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	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Center	700 Marvel Road Milford, DE 19963

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 44706 Based on record review and interviews, it was determined that for one (R107) out of five residents sampled for medication review. The facility failed to notify R107's representative of a change to R107's treatment plan involving medication. Findings include: Review of R107's clinical record revealed: 10/14/22 - R107 was admitted to the facility with a diagnoses of but not limited to anxiety disorder. 10/20/23 - An annual MDS documented R107 as severly cognitively impaired. 12/17/23 - A physician's order to discontinue lorazepam 1 mg one time a day for anxiety. 1/3/24 10:35 AM - During an interview with FM2, it was revealed that the facility did not notify the family regarding the change to R107's medication treatment plan. 1/5/24 1:20 PM - During an interview via telephone with E33 (Psychiatric Nurse Practitioner), it was confirmed that she had discontinued the aforementioned medication without notifying FM2. 1/5/24 2:10 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47142 Based on observation and interview it was determined that for one resident (R114) out of two residents reviewed for accommodation of needs, the facility failed to ensure that the resident had a pull cord for the overhead light. Findings include: A facility policy, last revised 2/1/23, titled Accommodation of Needs stated to make adaptations of the patient's bedroom . to ensure the patient can (if able): .operate room lighting. 12/12/23 3:56 PM - An observation of R114's room revealed a missing pull cord to the overhead light. The resident would have to get up in the dark, to the main doorway of the room, to turn on the main light switch to have light. Repeat observations on 12/13/23, 12/14/23 and 12/15/23 revealed the pull cord to the overhead light was still missing. 12/13/23 10:00 AM - During an observation, R114 demonstrated the ability to reach a pull cord for an overhead light using another overhead light. 12/18/23 8:20 AM - An interview with E5 (RN) confirmed R114 did not have a pull cord for the overhead light. 12/18/23 8:40 AM - An interview with E12 (Maintenance Director) confirmed R114 did not have a pull cord for the overhead light. He stated he had recently changed the switch for the overhead light, which has the pull cord attached. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46988 Based on interview and record review, it was determined that for two (R16 and R379) out of six residents reviewed for advance directives, the facility failed to assist a resident to enact an advance directive. Findings include: 1. Review of R16's clinical record revealed: 8/1/23 - R16 was admitted to the facility. 8/29/23 - A review of the quarterly MDS revealed R16 had a BIMS (Brief Interview for Mental Status) score of 12. 12/12/23 10:25 AM - An interview with R16 revealed that an advanced directive was not on file and confirmed the want to enact one. 12/13/23 - A review of R16's clinical record lacked evidence of an advanced directive on file or evidence the resident was offered the opportunity to make an advanced directive. 12/15/23 1:31 PM - An interview with E18 (social worker) revealed that the facility requests advance directives on admission to be brought in to file in the chart. E18 confirmed that the facility does not assist or offer new admissions to enact one. 2. Review of R379's clinical record revealed: 12/8/23 - R379 was admitted to the facility. 12/12/23 9:25 AM - An interview with R379 revealed that an advanced directive was not on file and confirmed the want to enact one. 12/13/23 - A review of R379's clinical record lacked evidence of an advanced directive on file or evidence the resident was offered the opportunity to make an advanced directive. 12/15/23 1:31 PM - An interview with E18 (social worker) revealed that the facility requests advance directives on admission to be brought in to file in the chart, and E18 confirmed that the facility does not assist or offer new admissions to enact one. The facility lacked evidence that new admissions are offered to enact an advanced directive. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40163 Based on observation and interview, it was determined that for one unit out of three units, the facility failed to maintain a clean, comfortable, and homelike environment. The facility failed to provide acceptable water temperatures to provide bathing. Additionally the facility failed to provide adequate lighting in a resident room. Findings include: 1. 12/12/23 9:32 AM - During an observation and interview, R379 stated that the water did not get hot. The surveyor tested the water temperature with her hands and the water was ice cold. The faucet was on for five minutes and did not warm up. 12/12/23 10:46 AM - During an interview, R12 stated that there was not any hot water this morning. 12/12/23 10:52 AM - During an interview, E12 (Maintenance Director) stated, the mixing valve was out since last night. The man is here working on it. The surveyor inquired how did the residents receive care without hot water, and he replied, there was still some warm water available this morning, (and) that it should be fixed soon. E12 stated that they were still adjusting the mixing valve. E12 stated that there was hot water available in the kitchen and that was close to the units. The CNA's could have gone to the kitchen to fill basins of water to bathe the residents. 