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: Millcroft Living Nursing Home

DATE SURVEY COMPLETED: October 19, 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. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from October 16, 2023 through October 19, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records, facility documentation and other resources as indicated. The facility census on the first day of the survey was 75. The survey sample size was 27 residents.			
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: Cross refer to the CMS 2567-L survey completed 10/19/23: F580, F686, F688, F695, F728, F730, F757, F760 and F812.			

Provider's Signature _____ Title Executive Director Date 11/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	C 10/19/2023

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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning October 19, 2023 through October 20, 2023 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 75. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/16/23-10/19/23 Survey Census: 75 Sample Size: 26 Supplemental Residents: 0	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		12/6/23

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

Electronically Signed | 11/15/2023

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.

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F 580	Continued From page 1 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

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F 580	Continued From page 2 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility investigation, the facility failed to notify the physician of an elevated anticoagulant lab value in a timely manner for one resident (Resident (R) 14) reviewed for a significant medication error out of a total sample of 26 residents. Findings include: Review of R14's "Admission Record" located in the electronic medical record (EMR) indicated she was admitted to the facility on 06/21/16 with a primary diagnosis of heart failure and atrial fibrillation (irregular heartbeat). Review of R14's "Care Plan," located in the EMR under the "Care Plan" tab and revised on 06/02/21, included usage of anti-coagulant therapy to manage the medical condition of atrial fibrillation and history of cerebral vascular accident (stroke). Review of R14's "Order Summary Report," located in the EMR and dated 02/24/22, included Coumadin 4mg tablet by mouth at bedtime due to permanent atrial fibrillation. Review of R14's "Order Summary Report," located in the EMR and dated 07/07/22, revealed a physician's order to check the INR (blood test to check clotting time) in the morning on 08/04/22	F 580	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. R14 is still a resident in this facility. The Medical Director and Director of Nursing have met to review the chart of R14 and to ensure no current change in the resident condition. No adverse effect of failure to notify Medical Director of elevated anticoagulant (INR) level and medication error noted. R14 has had her current medication regimen reviewed by the Medical Director and Director of Nursing to ensure order accuracy, including the order for Coumadin. The nursing staff has been educated on timely notification of physician of all anticoagulant lab results. Identification of Other Residents: " All Residents on anticoagulant have the potential to be affected. Other residents will be identified by ensuring that all resident changes of condition and lab values have been communicated to the physician. A 100% audit of all current residents on anticoagulant medication with laboratory draws to identify any abnormal anticoagulant (INR) lab values and to ensure physician notification has been completed. No new concerns regarding physician notification of changes were identified from this audit.	

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F 580	Continued From page 3 for Coumadin (blood thinner) usage. Review of R14's INR lab value on 08/04/22 at 8:00 AM, on the "Treatment Administration Record" in the EMR, revealed a reading of 3.3. Optimal values for a resident on Coumadin are 1-3, due to values above three may lead to increased risk for bleeding and bruising. Review of the facility investigation dated 08/04/22, provided by the facility, indicated R14 was administered Coumadin 4mg on the evening of 08/04/22 before the INR result of 3.3 was communicated to the Medical Director for further orders in response to the elevated INR. Review of the facility investigation report revealed that a former (no longer employed by facility) Licensed Practical Nurse (FLPN) on the 7:00 AM-3:00 PM shift on 08/04/22 did not report the elevated INR level to the physician or the evening shift nurse (3:00 PM-11:00PM) resulting in a dose of Coumadin 4mg being given on the evening of 08/04/22 by LPN2 at 8:00 PM. Based on the investigation report, the evening Unit Manager (RN1) notified the Nurse Practitioner. Orders were received to monitor for bleeding and recheck the INR on the morning of 08/05/22. During an interview on 10/19/23 at 11:57 AM, the Director of Nursing (DON) confirmed that the FLPN failed to report R14's elevated INR result to the Medical Director in a timely manner which resulted in a significant medication error. Cross Reference: F760.	F 580	System Changes: " The Root Cause of the concern was the failure to notify the primary care physician of an elevated anticoagulant (INR) lab value for R14 in a timely manner. The facility system for physician notification has been updated to include a review and verification of physician notification of all resident changes of condition during the interdisciplinary daily (Monday through Friday) clinical review meeting. All INR values to be reported to the Supervisor, Director of Nursing and Physician by charge nurse on receiving results. The facility policy Acute Condition Changes □ Clinical Protocol (revised 3.2018) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirements for physician notification of changes in resident□s condition and timely reporting of lab results. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents for physician notification of change of condition and timely reporting of anticoagulant (INR) lab results will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations,	

