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

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

**STATE SURVEY REPORT**



**NAME OF FACILITY: Milford Center**

**DATE SURVEY COMPLETED: August 30, 2023**

| 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.**<br><br>An unannounced complaint survey was conducted at this facility on August 30, 2023. The facility census on the first day of the survey was 117. The survey process included observations, interviews, review of residents' clinical records, and review of other facility documentation.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>Director of Nursing (DON); | Cross reference CMS 2567-L<br>Plan of Correction<br><br>A. No Resident was identified<br>B. All Residents have the potential to be affected by staffing levels below the 3.28 hours of direct care per resident per day.<br>C. Root Cause Analysis indicated that ppd staffing was related to hiring needs and staff call-offs.<br>The facility has contracted with staffing agencies to provide supplemental staff, contracting staff with guaranteed hours of work per week.<br>Local advertising for help wanted.<br>Offering bonuses as needed for staff to pick up shifts.<br>Development of gift card drawings for attendance, not calling off.<br>D. The Director of Nursing/designee will monitor the projected and actual hours of direct care per resident per day to meet or exceed the minimum 3.28 hours per patients day. Results will be reported to the QAPI Committee for further direction. | 09/27/2023 |
| 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.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross Refer to the CMS 2567-L survey completed August 30, 2023: F812. | | |

Provider's Signature Amy Hollaze NHA Title Administrator Date 9/15/23

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| 16 Del. Code, Ch. 11, Sub-chapter VII, §1162 Nursing Staffing | **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.**<br><br>**Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:**<br>**RN/LPN — CNA***<br>**Day 1 nurse per 15 res. — 1 aide per 8 res.**<br>**Evening 1:23 — 1:10**<br>**Night 1:40 — 1:20**<br><br>*** or RN, LPN, or NAIT serving as a CNA.**<br><br>**(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.**<br><br>**This requirement is not met as evidenced by:**<br><br>A staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long-Term Care Residents Protection on August 30, 2023. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities.<br><br>Based on review of facility documentation, it was determined that for six (6) days out of twenty-one (21) days, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: | | |

Provider's Signature Amy Hallinger DHA Title Administrator Date 9/15/23

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| | Review of facility staffing worksheets revealed the following:<br><br>6/3/23 PPD = 3.19<br><br>7/2/23 PPD = 3.06<br><br>7/3/23 PPD = 3.22<br><br>7/4/23 PPD = 3.24<br><br>7/5/23 PPD = 3.14<br><br>7/6/23 PPD = 3.08<br><br>7/8/23 PPD = 3.24<br><br>8/13/23 PPD = 2.97<br><br>8/15/23 PPD = 3.21<br><br>8/16/23 PPD = 3.21<br><br>8/17/23 PPD = 3.23<br><br>8/18/23 PPD = 2.94<br><br>8/19/23 PPD = 3.17<br><br>8/30/23 3:07 PM – Findings were reviewed with E1 (Corporate), E2 (Senior Market DON) and E3 (DON) during the exit conference.<br><br>The facility failed to maintain the minimum PPD staffing requirement of 3.28. | | |

Provider's Signature Lucy Hollinger NHA Title Administrator Date 9/15/23

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085010 | A. BUILDING _____ B. WING _____ | C 08/30/2023 |

| 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<br><br>An unannounced complaint survey was conducted at this facility on August 30, 2023. The facility census on the first day of the survey was 117. The survey process included observations, interviews, and review of other facility documentation.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>DON - Director of Nursing. | F 000 | | |
| F 812 | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to prevent the | F 812 | A. No Resident Was identified.<br>B. All Residents had the potential to be | 9/27/23 |

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

Electronically Signed | 09/15/2023

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 812 | Continued From page 1<br>occurrence of mold in high moisture areas and maintain food storage areas in a clean and safe condition. Findings include:<br><br>8/30/23 9:38 AM - The surveyor observed the bottoms of all of the shelving and several of the tops of the shelving in the walk-in refrigerator were covered with numerous areas of small to medium black spots, which appeared to be mold.<br><br>8/30/23 9:52 AM - One of the seams in the metal floor if the walk-in refrigerator was not sealed tightly leaving a space for rodents and other pests to access the refrigerator and allowing debris to accumulate preventing proper sanitation of the area. The upper edge of the floor seam showed a large area of heavy rust staining indicating prolonged contact with water.<br><br>8/30/23 3:07 PM - Findings were reviewed with E1 (Corporate), E2 (Senior Market DON) and E3 (DON) during the exit conference. | F 812 | affected by the identified deficient practice,<br>C. Root Cause Analysis identified that the previous Dietary Services Manager did not educate and monitor staff duties including the proper cleaning of shelving in the walk-in refrigerator.<br>The previous facility Administrator did not identify and follow through with obtaining the corrections for the floor of the walk-in refrigerator.<br>The walk-in plate floor was removed to thoroughly clean the subfloor, then sealing the floor with an epoxy system, then re-installing and sealing the diamond plate.<br>Re-education of Dietary staff by the Dietary Services Manager/designee on the cleaning protocols of the walk-in shelving.<br>D. The Dietary Services Manager/designee will monitor the shelving and seams of the walk-in for potential signs of mold growth and that the floor seams are functional 3 times per week for two weeks. If 100% compliance is achieved, then weekly for 3 weeks. Results will be reported to the QAPI Committee for further direction. | |