12/12/23 11:32 AM - During an interview, E21 (CNA) confirmed the water was cold when she arrived at 8:00 AM. E21 stated, the only thing that we could do was change the residents. (the resident's incontinence briefs). E21 stated that the residents did not receive any bathing because the water was too cold. 12/13/23 10:33 AM - During an interview, E12 stated that he found out about the hot water situation at about 2 or 2:30 PM (on 12/11/23). 12/21/23 8:42 AM - During and interview, E8 (CNA), E25 (CNA) and E26 (CNA) reported that the facility management did not instruct them on what to do regarding the water being cold and that there was hot water available in other parts of the facility. 2. 12/13/23 8:52 AM - Observation revealed: - A tube of incontinence barrier cream on the floor up against the wall on the right side of the bed. - The floor was smeared with drops of unknown organic matter to the right side of the bed. - In the right corner of the room there was an approximately two-and one-half inch chunk out of the floor tile. - The wall adjacent to the foot of the bed had approximately six inches at one area and two inches at another area of cracks and dirt between the wall and the baseboard. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was a soiled hospital gown bunched up on the beside dresser. - A Gerichair was visibly soiled with food debris. - A tray table for eating was soiled and had approximately a six by three-inch water-like spill on it. 12/13/23 9:01 AM - During an interview, E8 (CNA) confirmed the room was in disrepair and was not clean nor homelike. E8 stated housekeeping is terrible. 3. 12/12/23 11:25 AM - During an observation and interview, R65 stated her over the bed light has not worked for about a month. The Surveyor tested the light, and it did not turn on. R65 stated that the staff had to keep the privacy curtain open to get light from the bed next to her to complete her care at night. 12/12/23 11:28 AM - During an interview, E21 (CNA) confirmed that R65 did not have a working over the bed light and that there was no alternative light source in R65's area in the room. 12/13/23 10:33 AM - During an interview, E12 stated that he was aware that there were over the bed lights that were not working. E12 stated that he had tried a new lightbulb in R65's over the bed light and that every time he put a new bulb in that they blew. E12 stated that an electrician had been there, and it was the lights themselves that were not working. E12 stated that there were three rooms that the lights were not working. When asked if there was an alternative light source being provided, E12 replied that the facility cannot have lamps related to it was a fall risk, and that the facility could not have extension cords longer than six feet. When asked if any other alternative solutions for lighting were considered he stated no. E12 stated that lights were on order. 12/13/23 11:11 AM - During an interview, E24 (UM) stated that she was not aware of R65's light being out until today. E24 stated that R65 was going to be moved to the other side of the room until the new light came in. 12/13/23 11:13 AM - During an interview, E12 provided the surveyor with a work order which revealed that the new lights would not be arriving until 1/26/24. 12/15/23 9:09 AM During an interview R65 stated that the facility had not provided an alternate lighting source. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 40163 Based on record review and interview, it was determined that for one (R21) out of thirty-two residents reviewed for MDS assessments, it was determined that a significant change MDS assessment was not completed after a decline in status. Findings include: Review of R21's clinical record revealed: 12/16/22 - R21 was admitted to the facility with respiratory failure. 6/23/23 - The quarterly MDS documented R21 was moderately cognitively impaired, had a depressed mood, no behaviors, required extensive assistance of staff for ADL's and was frequently incontinent of bowel and bladder. 9/23/23 - A quarterly MDS assessment documented R21 was not assessed for cognitive status or depression, had a new onset of behaviors (one to three times per week), was dependent on staff for ADL's and was always incontinent of bowel and bladder. The change was not identified, nor was the need for a significant change MDS assessment. 12/15/23 12:03 PM - During an interview, E24 (UM) confirmed that R21 did have a significant decline in status, and that a significant change in status MDS should have been completed. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 40163 Based on interview and record review, it was determined that for three (R20, R21 and R63) out of thirty-two sampled residents, the facility failed to ensure the MDS assessments accurately reflected the resident's status. Findings include: 1. Review of R21's clinical record revealed: 12/16/22 - R21 was admitted to the facility with respiratory failure. 9/23/23 - A quarterly MDS assessment documented R21 was not assessed for cognitive status or depression. 12/15/23 12:03 PM - During an interview, E24 (UM) stated that the facility did not have a full-time MDS coordinator or a full-time social worker at the time of the survey. E24 stated that it was the full-time social worker who assessed residents for cognition and depression. E24 confirmed that R21's cognition and depression were not assessed on her 9/23/23 quarterly MDS assessment. E24 confirmed that a resident or staff interview for cognition and depression should have been completed and should not have been documented as not assessed. 