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F 580	Continued From page 4	F 580	and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility policy, the facility failed to ensure one of one residents (Resident (R) 50) reviewed for prevention of skin breakdown out of a total sample of 26 residents received padding to the skin as ordered by the physician. Findings include: Observation on 10/16/23 at 10:42 AM revealed the padding on R50's hip was dated 10/06/23. During interview on 10/16/23 at 1:35 PM, R50's	F 686	Corrective Action: " Resident #50 is still a resident of this facility and has experienced no adverse effects regarding the deficient practice, as evidenced by no development of pressure ulcer. Protective dressing was immediately changed as ordered. The physician order and care plan for Resident #50 has been reviewed and updated to reflect current skin care interventions and pressure relieving interventions. The Braden assessment has been reviewed	12/6/23

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F 686	Continued From page 5 family member (F)1 stated that she also noted the date of the padding was 10/06/23. Review of R50's "Admission Record," provided by the facility, revealed the resident was admitted to the facility on 09/22/22 with a diagnosis of dementia and protein calorie malnutrition. Review of the quarterly "Minimum Data Set (MD)" with an Assessment Reference Date (ARD) of 09/07/23 revealed R50 was at risk for developing pressure ulcers but had no pressure ulcers or skin breakdown. Observation on 10/16/23 at 2:17 PM revealed the left hip patch was dated 10/06/23. Further observation on 10/16/23 at 2:45 PM with Licensed Practical Nurse (LPN) 1 revealed R50 with patches to bilateral hips that were dated 10/06/23. LPN1 confirmed that the resident had orders for the padding to be changed every three days. LPN1 stated she was not sure why the padding had not been changed since 10/06/23. Review of the "Physician Order," provided by the facility and dated 12/30/22, indicated "Bilateral Hips: Tx: [treatment] Foam Q3D [every three days] & [and] PRN [as needed] for protection." Review of the "Treatment Administration Record (TAR)" from 10/01/23 through 10/31/23 revealed that order was signed off as completed on 10/09/23, 10/12/23, and 10/15/23 even though observations of the padding revealed a date of 10/06/23. Interview with the Director of Nursing (DON) on 10/19/23 at 1:31 PM, stated he expects staff to follow all physician orders and dressing changes to be done as ordered.	F 686	and revised to accurately reflect the resident skin risk. The treatment orders for the wound have been reviewed and found to be appropriate. Nursing personnel have been educated on the care plan for Resident #50, including pressure relieving interventions, implementing physician treatment orders as written, and skin care interventions. Identification of Other Residents: " All Residents have the potential to be affected by the deficient practice. A 100% audit of all residents with wounds and protective dressings has been completed to ensure that nursing staff are following physician□s treatment orders and applying treatment when due. Nursing personnel have been educated regarding following physician orders and applying treatment when due. System Changes: " The root cause of the concern was a failure by nursing staff to follow physician orders for wound prevention. The facility policy for wound management was reviewed and found to meet professional standards. Nursing personnel have been educated regarding pressure relieving interventions, and skin care interventions. Weekly Wound Rounds (Thursdays)will be followed by a Weekly (Tuesdays) Interdisciplinary Team (IDT) risk review to determine any needed changes to the plan of care. The nursing management team will provide oversight to ensure ongoing compliance.	

