; E18 (CNA) with a hire date of 7/5/22 had only 4.5 hours of training; E20\(CNA) with a hire date of 9/8/21 had only 4.56 hours of training.	F 947	A. E16, 17, 18, 19, 20 unable to correct as it is no longer 2023. B. All current nursing aides have potential to be affected by the deficient practice. The Nurse Practice Educator/Designee will audit all current nursing aides to ensure that they have completed their Q1 mandatory education. C. Root cause analysis determined that there is not a process in place for ensuring that all nursing aides are completing the mandatory 12 hours of education annually. The center will implement a new process where monthly the Nurse Practice Educator will audit the quarterly mandatory in-services in	

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F 947	Continued From page 27 The facility lacked evidence that these employees completed the mandatory twelve hours of annual in-service training. 2/27/23 1:45 PM - In an interview, E1 confirmed that the facility has no additional information regarding the training and that it was not completed by E16, E17, E18 and E20. E1 stated that those were the only training records that the facility has on file. E1 further confirmed that the facility has no other additional records of the employees' training's from anniversary date to anniversary date. 2/27/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (RRM) during the exit conference.	F 947	healthstream to ensure all current nursing aides complete the requirement by each quarterly deadline date to ensure that all current nursing aides will have completed the requirement of yearly 12 hours of education annually. Administrator/Designee will educate Nurse Practice Educator on the new process to monitor the completion of the mandatory 12 hours of training by all current nursing aides. D. The Nurse Practice Educator/Designee will complete an audit (Attachment G) of all current nursing aides to ensure mandatory quarterly training has been completed to ensure an annual total of no less than 12 hours of training. Audits will occur quarterly x 1 year, or until 100% compliance has been achieved. Results of the audits will be reviewed at the monthly QAPI committee meeting.	