12/15/23 1:22 PM During an interview, E1 (NHA) confirmed R21's cognition and depression had not been assessed on her 9/23/23 quarterly MDS. 44706 2. Review of R20's clinical record revealed: 12/25/18 - R20 was admitted to the facility. 5/4/23 - A dental exam performed by S3 (DDS) documented the following: upper, four roots that are dead and lower, two dead roots and six missing teeth. R20 denied any pain or oral problems. 7/6/23 - An annual MDS Assessment documented that R20 had her natural teeth with no problems noted. 10/6/23 - A quarterly MDS Assessment also documented that R20 had her natural teeth with no problems noted. 12/12/23 at approximately 11:10 AM - During an interview,this surveyor observed that R20 had no front teeth and asked if she had any mouth pain or trouble chewing? R20 replied no I don't. When asked if she had ever seen a dentist she couldn't remember. 12/18/23 09:54 AM - During an interview E2 (DON) confirmed that R20 did have missing and broken teeth and the annual and quarterly MDS assessments were inaccurate. 3. Review of R63's clinical record revealed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/14/20 - R63 was admitted to the facility. 4/21/23 - A physician order was written to admit R63 to hospice care with a diagnosis of Alzheimer's. 4/28/23 - A physician order was written to discontinue hospice care. 5/31/23 - A significant change MDS Assessment documented Hospice - Yes. 8/31/23 - A quarterly MDS Assessment documented Hospice - Yes. 12/18/23 1:35 PM - This Surveyor asked E22 (LPN) to see R63's hospice binder. E22 replied he's not on hospice anymore and confirmed that the order was listed in the active orders as well as the discontinued orders with an end date of 4/28/23. 12/19/23 9:38 AM - During an interview E2 (DON) confirmed the abovementioned findings. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 40260 Based on interview and record review, it was determined that for two (R86 and R110) out of four residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: 1. Review of R86's clinical record revealed: 7/30/22 - Resident was admitted to the facility. 7/25/2022 - A PASARR Level 1 completed, which reflected There are no known recent or current mental health symptoms. 9/6/22 - A diagnosis of schizophrenia was added to R86's list of diagnoses. 12/14/23 9:15 AM - E1 (NHA) provided a copy of the above-mentioned PASARR I in response to surveyor's request for all of R86's PASARR's. 12/18/23 9:16 AM - In an email correspondence, S1 (PASARR State Authority) confirmerd that the facility should have submitted a resident review PASARR. 47142 2. Review of 110's clinical record revealed: 1/10/23 - R110 was admitted to the facility. 4/28/23 - A PASARR Level 2 evaluation was completed for R110 with a short term approval period to expire on September 25, 2023. The facility could not provide documentation of a current Level 2 PASARR after September 25, 2023. 12/18/23 7:26 AM - In an email correspondence, S1 (PASARR State Authority) confirmed that a PASARR Level 2 evaluation was required for R110 to be completed prior to the expiration of the previous PASARR. 12/18/23 8:10 AM - An interview with E1 (NHA) confirmed that the facility did not have any Level 2 evaluations for R110 after September 25, 2023. E1 stated, we probably should have another one for her [R110]. 12/21/23 12:00 PM - Findings were reviewed with E1 and E2 (DON).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40163 Based on interview and record review, it was determined that for eight (R8, R13, R50, R65, R66, R86, R109 and R112) out of thirty-two sampled residents, the facility failed to ensure the required interdisciplinary team members participated at the quarterly care plan meetings. In addition, for R65, the facility lacked evidence that a quarterly care plan conference was completed in March of 2023. Findings include: 1. Review of R50's clinical record revealed: 1/2/20 - R50 was admitted to the facility with schizoaffective disorder. 12/18/23 8:54 AM - A late entry care plan note for a 10/5/23 care plan meeting lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 2. Review of R65's clinical record revealed: 10/28/20 - R65 was admitted to the facility with dementia. 10/20/22 10:22 AM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 1/19/23 12:44 PM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 1/19/23 - 7/20/23 - The facility lacked evidence of a quarterly care plan conference. 7/20/23 4:33 PM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/26/23 11:43 PM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 40260 3. Review of R8's clinical record revealed: 3/25/22 - R8 was admitted to the facility. 12/29/22 - A care plan meeting note lacked evidence that the the attending physician, certified nursing assistant and dietary participated in this meeting. 6/29/23 - A care plan meeting note lacked evidence that that the attending physician, certified nursing assistant and dietary participated in this meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/12/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R8's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred in March, 2023. 4. Review of R13's clinical record revealed: 10/31/14 - R13 was admitted to the facility. 12/29/22 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 6/29/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/5/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R13's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred in March, 2023. 