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F 686	Continued From page 6 Review of the facility's policy titled, "Wound Care," revised October 2010, indicated, "Preparation ...1. Verify there is a physician's order for this procedure ...Documentation ...The following information should be recorded in the resident's medical record ...1. The type of wound care was given.."	F 686	Success Evaluation: " A wound management audit to ensure the proper treatment, and care planning of all wounds and protective dressings will be completed by the Director of Nursing or designee; An audit of a random sample of 10% of residents with wounds and protective dressings. Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		12/6/23

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F 688	Continued From page 7 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide nursing services as ordered for one of three residents (Resident (R) 36) reviewed for application of splints out of a total sample of 26 residents. This failure had the potential to decrease physical functioning, quality of life, and independence. Findings include: Review of the facility policy titled, "Resident Mobility and Range of Motion," revised 07/2017, stated in part " ... 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM [range of motion]. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable ..." Review of R36's "Admission Record," located in the electronic medical record (EMR) indicated he was admitted to the facility on 01/05/18 with a primary diagnosis of acute respiratory failure with hypoxia. Comorbidities included muscle wasting and atrophy, hemiplegia and hemiparesis (partial paralysis and weakness) following a cerebral infarction (stroke) affecting the right dominant side. Review of R36's "Order Summary Report," located in the EMR under the "Orders" tab, included "Patient to wear resting hand splint on	F 688	Corrective Action: " R36 is still a resident of this facility. R36 displayed no adverse effects related to the deficient practice. The order for equipment for limited range of motion and care plan for the resident was reviewed and found to meet the residents current care needs. All therapy staff members were educated on how to transcribe and schedule orders to eMAR, and nursing staff members were educated on the application of splints on resident. Identification of Other Residents: " All Residents have the potential to be affected by the deficient practice. A 100% audit of residents with orders for special equipment's to maintain range of motion has been completed. Therapy personnel were educated on how to transcribe and schedule orders to the eMAR. Nursing personnel re-education has been provided on the facility resident mobility and range of motion policy. System Changes: " The root cause of the concern was failure by therapy to correctly transcribe and schedule the order for equipment application resulting in failure of nursing staff to apply equipment. The facility policy for resident mobility and range of motion was reviewed and found to meet professional standards. Staff education	

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F 688	Continued From page 8 right hand nightly as patient tolerates to prevent further flexion contracture" dated 08/17/23. Review of R36's "Care Plan," located in the EMR under the "Care Plan" tab and revised 07/26/23, revealed it did not include use of hand splints. During an interview on 10/17/23 at 2:29 PM, R36 stated he was supposed to wear a splint on his right hand at night, but no one put it on him. When asked where the splint was located, the resident stated he hadn't seen it in quite some time. Additionally, R36 stated that the therapy department told him he should be wearing the splint at night. During an observation on 10/17/23 at 9:40 PM, it was revealed R36 was in his bed not wearing his splint. During an interview on 10/17/23 at 9:40 PM, Certified Nursing Aide (CNA)1 confirmed that R36 was not wearing a splint on his right hand, that he did not know the location of the splint but was willing to look for it. CNA1 located the splint in the second drawer of the nightstand under the incontinent briefs. CNA1 attempted to place the splint on the right hand of R36 who then complained of pain and was unable to tolerate application of the splint at that time. During an interview on 10/18/23 at 9:59 AM, the Director of Rehabilitation (DOR) confirmed that R36 had been wearing a right-hand splint since 2021. The DOR stated that R36 had received occupational and physical therapy services from 07/26/23 through 09/08/23 and at that time he was able to put on and take off the splint himself. The facility's protocol was for the therapy	F 688	has been provided to all therapy personnel on scheduling transcribed order on eMAR, and to nursing personnel on resident mobility and range of motion policy, and how to apply splints. Director of Nursing or Designee will monitor new orders for proper transcription. Monday (Monday to include the weekend) □ Friday an order report will be printed, and orders checked for accuracy. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all residents with special equipment to maintain range of motion has been completed to ensure compliance with care and documentation. An audit of 10% of same group will then be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 688	Continued From page 9 department to train the CNA's to apply the splints, then if there are any changes in status, then the therapy department would be notified by the nursing department, and a new screening would be completed by the therapy department. During an interview on 10/18/23 at 11:30 AM, Licensed Practical Nurse (LPN) 2 confirmed R36 had an order for nightly hand splint application, but the order had not been activated in the electronic medical record and that staff had not been applying the splint. During an interview on 10/18/23 at 11:34 AM, Unit Manager (UM) 1 confirmed that R36 had an order in the EMR for nightly splint usage at bedtime, but it was not triggered for the nurses on the treatment record so it had not been being done as of that time but should have been.	F 688		
F 695 SS=D	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, record review, and policy review, the facility failed to clean respiratory equipment for one of one resident (Residents (R) 65) reviewed for oxygen therapy out of a total sample of 26 residents.	F 695	Corrective Action: " R65 is still a resident of this facility. No adverse effect noted from the deficient practice. Corrective actions have been ensured by the Director of Nursing. The	12/6/23