5. Review of R66's clinical record revealed: 1/31/19 - R66 was admitted to the facility. 1/26/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 7/27/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/12/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R66's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred between October 6, 2022 through July 13, 2023. 6. Review of R86's clinical record revealed: 7/30/22 - R86 was admitted to the facility. 1/26/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 7/27/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of R109's clinical record revealed: 4/24/23 - R109 was admitted to the facility. 12/22/22 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/12/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R109's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred in March, 2023 and July, 2023. 8. Review R112's clinical record revealed: 7/7/23 - R112 was admitted to the facility. 12/18/23 - untimed. A review of R109's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred in October, 2023. Additionally, R109's care plan reflected that he has a tracheostomy, but this was removed in August, 2023. 12/21/23 approximately 9:15 AM - Findings regarding care plan meetings were reviewed with E2 (DON). 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 40163 Based on observation and interview it was determined that for one (R14) out of three residents reviewed for range of motion, the facility failed to ensure that R14 received treatment and services to prevent further decrease in range of motion. Findings include: Review of R14's clinical record revealed: 9/25/20 - R14 was admitted to the facility with Parkinson's Disease and dementia. 6/7/22 - R14's care plan for splinting included a goal to prevent further contractures and maintain skin integrity. 9/4/23 - An annual MDS assessment documented that R14 was severely cognitively impaired and had bilateral upper and lower extremity limited range of motion. 11/1/23 7:00 AM - A physician's order included Apply resting hand splint to R (right) hand after AM (morning) care and ROM (range of motion). The following dates and times R14 was observed without a right hand splint: 12/14/23 10:23 AM, 12/15/23 11:26 AM, 12/15/23 2:46 PM,12/18/23 11:22 AM and 12/20/23 10:58 AM. 12/20/23 11:05 AM - E27 (CNA) confirmed R14 was not wearing his right hand. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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	085010	A. Building B. Wing	01/05/2024

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Milford Center	700 Marvel Road Milford, DE 19963

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40163 Based on observation, interview and record review, it was determined that for two (R8 and R50) out of five residents reviewed for accident hazards, the facility failed to follow the plan of care. For R8 and R50 the facility failed to accurately /implement or obtain physician's orders for their wanderguards. In addition, the facility lacked evidence that R8 and R50 were adequately assessed for elopement risk. Findings include: A facility policy effective [DATE] (last revised [DATE]) titled Elopement of a Patient included: Patients/Residents will be evaluated for elopement risk upon admission, re-admission, quarterly, and with a change in condition as part of the clinical process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Security system checks will be conducted routinely and documented to ensure the function of .trigger bracelets (wanderguards) . 1. Review of R50's clinical record revealed: [DATE] - R50 was admitted to the facility with schizoaffective disorder. [DATE] - A care plan included that R50 was at risk for elopement related to a diagnosis of paranoid schizophrenia, impulsive, hearing voices that others do not hear as evidenced by attempt to leave the building without an escort (States I'm not doing good and I want out of here). [DATE] 1:41 PM - An elopement evaluation documented that R50 had a history of actual or attempted elopement, a history of wandering that places the patient at significant risk of getting to a potentially dangerous place and has expressed the desire to leave. R50 was not assessed for elopement on admission or quarterly thereafter. [DATE] 11:00 PM - A physician' order included, Wander Guard/Wander Elopement Device due to poor safety awareness every shift for elopement check the placement of the device and in supplemental documentation document the location and every night shift for elopement until [DATE] 00:00 check function and document in supplemental documentation Expiration date: [DATE] (update the order with the new date when the bracelet is changed). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 6:35 PM - A progress note documented, I was standing in hall way around 1630 (4:30 PM), around room [ROOM NUMBER], I heard the front alarm go off and saw a person go out the door. The secretary at the front desk said she let him out not knowing that he was ours [a resident of the facility]. As I was headed outside I saw a CNA [name] in the parking lot assisting another resident, and asked for her assistance. Pt (patient) kept going towards highway, I slowly approached pt and he said he was going home. I asked him to stop and to talk to me. Pt raised his right arm as to hit me, glared at me and said he was going home and continued to walk towards highway. At that time I asked the CNA to go get help. [E29] (CNA) came out to assist, and pt started to walk faster, and became more agitated. I asked [E29] to call the cops for assistance in case he became violent