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F 695	Continued From page 10 Findings include: Review of R65's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR), revealed R65 was admitted to the facility on 05/08/23 with diagnoses which included pneumonia, acute respiratory failure hypoxia, depression, and anxiety disorder. Review of R65's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/12/23, located under the "RAI" tab, indicated R65 was extensive assist of one staff member for bed mobility, dressing, and toileting; transfers only happened once or twice. The MDS showed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 indicating R65 was cognitively intact. Review of R65's EMR under the "Orders" tab revealed the following physician's orders: "Continuous oxygen 2 Liter/minute via NC (nasal cannula). Change O2 (oxygen) tubing and humidifier bottle on admission and q weekly - every night shift on Monday." Both orders dated 05/08/23. During observations on 10/16/23 at 10:13 AM and 10/18/23 at 3:02 PM, R65's concentrator was observed with one air filter on the back of the machine. The air filter was noted to have a thick coating of dust upon it. During an interview on 10/19/23 at 9:44 AM, the Director of Nursing (DON) was shown the concentrator and the dust covered air filter. The DON agreed the air filter was dusty and washed the filter immediately. Review of the facility's policy titled, "Departmental	F 695	order for respiratory equipment cleaning and policy were reviewed and found to be appropriate. All nursing staff members were educated on the facility□s policy Departmental (Respiratory Therapy)- - Prevention of Infection (rev.2011) Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all oxygen concentrator filters are changed or washed weekly when all oxygen tubing and equipment is changed. A 100% audit of all oxygen concentrators has been completed to ensure that each concentrator has a clean filter. No new concerns regarding oxygen concentrator filters were identified from this audit. System Changes: " The Root Cause of the concern was a failure to check oxygen concentrator filters when checking other oxygen equipment routinely. The facility system for weekly routine oxygen tubing and equipment changing has been changed to include oxygen concentrator filters are changed or washed weekly. The facility policy for Departmental (Respiratory Therapy) □ Prevention of Infection (rev. 11.2011) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for infection control considerations related to oxygen administration and oxygen concentrator filters. The nursing management team will provide oversight	

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F 695	Continued From page 11 (Respiratory Therapy) - Prevention of Infection," revised 09/10, stated "Purpose The purpose of this procedure is to guide the prevention of infection associated with respiratory therapy tasks and equipment ...among residents and staff ...Steps in the Procedure Infection Control Considerations Related to Oxygen Administration ...9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry ..."	F 695	to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents who have oxygen concentrators will be completed by the Director of Nursing or Designee to ensure that each concentrator has a clean filter; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or	F 728		12/6/23

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F 728	Continued From page 12 determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and personnel record review, the facility failed to ensure that a Certified Nursing Aid (CNA) was registered with the state of Delaware for one of five personnel records reviewed. Findings include: Review of the personnel record of CNA1, indicated CNA1 was employed at the facility as a CNA on 03/29/22. Further review of CNA1's personnel file indicated CNA1 had obtained a "Certificate of Completion as a Temporary Nurse Aide" on 06/12/21. CNA1's CNA Registry for the State of Delaware could not be located in the	F 728	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. C.N.A1 is no longer employed by the facility. The facilities human resource personnel was educated by the Administrator on ensuring that all policy□s are observed in vetting employees for competency to work in the facility. Identification of Other Residents: " All Residents have the potential to be affected. Residents will be protected by ensuring that all employees meet the regulatory requirement for licensure. A	

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F 728	Continued From page 13 personnel file. During an interview on 10/19/23 at 1:14 PM with the Administrator, the Administrator confirmed CNA1 was not a registered CNA in the state of Delaware. The Administrator explained CNA1 had received temporary status during the Coronavirus disease 2019 (COVID - 19) epidemic but had not obtained an actual/active registry since the COVID-19 waiver had been lifted. The Administrator stated CNA1 worked in the building as recently as yesterday but will not be returning as an employee of the facility at this time.	F 728	100% audit of employee license requirement has been completed to ensure proper licensure. No new concerns regarding staff licensure were identified from this audit. System Changes: " The Root Cause of the concern was a failure to complete the audits regarding staff licensure requirements. The facility system for licensure audits has been updated to ensure that no employee begins working until their licensure is verified. The facility policy was reviewed and found to meet professional standards. The Administrator or Designee will complete education for the human resource staff regarding the licensure audits policy. The administrator will provide oversight to ensure ongoing compliance. Success Evaluation: " A random sample of 10% of employees will be completed to ensure that all employees meet the regulatory requirement for pre-employment screening for licensure; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality	

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F 728	Continued From page 14	F 728	Assurance Team.	
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 personnel record review, the facility failed to ensure that Certified Nursing Assistant (CNA)1 received a yearly performance evaluation for one of five personnel records reviewed. Findings include: Review of the personnel record for CNA1, indicated CNA1 completed the "Temporary Nurse Aide" online course on 06/12/21. The personnel record indicated CNA1 had been employed as a CNA at the facility since 03/29/22. During an interview on 10/19/23 at 1:14 PM with the Administrator, the Administrator confirmed CNA1 had not received a yearly performance evaluation (due March of 2023). The Administrator explained CNA1 was an employee of the assisted living side and had moved over to the long-term care side. The Administrator explained it was an oversight of the Human Resource Departments of the Long-Term Care and the Assisted Living areas of the facility that the performance evaluation was not completed.	F 730	Corrective Action: " Corrective actions have been ensured by the Administrator and the Director of Nursing. C.N.A 1 is no longer employed by the facility. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, the facility has completed a 100% audit of all current employees to ensure that all performance review and training requirements have been completed. System Changes: " The Root Cause of the concern was a failure to adhere to the facility policy for Staff Development Program (rev. 5.2019) and annual performance review. The facility policy for Staff Development Program (rev. 5.2019) was reviewed and found to meet professional standards. The facility system for managing the Staff Development Program has been updated	12/6/23

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F 730	Continued From page 15	F 730	to include a monthly review of compliance in the monthly Quality Assurance and Performance Improvement (QAPI) committee meeting. The administrator and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A Staff Development Program audit to ensure compliance with staff performance review and training requirements will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		12/6/23

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F 757	Continued From page 16 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide the appropriate dosage of antibiotics upon admission for one of six residents (Resident (R) 176) reviewed for medication administration out of 26 sample residents. Findings include: Review of R176's "Admission Record," found in the "Profile" tab of the electronic medical record (EMR), revealed he was admitted to the facility on 08/16/23, with diagnoses including acute osteomyelitis (infection of the bone) right ankle and foot. The resident was discharged on 08/23/23. Review of R176's admission "Minimum Data Set (MDS)" assessment located in the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 08/19/23, revealed a "Brief Interview for Mental Status (BIMS)" assessment with a score of 15 out of 15 which indicated no cognitive impairment. R176 required limited assistance	F 757	Corrective Action: " Corrective action was ensured by the Director of Nursing. Error was corrected before the next dose of antibiotics was due to be administered to R176. R176 is no longer a resident of this facility. No adverse effect was noted from failure to provide appropriate dosage of Antibiotics to resident. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, all nursing staff members will be educated on the requirements regarding resident drug regimens being free of transcription error. An initial 100% audit of all new admissions for the last 1 month has been completed to ensure adequate transcription and implementation of orders received on admission. No new concerns regarding Medication Reconciliation completion were noted from this audit.	