or went towards the highway. Pt sat on the railing to the right of [NAME] rd (road) entrance. A male CNA [E30], came out to assist. Male CNA was able to talk pt into coming back into the facility. CNA tried to call back 911 and cancel the 1st call. Primary Nurse of pt updated with incident. Cops did show up to facility to make sure everything was ok with resident. I explained situation and thanked them for checking in on pt. Pt safely went back to room with big grin on his face. Review of R50's September, October, November and December's 2023 treatment records revealed that the wanderguard order remained the same as above. The facility lacked evidence that the wanderguard was changed or checked for function until a new physician's order (while the surveyors were onsite) to check for function dated [DATE]. [DATE] 3:15 PM - During an observation, R50's wanderguard was in place to his left ankle. [DATE] 3:17 PM - During an interview, E24 (UM) stated that the facility knows when a wanderguard is expired because they are checked routinely every week. [DATE] 3:21 PM - During an interview E24 (UM) confirmed R50's order for the wanderguard was [DATE], the expiration was [DATE], the facility failed to update the order and the facility lacked evidence that R8's wanderguard had been changed. [DATE] 3:24 PM - During an observation and interview, E31 (LPN) showed the surveyor the device to check a wandergaurd's function, and stated that nursing was supposed to check resident wanderguards for function. [DATE] 3:39 PM - During an observation and interview, E24 (UM) and E31 (LPN) utilized the testing device on R50's wanderguard and it did not read as activated. E31 was going to put a new device on R50, but the surveyor identified that the new wanderguard was also expired related to it had to be activated by [DATE] and it was now [DATE]. E31 confirmed the expired wanderguard. [DATE] 3:46 PM - E31 (LPN) returned with another wanderguard which would not expire until [DATE]. [DATE] 3:49 PM - During an observation, E31 (LPN) cut the expired wanderguard from R50's ankle, presented the expired wanderguard to the surveyor, and applied the new one (expiration date [DATE]) to R50's ankle. [DATE] 3:55 PM - During an observation and interview, E31 (LPN) accompanied the surveyor to the front door of the facility (with the [DATE] expired wanderguard), opened the door, and confirmed the alarm failed to sound. During an additional observation, E31 tested the wanderguard at the exit to the smoking area and confirmed the alarm also failed to sound when the door was opened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 4:47 PM - An elopement evaluation was completed at the time of the survey which included R50 had a history of elopement at home and in the facility, verbally expressed the desire to go home (packed belongings to home or stayed near an exit door) and R50 wandered. [DATE] 11:11 AM - During an interview, E1 (NHA) confirmed the status of the elopement assessments for R50 and that they had not been completed as required. E1 stated that that elopement assessment should be completed at least annually, and that some (residents) had not been done. E1 confirmed R50's risk for elopement, and that their orders could allow their wanderguards to be expired and fail to function. 2. Review of R8's clinical record revealed: [DATE] - R8 was admitted to the facility with back issues and was later diagnosed with dementia. An elopement evaluation was not completed on admission. [DATE] - R8's admission MDS documented that R8 had moderate cognitive impairment. [DATE] - An elopement evaluation documented that R8 had a history of actual or attempted elopement and of wandering that placed the resident at significant risk of getting to a potentially dangerous place. [DATE] - R8's care plan included, Resident/Patient is at risk for elopement related to cognitive loss/dementia as evidenced by attempt to leave the building without an escort. Utilize and monitor security bracelet (wanderguard) per protocol. [DATE] - A physician's order included that R8 was to wear a wanderguard due to poor safety awareness and that the wanderguard expiration date was [DATE] (update the order when changed). The facility lacked evidence that the wanderguard was changed and that the order was updated to include a new expiration date. ,d+[DATE] - The facility lacked evidence that a yearly elopement evaluation had been completed. [DATE] - R8's quarterly MDS documented that R8 was severely cognitively impaired. [DATE] 10:00 PM - A care plan evaluation note included that R8 had wandered eighteen out of thirty days. [DATE] 4:47 PM - R8's reassessment elopement evaluation was completed which indicated a risk for elopement and was not completed until the surveyor inquired. [DATE] 11:11 AM - During an interview, E1 confirmed the status of the elopement assessments for R8 and that they had not been completed as required. E1 stated that that elopement assessment should be completed at least annually, and that some (residents) had not been done. E1 confirmed R8's risk for elopement, and that their orders could allow their wanderguards to be expired and fail to function. [DATE] 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46988 Based on observation, interview and record review it was determined that for one (R379) out of one resident reviewed for bowel and bladder, the facility failed to ensure that appropriate assessments and services were rendered to maintain bowel and bladder continence. Findings include: A policy titled Continence Management revised on 6/15/22 stated patients will be assessed for the need for continence management as part of the nuring assessment process. Identify patient's continence status and need for continence management by conducting a nursing assessment. Review of R379's clinical record revealed: 12/8/23 - R379 was admitted to the facility. R379 was alert and oriented to person, place, and time. 12/8/23 2:37 PM - A review of R379's clinical admission assessment lacked evidence that bowel and bladder continence was assessed by nursing. 12/8/23 - A review of the CNA task flow sheet revealed that R379 had two continent episodes out of two opportunities using a urinal with staff assistance. The CNA task flow sheet marked R379 as a set up for toileting and requiring max assistance from staff. 12/9/23 - A review of R379's baseline careplan lacked evidence of how to provide care to assist with toileting for R379. The baseline careplan was pre-populated text that required staff to edit to personalize per residents needs, and the baseline careplan was not personalized to reflect R379's toileting needs. 12/9/23 - A review of the CNA task flow sheet revealed that R379 had three incontinent episodes out of three opportunities. The CNA task flow sheet marked R379 as dependent and requiring max assistance from staff for toileting. 12/10/23 - A review of the CNA task flow sheet revealed that R379 had three incontinent episodes out of three opportunities. The CNA task flow sheet marked R379 as dependent and requiring max assistance from staff for toileting. 12/11/23 - A review of the CNA task flow sheet revealed that R379 had one continent using the toilet with staff assistance episode out of three opportunities. The CNA task flow sheet marked R379 as indepent, dependent and requiring max assistance from staff for toileting. 12/12/23 - A review of the CNA task flow sheet revealed that R379 had one continent episode using the toilet with staff assistance out of three opportunities. The CNA task flow sheet marked R379 as indepent, dependent and requiring max assistance from staff for toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/12/23 9:29 AM - An interview with R379 revealed that he started having problems with incontinence related to the stroke and required assistance with toileting. R379 also revealed that staff would tell him to urinate in his brief. 12/13/23 - The CNA task flow sheet revealed that R379 was marked for incontinence twenty four episodes out of twenty four opportunities from 12/13 to 12/21/23. The CNA task flow sheet marked R379 as dependent and requiring max assistance from staff for toileting. 12/20/23 8:30 AM - An interview with E16 (unit clerk) revealed that the facility does not complete voiding diaries on new admissions. 12/20/23 9:15 AM - An interview with E14 (CNA) confirmed that R379 stated he was continent and able to use a urinal upon admission. 12/20/23 9:25 AM - An interview with E15 (RN) confirmed that R379 lacked a bowel and bladder assessment upon admission. E15 stated the admitting nurse was responsible to complete this assessment with the admission assessment. The facility failed to initiate a plan to assist R379 in maintaining urinary continence. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44706 Based on observation, interview and record review, it was determined that for one (R58) out of one sampled residents for respiratory care, the facility failed to maintain oxygen as ordered. Findings include: Review of R58's clinical record revealed: 1/7/21 - R58 was admitted to the facility with a diagnoses of COPD and chronic respiratory failure. 1/8/21- A physician order was written to administer oxygen continuously at 3 L/min (liters per minute) using a nasal cannula to maintain O2 (oxygen) saturation above 90%, change oxygen tubing weekly and label each component with date and initials. 12/12/23 10:23 AM - Upon screening residents, this Surveyor observed R58 sitting in her wheelchair and there was a portable oxygen tank hanging on the back. The oxygen tubing was connected and the tank was set at 3L/min. There was also an oxygen concentrator in the room and neither tubing was labeled. 12/12/23 10:30 AM - During an interview, E23 (Director of the memory care unit) confirmed that neither tubing was labeled. 12/12/23 10:46 AM - During an interview, E22 (LPN) also confirmed that the tubing connected to the oxygen tank and the concentrator was not labeled. E22 stated that the tubing is changed on Tuesday's and was due to be changed that night. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46988 Based on record review and interview, it was determined that for one (R397) out of three residents sampled for pain the facility failed to provide pain management according to professional standards of practice . R397, a resident with chronic pain, was not assessed for pain and not scheduled timely for a pain management consult. Findings include: Review of R379's clinical record revealed: 12/8/23 - R379 was admitted to the facility with a history of chronic pain managed by a pain management specialist. 12/8/23 11:30 AM - A review of hospital discharge summary records revealed that R379 has a history of chronic pain and to defer to discretion of pain management regarding medication regimen. R379 was discharged with no active pain medication orders and recommended to follow up with pain management. 12/8/23 2:37 PM - A review of R379's clinical admission assessment lacked evidence that a pain assessment was completed. 12/10/23 - A review of R379's baseline care plan failed to include R379's acceptable pain level or a baseline pain level. 