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F 757	Continued From page 17 from one staff with bed mobility, transfer, walk in room, dressing, and toileting. R176 also had impairment on one side lower extremity. He had received antibiotics for three days. Review of R176's "Care Plan," located in the "Care Plan" tab of the EMR, dated 08/17/23, revealed "The resident is on antibiotic therapy r/t [related to] right foot s/p [status post] surgical procedure infection." The resident's goal was, "The resident will be free of any discomfort or adverse side effects of antibiotic therapy through the review date." The resident's interventions included "Administer antibiotic medications as ordered by the physician. Monitor/document side effects and effectiveness Q-Shift." Record review of R176's EMR under "Miscellaneous" revealed a hospital discharge summary on 08/16/23 that documented "Plan at discharge: Continue Augmentin [antibiotic] 875-125 twice daily for 14 days post-op (end 8/24)." Review of R176's "Progress Note," located under the "Progress Notes" tab, dated 08/16/23, documented that R176 would receive Augmentin Oral Tablet 500-125 mg. Record review of R176's EMR under "Physician Orders" revealed an 08/16/23 physician order for "Augmentin Oral Tablet 500-125 mg [Amoxicillin-Pot Clavulanate]. Give one tablet by mouth every 12 hours for Osteomyelitis." This physician order was discontinued on 08/17/23. Record review of R176's EMR under "Physician Orders" revealed an 08/17/23 physician order for "Amoxicillin-Pot Clavulanate Tablet 875-125 mg.	F 757	System Changes: " " The Root Cause of the concern was a failure to correctly transcribe medication order on admission. The facility policy for Medication and Treatment Orders (rev. 7.2016) and the policy for Medication Therapy (rev. 4.2017) were reviewed and found to meet professional standards. The facility system for medication reconciliation and transcription for new admissions will include the Director of nursing or designee to review all new admission medication order on the day of admission. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirement for Medication Reconciliation completion on admission. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An initial 100% audit of all Medication Reconciliation for all new admission for the last 1 month has been completed to ensure adequate follow-up on recommendations, including Physician signature and order implementation. " In addition, Medication reconciliation audits for a random sample of 10% of residents will be completed by the Director of Nursing or Designee to ensure that resident's medication orders are transcribed correctly; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations,	

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F 757	Continued From page 18 Give one tablet by mouth every 12 hours for right foot Osteomyelitis." Review of R176's EMR August 2023 "Medication Administration Record (MAR)" revealed the physician order for "Augmentin Oral Tablet 500-125 mg (Amoxicillin-Pot Clavulanate). Give one tablet by mouth every 12 hours for Osteomyelitis." This medication was administered on 08/17/23 at 9:00 AM before being discontinued. Review of the August 2023 "MAR" revealed the physician order for "Amoxicillin-Pot Clavulanate Tablet 875-125 mg. Give one tablet by mouth every 12 hours for right foot Osteomyelitis." This medication was initiated for administration on 08/17/23 at 9:00 PM. Further review of the EMR revealed an 08/17/23 "History and Physical" by the physician, documented "Osteomyelitis. Patient has been on Augmentin 875 mg two times a day. We will continue." The physician note did not document that R176 had not been on the correct dosage of antibiotic. Review of R176's "Progress Note," located under the "Progress Notes" tab, dated 08/17/23, documented that "Augmentin 500-125 mg to be discontinued per MD." The note also documented that "Amoxicillin-Pot Clavulanate Tablet 875-125 mg. Give one tablet by mouth every 12 hours for right foot Osteomyelitis." Further review of the EMR revealed an 08/17/23 "Progress Note" that documented "Medication transcription dosage error was noted while medication order was being reviewed at IDT	F 757	then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 757	Continued From page 19 [interdisciplinary team] meeting the day after admission. Amoxicillin 500-125 mg was transcribed instead of Amoxicillin 875-125 mg ordered. IDT unaware that the wrong dosage was already administered at the time of the IDT meeting. NP [nurse practitioner] made aware and order was re-written to reflect the original order from discharging MD. Family made aware of medication change by RN supervisor." Interview on 10/19/23 at 8:40 AM with the Medical Director revealed that another facility physician had admitted R176. He stated that he had only seen R176 once, the day after admission. A concurrent interview on 10/19/23 at 12:20 PM with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Clinical revealed, the admission nurse would admit residents. If they were busy or had multiple admissions at once, a floor nurse would also admit residents. ADON stated the admission procedure was that the facility received an interagency and physician discharge summary with new admissions from the hospital, which would include physician orders. She stated that usually the facility would receive these physician orders prior to admission and would then be uploaded into the EMR. If a hospital did not provide it, the facility may have to call the hospital and get what they needed. DON stated that R176 received one dose of the lower strength antibiotic on admission. She stated that each morning the IDT reviewed admitting residents and when they had been made aware, had made an immediate rectification. DON stated it had been a transcription error. The Administrator and Regional Clinic confirmed the error had been corrected on 08/17/23.	F 757		