12/12/23 - An interview with R379 revealed a pain level of 8 out of 10 (pain is identified between 0 and 10, with 10 being the worst pain imaginable and 0 being no pain.) R379 received tylenol (pain medication) with post pain assessment marked as effective on MAR. The facility failed to use the same pain scale to assess pre and post pain. 12/12/23 - An interview with R379 revealed a pain level of 8 out 10 post tylenol administration. R379 confirmed the medication is not effective for his pain. 12/14/23 11:19 AM - An interview with R379 revealed a pain level of 8 out of 10. 12/14/23 11:25 AM - An interview with E17 (LPN) revealed that she was unaware of R379's pain level. The MAR lacked evidence of pain medication administration and monitoring of pain level. 12/15/23 10:07 AM - An interview with E16 (unit clerk) revealed that a physician saw R379 this morning and requested R379 to follow up with pain management for chronic pain. E16 stated a call has been placed to schedule appointment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/18/23 10:02 AM - An interview with E3 (UM/ADON) revealed that when a resident is admitted to the facility a pain assessment is completed and that determines the acceptable pain level. The admitting nurse and nurse responsible for chart check are responsible to update care plan and ensure all assessments are completed upon admission. E3 confirmed the initial pain scale was not completed and acceptable pain level was not updated. It was also confirmed that the resident is not being monitored every shift for pain level as that standing order was not initiated. E3 stated she is following up with pain management today for a course of action regarding pain management. 12/18/23 10:38 AM - An interview with E17 revealed that R379 had a pain management appointment scheduled for 12/19/23. 12/20/23 9:10 AM - An interview with E4 (NP) revealed that she does not review discharge paperwork until the resident arrives to the facility and she discussed scheduling R379 for pain management with E16 on 12/15/23. It is unclear based on interview why the pain management appointment was not made sooner. 12/21/23 12:00 PM - Findings were reviewed with E1(NHA) and E2 (DON).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 40260 Based on record review and interview, it was determined that for five (E6, E8, E9, E10 and E11) out of five certified nursing assistants reviewed, the facility failed to complete an annual evaluation. Findings include: 12/15/23 approximately 1:15 PM - E1 (NHA) provided documentation regarding CNA evaluations for the following employees and stated that no annual evaluations had been completed: E6 with a hire date of 8/30/22; E8 with a hire date of 11/8/22; E9 with a hire date of 10/22/22; E10 with a hire date of 8/9/22; E11 with a hire date of 7/5/22. 12/21/23 12:00 PM - Findings were reviewed with E1 and E2 (DON).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44706 Based on record review and interview, it was determined that for two (R72 and R107) out of five residents sampled for medication review, the facility failed to re-evaluate the need for a PRN medication for anxiety every fourteen days. Findings include: 1. Review of R72's clinical record revealed: 8/27/20 - R72 was admitted to the facility with a diagnoses of dementia with other behavioral disturbance and anxiety disorder. 10/21/22 - A physician order was written for lorazepam 0.5 mg to be given every six hours as needed for signs and symptoms of increased anxiety. 7/27/23 - A quarterly MDS assessment documented no adverse behaviors. 10/1/23 through 12/21/23 - Review of MAR revealed no adverse behaviors and no use of the above mentioned medication. 10/27/23 - An annual MDS assessment documented no adverse behaviors. Record review lacked evidence of the attending physician or prescribing practitioner's reason for the appropriate continued use of the PRN medication. 2. Review of R107's clinical record revealed: 10/14/22 - R107 was admitted to the facility with a diagnoses of dementia without behavioral disturbance and anxiety disorder. 7/20/23 - A quarterly MDS assessment documented physical behaviors directed towards others and behavioral symptoms not directed towards others occurred 4-6 days. 10/1/23 through 12/21/23 - Review of MAR revealed no adverse behaviors. 10/20/23 - An annual MDS assessment documented no adverse behaviors. 10/25/23 - A physician order was written for lorazepam 0.5 mg to be given every eight hours as needed anxiety. Record review lacked evidence of the attending physician or prescribing practitioner's reason for the appropriate continued use of the PRN medication. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47142 Based on observation and interview, it was determined that the facility failed to ensure that medications were stored and labeled properly in three out of six medication carts and in two out of three medication rooms reviewed. In addition, the facility failed to monitor refrigerator temperatures in one medication fridge on the Central Unit. Findings include: [DATE] 12:30 PM - During a medication storage review of the Central unit medication room, the following was observed inside: 1. Expired on ,d+[DATE], two epinephrine (medication to treat allergic reactions) injection pens. 2. The Emergency Medication box was unsealed. [DATE] 12:35 PM - A review of the temperature log for the medication refrigerator revealed that the facility failed to monitor temperatures. [DATE] 12:50 PM - An interview with E28 (RN) confirmed medications were expired, the emergency medication box was unsealed and the temperature log had five missed log days out of 18 days documented. [DATE] 1:38 PM - During a medication storage review of the East unit medication room, the following was observed inside: 1. Expired on ,d+[DATE] two boxes of Chewable calcium supplements. 2. Expired on [DATE] four bags of Cefazolin (antibiotic) medication. 3. Expired on [DATE] Pneumovax (vaccine against pneumonia) injection solution. 4. Multidose Tuberculin (skin test to determine tuberculosis) solution vial: opened and dated [DATE]. [DATE] 3:16 PM - An interview with E24 (UM) and E31 (LPN) confirmed medications were expired and/or undated. [DATE] 2:03 PM - During a medication storage review of the Central unit medication cart 1, the following was observed inside the medication cart: 1. Expired on ,d+[DATE] a bottle of zinc supplement tablets with an opened date of [DATE]. 2. Expired on ,d+[DATE] a bottle of multi-vitamin tablets with an opened date of [DATE]. 3. Two insulin Lispro (medicine for diabetes) injection pens: opened with no open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Two Advair discus metered dose inhalers: opened with no open date. 5. Anoro metered dose inhaler: opened with no open date. 6. Fluticasone propionate nasal spray: opened with no open date. 7. Deep sea nasal spray: opened with no open date. [DATE] 2:24 PM - An interview with E15 (RN) confirmed medications were expired and/or undated. [DATE] 2:36 PM - During a medication storage review of the Homestead unit medication cart 1, the following was observed inside the medication cart: 1. Expired on ,d+[DATE] an unopened vial of olanzapine (an antipsychotic medication). 2. Advanced antacid magnesia: opened with no open date. [DATE] 2:54 PM - An interview with E3 (ADON) and E22 (LPN) confirmed medications were expired and/or undated. [DATE] 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38302 Based on observation and interview, it was determined that the facility failed to ensure that food was stored, prepared, and served in a manner that prevents foodborne illness to the residents. Findings include: 1. 12/12/23 8:57 AM - During the initial tour of the kitchen, the surveyor observed seven rectangular plastic food storage canisters from the refrigerator containing various food items with the following use by dates: 10/23, 11/15, 11/21, 11/21, 11/29, no date and no date, on the counter. E7 (Dietary Manager) stated that the items were on the counter to be discarded as part of the weekly food management procedure. Interview with E7 revealed that these items had been on a top shelf and were missed in previous refrigerator cleanings. 2. 12/12/23 10:39 AM - During a tour of the kitchen, there was significant ice build-up on the plastic flaps in the doorway of the walk-in freezer, and what appeared to be water damage to the ceiling area of the door frame of the walk-in freezer. 3. 12/12/23 11:03 AM - A one pound stick of butter was partially unwrapped, preventing protection from dust, debris, and other contaminants, and a rectangular plastic food storage canister containing peeled pears in juice had no date label. 4. 12/12/23 11:06 AM - Kitchen cloths used for sanitizing food prep surfaces were left on the counter more than forty-five minutes. 5. 12/12/23 1:35 PM - E13 (District Dining Manager) was observed testing the sanitizer level of the solution in two red sanitizing buckets. When E13 tested the sanitizing solution, the test strips from both buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 6. 12/12/23 2:43 PM - During a review of the food temperature logs, the facility kitchen records had no food temperatures recorded for one-hundred seven (107) meals out of two-hundred sixteen (216) meals sampled. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. Fish, meat, and poultry must be heated to an appropriate specific temperature depending on the type of food and the method used to prepare it. Vegetables must be heated to one hundred thirty-five (135) degrees Fahrenheit (F), and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. 12/12/23 2:15 PM - Findings were confirmed with E1 (NHA). 12/21/23 12:00 PM - Findings were reviewed with E1 and E2 (DON).

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	01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Center	700 Marvel Road Milford, DE 19963

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40260 Based on record review and interview, it was determined that for three (E8, E10 and E11) out of five Certified Nursing Assistants (CNA) reviewed, the facility failed to ensure that these employees had the mandatory twelve hours of annual in-service training. Findings include: 12/15/23 approximately 12:15 PM - The surveyor received documentation regarding staff training hours. Review of this documentation revealed the following: E8 (CNA) with a hire date of 11/8/22 had only 4 hours of training; E10 (CNA) with a hire date of 8/9/22 had only 2 hours of training; E11 (CNA) with a hire date of 7/5/22 had only 4.45 hours of training. The facility lacked evidence that these employees completed the mandatory twelve hours of annual in-service training. 12/19/23 approximately 12:00 PM - During an interview, E1 (NHA) and E2 (DON) stated they will review additional records to provide confirmation of training's. 12/19/23 2:41 PM - In an email correspondence, E1 confirmed that the facility has no additional information regarding the training and that it was not completed by E8, E10 and E11. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).