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F 757	Continued From page 20 A further interview on 10/19/23 at 1:00 PM with the Medical Director revealed that he had been made aware that R176 received a lower dose than ordered of antibiotic at admission. He stated that this error was corrected the next day when he met with the resident. Review of the facility's policy titled, "Medication and Treatment Orders," with a revised date of July 2016, revealed "Orders for medications and treatments will be consistent with principles of safe and effective order writing." Review further revealed "Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state." Review of the facility's policy titled "Medication Orders," with a revised date of November 2014, revealed "The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders." Review further revealed "When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered."	F 757		
F 760 SS=D	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 interviews, record reviews, facility record reviews, and policy reviews, the facility failed to ensure that one resident (Resident (R) 14) out of a total sample of 26 residents was free	F 760	Corrective Action: " R14 is still a resident in this facility. Corrective actions have been ensured by the Director of Nursing. R14 has had her	12/6/23

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F 760	Continued From page 21 from significant medication errors. Specifically, R14 was erroneously administered Coumadin (anticoagulant medication) four mg (milligrams). This failure had the potential to increase the risk for bleeding, bruising, and death. Findings include: Review of the facility's policy titled, "Medication and Treatment Orders," revised 07/2016, stated in part "Orders for medications and treatments will be consistent with principles of safe and effective order writing ...Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring ..." Review of the facility's policy titled, "Anticoagulation- Clinical Protocol," revised 11/2018, stated in part " ...the nurse shall assess and document/ report the following: a. current anticoagulation therapy, including drug and current dosage; b. recent labs, including therapeutic dose monitoring; c. other current medications; and d. all active diagnoses...In individuals receiving anticoagulation who are bleeding or who have a markedly elevating PT [prothrombin time]/INR [international normalized ratio- the higher the number the longer it takes the blood to clot], it may suffice to stop the anticoagulant and recheck the PT/INR if the individual is stable, there is no more than minor bleeding, and the INR is not more than 9. Once Vitamin K is given to try to reverse the effects of warfarin, it can hamper subsequent resumption of anticoagulation for a week or more ..." Review of R14's "Admission Record," located in the electronic medical record (EMR), indicated she was admitted to the facility on 06/21/16 with a	F 760	current medication regimen reviewed by the Medical Director and Director of Nursing to ensure that medication order matches lab value for anticoagulant. The Medication Administration Record for R14 has been reviewed to ensure no additional medication errors in the last quarter. No new medication error concerns were identified from this review. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be identified by ensuring that medication error prevention measures are in place, including ensuring that orders for anticoagulants be prescribed only with appropriate clinical and laboratory monitoring, medication reconciliation on admission, two-person verification of order entry, an admission audit to include medication orders, and daily interdisciplinary clinical review of new medication orders. A 100% audit of residents on anticoagulant medications has been completed to ensure that the above medication error prevention measures are in place, as well as professional standards of practice for medication administration (including the 7 rights of medication administration). No new concerns regarding medication errors were identified in this audit. System Changes: " The Root Cause of the concern was a failure to timely report lab value for R14, leading to failure to prevent the wrong medication dosage from being	

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F 760	Continued From page 22 primary diagnosis of heart failure and a comorbidity including atrial fibrillation (irregular heartbeat). Review of R14's "Care Plan," located in the EMR under the "Care Plan" tab and revised on 06/02/21, included usage of anti-coagulant therapy to manage medical condition of atrial fibrillation and history of cerebral vascular accident (stroke). Review of R14's "Order Summary Report," located in the EMR and dated 02/24/22, included Coumadin 4mg tablet by mouth at bedtime due to permanent atrial fibrillation. Review of R14's "Order Summary Report," located in the "EMR and dated 07/07/22, revealed a physician's order to check INR in the morning on 08/04/22 for Coumadin (blood thinner) usage. Review of R14's INR lab value on 08/04/22 at 8:00 AM, on the "Treatment Administration Record (TAR)" in the EMR, revealed a reading of 3.3. Optimal values for a resident on Coumadin are 1-3, due to values above three may lead to increased risk for bleeding and bruising. Review of the facility investigation report revealed that the Former (no longer employed at the facility) Licensed Practical Nurse (FLPN) on the 7:00 AM-3:00 PM shift on 08/04/22 documented the elevated INR on the "TAR." The evening shift nurse, LPN2, failed to review the "TAR" for the INR result, and administered Coumadin 4mg the evening of 08/04/22 even though the INR was elevated. Based on the investigation report, the evening Unit Manager (RN1) notified the Nurse Practitioner. Orders were received to monitor for	F 760	administered. The facility system for medication error prevention has been updated to add a review meeting to include daily medication reconciliation, two-person verification of order entry, and a daily admission audit to include medication orders audit. Nursing staff to document last lab value (INR) before administering Coumadin daily. The facility policies for Medication and Treatment Orders (revised 7.2016) and Anticoagulation □ Clinical Protocols (revised 11.2018) were reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirements for preventing medication errors. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A medication error prevention audit to ensure compliance regarding medication error prevention practices will be completed by the Director of Nursing or designee; audits will have a goal of 100% compliance; 100% Audit of residents on anticoagulant medication will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality	

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F 760	Continued From page 23 bleeding and recheck the INR on the morning of 08/05/22. During an interview on 10/19/23 at 11:57 AM, with the Director of Nursing confirmed that FLPN did not notify the physician of the INR level, and that the oncoming nurse administered the evening dose of Coumadin on 08/04/22 resulting in a significant medication error. Cross Reference: F580.	F 760	Assurance Team.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 store foods in a sanitary manner. Findings include:	F 812	Corrective Action: " Corrective actions have been ensured by the Administrator and the Food and Beverage Director. It is the practice of	12/6/23

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F 812	Continued From page 24 The following were found during the initial kitchen tour on 10/16/23 from approximately 8:45AM through 9:45AM: - The walk-in refrigerator in the main kitchen had moldy strawberries and peppers; - The shelves in the walk-in were moldy. Findings were reviewed and confirmed by Dietary Manager (DM) on 10/16/23 at approxmately 10:00AM:	F 812	Millcroft Living to ensure that a weekly sanitation audit of the kitchen is done. The walk-in refrigerator in the main kitchen is maintained at 41 degrees or below. Shelves were cleaned per protocol and new shelves ordered to replace current shelves. Identification of Other Residents: " All Residents have the potential to be affected. To prevent other residents from being affected, the food and beverage director or designee will ensure that the kitchen refrigerator is in working order and is maintained so that it is always in good sanitary condition, and that no food item is moldy. System Changes: " The Root Cause of the concern was a failure to ensure that the kitchen walk-in refrigerator is in good sanitary condition to prevent moldy food items. The facility system for kitchen sanitation rounds has been updated to include weekly rounds with the dietician and food service director to ensure that the walk-in refrigerator is in good sanitary condition and working order with no sanitation concerns. The facility policy for Preventing Foodborne Illness □ Food Handling (rev. 2014) was reviewed and found to meet professional standards. The Food and Beverage Director or Designee will complete education for all dietary staff regarding appropriate standards for kitchen sanitation including ensuring that the kitchen walk-in refrigerator is in proper sanitary condition	

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F 812	Continued From page 25	F 812	and all other areas of the kitchen storage and equipment are maintained in good repair and sanitation. The Food and Beverage Director or Designee will provide oversight to ensure ongoing compliance. Success Evaluation: " A food service sanitation audit to ensure compliance regarding kitchen sanitation, including ensuring that the kitchen refrigerator is in working order and with no sanitation concerns will be completed by the Food and Beverage Director or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team at the monthly Quality Assurance meeting.	