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	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 40163 Based on record review and interview, it was determined that, for four (R29, R67, R87 and R317) out of 39 residents sampled for MDS assessments, the facility failed to accurately complete MDS assessments reflective of the residents' status at the time of the assessment. Findings include: 1. Review of R317's clinical record revealed: 10/6/20 - An admission MDS assessment was completed for R317. The cognitive and mood patterns sections documented not assessed. 6/22/22 10:14 AM - During an interview, E27 (MDS Coordinator) confirmed the MDS assessments cognitive and mood patterns sections documented not assessed and did not reflect that a resident or staff interview was completed at the time of the assessment. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON). 32810 2. Review of R29's clinical record revealed: a. 10/12/21 - An annual MDS assessment was completed for R29, the cognitive patterns section documented that cognition was not assessed. During an interview on 6/14/22 at 12:55 PM, E27 (MDS Coordinator) confirmed the finding and reported the paper assessment was submitted too late to incorporate into the MDS assessment. b. 4/4/22 - A quarterly MDS assessment documented R29 was receiving anticoagulant medication. Review of R29's April 2022 MAR's and physicians orders revealed no anticoagulant was ordered or given to R29. During an interview on 6/14/22 at 12:00 PM, E27 confirmed the error. 3. Review of R67's clinical record revealed: (continued on next page)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/17/22 - An annual MDS assessment was completed for R67 and the section for preferences was not completed, questions were marked as disabled. During an interview on 6/14/22 at 11:57 AM, E27 (MDS Coordinator) confirmed the finding and reported the paper assessment was submitted too late to incorporate into the MDS assessment. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON). 20835 4. Review of R87's clinical record revealed: 5/24/22 - An admission MDS assessment was completed for R87. The cognitive and mood patterns sections documented not assessed. 6/10 /22 11 AM - During an interview, E9 (DOSS) confirmed that Social Services Staff completed the MDS assessment sections for cognitive and mood patterns, however, the information was not provided before the end of the assessment period on 5/24/22. 6/14/22 11:30 AM - During an interview, E27 (MDS Coordinator) confirmed the MDS assessment cognitive and mood patterns sections documented not assessed and did not reflect that a resident or staff interview was completed at the time of the assessment. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40163 Based on record review and interview, it was determined that, for two (R81 and R319) out of 39 residents sampled for care plan review, the facility failed to develop and implement a comprehensive person centered care plan. Findings include: 1. Review of R319's clinical record revealed: 7/28/21 - R319 was admitted to the facility. 8/3/21 - An admission MDS assessment documented that R319 was alert and oriented and required extensive assistance for toileting due to incontinent episodes. Review of R319's care plan revealed that the facility failed to develop and implement a comprehensive person centered care plan for incontinence. 6/21/22 11:04 AM - During an interview, E2 (DON) confirmed that R319's record lacked evidence of an incontinence care plan. 20835 2. Review of R81's clinical records revealed the following: 5/13/22 - R81 was readmitted to the facility from the hospital with an indwelling urinary catheter. 5/13/22 through 6/1/22 - The following Physician's orders were written: - 5/13/22 change Foley catheter when occluded or leaking as needed, empty catheter drainage bag at least once every eight hours when it becomes 1/2 to 2/3 full; every shift and as needed, perform Foley catheter care every day and evening shift and as needed - 6/1/22 Foley catheter 16 FR (French) with 10 cc balloon to bedside straight drainage. There was lack of evidence of development and implementation of a comprehensive care plan for the indwelling urinary catheter. 6/17/22 11:15 AM - During an interview, E3 (RNC) was advised of the lack of a care plan and E3 stated she would review. 6/17/22 12:39 PM - A comprehensive care plan created on 6/17/22 was provided to the Surveyor by E5 (RN UM). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40264 Based on record review, interview and review of other facility documentation as indicated, it was determined that for three (R37, R89 and R105) out of 25 initial pool residents reviewed for Advance Directives in relation to code status, the facility failed to ensure that code status' were accurate and congruent in all facility documents. For R37, his electronic medical records (EMR) failed to match the Resident Healthcare Instructions Checklist filed in the advance directive tab of the paper chart located in the Memory Care nursing station. For two residents (R89 and R105), their EMRs failed to match the staff generated shift report that R89's staff nurse in the Memory Care unit and R105's staff nurse in the East unit use as a reference in determining the code status. Furthermore, interviews with multiple staff revealed inconsistencies regarding where to find the back up information on each resident's code status in the event of an EMR system failure. The discrepancy put R37, R89 and R105 at immediate jeopardy (IJ) of a serious adverse outcome by not having a confirmed, accurate code status in the event of a medical emergency. The inaccuracies could result in CPR being administered to a resident requesting to not be resuscitated (DNR) or CPR not being performed on a resident requesting that all life sustaining measures be performed (Full Code). The IJ was identified on [DATE] at 4:00 PM and was abated on [DATE] at 3:42 PM. Findings include: The facility policy on Code Status Orders, dated [DATE], indicated that Code status communicates to the clinical staff whether the patient desires cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. Patient identification mechanisms and information about each patient's code status (Full code vs. Do Not Resuscitate (DNR)) will be easily accessible to the clinical staff for all patients .To ensure that the patient's desired resuscitation wishes are documented in the medical record. 1. Review of R37's clinical records revealed the following: [DATE] - R37 had an active physician's order for DNR. [DATE] at 4:05 PM - Review of R37's code status was displayed in the EMR as DNR. [DATE] at 9:40 AM - During an interview, E35 (LPN) stated that the facility provides a copy of the signed advance directive with the code status to the receiving provider. E35 further stated that the documents were usually scanned into the EMR and added, .if we can't find a scanned signed copy of the code status in the (EMR), we look at the chart and print copies from the documents filed in the advance directive tab. [DATE] at 9:42 AM - Review of R37's paper chart revealed an undated Resident Healthcare Instructions Checklist filed in the advance directive tab that documented Attempt CPR. [DATE] at 9:43 AM - When asked about the discrepancy of R37's code status from the EMR physician's order for DNR compared to the record found in the paper chart documenting Attempt CPR, E35 (LPN) confirmed the code status in the paper chart was not updated. R37's code status was recorded in two different documents that did not match. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of R89's clinical records revealed the following: [DATE] - R89 had an active physician's order for DNR. [DATE] at 3:45 PM - Review of R89's electronic physician's order for code status was displayed in the EMR as DNR. [DATE] at 9:40 AM - During an interview, E35 (LPN) stated that in the event that a resident becomes unresponsive, she will first determine the code status by checking the shift report sheet. E35 stated, It has the residents' updated code status. The night nurse in the Memory Unit checks and updates the resident's code status for any status changes in the staff generated shift report. [DATE] at 2:00 PM - Review of the Memory Care Unit's shift report sheet documented R89's code status as a Full Code. R89's code status was recorded in two different documents that did not match. 32810 3. Review of R105's clinical records revealed the following: [DATE] - An order for DNR was written for R105. [DATE] at 2:45 PM - Review of R105's EMR documented the residents code status as DNR. During an interview on [DATE] at 2:52 PM, E32 (RN) stated the resident's code status was located at the front of chart and in the computer. I can also see it on the MAR, in front of the chart and on the assignment sheet too. During an interview on [DATE] at 2:54 PM, E45 (LPN) stated residents' code statuses were located In the computer, its right there on the dashboard [EMR] and then in the beginning of the chart. E45 stated she would not look at the resident assignment sheets because they may not be up to date. [DATE] 2:55 PM- Review of the East unit's resident assignment sheets for nurses documented R105 as having a code status of full code. [DATE] 3:33 PM- Review of the undated resident healthcare instructions checklist documented R105 as a DNR code status, reviewed with E43 (MD). The checklist was filed in the advance directives tab in the chart. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:36 PM, E6 (RN UM) was asked the locations of resident code status information. E6 answered Under their name and picture in the EMR, physicians orders and front of paper chart. E6 then explained under emergent conditions, E6 would look it up depending on where I was in the building, whatever was closest. E6 confirmed R105's code status as a DNR using the EMR. When asked where else staff could locate resident code status and information, E6 stated, The healthcare instruction checklist and staff can use the assignment sheets. E6 was shown the discrepancy between R105's EMR that documented the resident as a DNR and the resident assignment sheet which documented the resident as a full code. R6 stated, That has not been updated . the nurses are supposed to update them, I would have to ask them how often they update them. There is one that can be generated from the software. I don't work the cart, but this (the resident assignment sheet) is what nurses use. E6 then reported she would update the resident assignment list to reflect R105's ordered code status as well as review the rest of the residents on the assignment sheet. [DATE] 4:00 PM - E3 (RNC) and E1 (NHA) were made aware of the above findings. [DATE] at 3:20 PM - In an interview, E36 (LPN) stated that when a resident becomes unresponsive, she would check the resident's profile and code staus order in the EMR. E36 also stated that the code status is documented in the nurse shift report (referring to the staff generated shift report). In the event that the EMR is not available, E36 stated that she would go to the chart and check the advance directive tab for the signed copy of the residents code status. [DATE] at 4:00 PM - E1 (NHA) and E3 (RNC) were notified by the survey team that during the initial pool record review, it was identified that three residents (R37, R89 and R105) did not have consistent advance directives related to code status in their medical records and that nursing staff were unable to consistently state where the accurate code status could be found. [DATE] at 5:58 PM - In an interview, E1 reported that an abatement plan had been initiated and that facility - wide education related to resident emergency code status, location of code status, and protocol for determining code status was being implemented. [DATE] at 7:36 PM - E1 confirmed that an audit was completed of all residents to ensure accurate code status'. [DATE] at 10:24 AM - E1 provided the survey team with an action plan for continued training. [DATE] at 3:42 PM - E1 provided the survey team with updated policies and evidence of licensed staff education. The survey team through interview and record review confirmed: -advanced directives/code status for all residents were accurate and congruent in all facility documents. -facility nursing staff were able to articulate how to find the code status for all residents. -staff education was conducted and was ongoing for staff prior to working. Abatement of the IJ was called at 3:42 PM on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on [DATE], beginning at 3:15 PM.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 20835 Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the activities program was directed by a qualified professional from 9/18/21 to 6/16/22, approximately nine (9) months. Findings include: 6/14/22 2:00 PM - During an interview with E23 (Director of Recreation - DOR), E23 stated she began her employment as the DOR on 11/2/21 and until approximately one month ago, a Regional DOR was providing guidance to E23, however, E23 confirmed that she was responsible for overseeing the facility's activity program, which included completing each resident's activity preferences in various MDS assessments, conducting quarterly activity participation reviews for each resident, managing the activity program calendars, writing progress notes in resident's clinical records and participating in care planning for each resident. E23 confirmed that she currently was not licensed or registered as an activities professional. 6/15/22 approximately 3:30 PM - During an interview with E1 (NHA), the Surveyor requested evidence of E23's meeting the qualifications as an activity professional. In addition, the dates of employment for E48 (PDOR) and E23 were requested. 6/16/22 10:00 AM - The Surveyor was provided employment dates for both E57 and E23. E57's last date as the DOR was 9/17/21 and E23's first day as the DOR was 11/2/21. 6/17/22 9:45 AM - An interview with E1 (NHA) was conducted and E1 provided evidence that E23 completed a Certificate of Art Therapy on 6/16/22, thus, meeting the qualification as an activity professional as of 6/16/22. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 and E2 (DON).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 20835 Based on interview and record review, it was determined that the facility failed to ensure that two (2) residents received treatment and care in accordance with the residents comprehensive person-centered care plan. For two (R75 and R87) out of seven (7) residents reviewed for potential for constipation, the facility failed to assess the residents for signs or symptoms of constipation and administer medications as ordered for no bowel movement (BM) after three (3) days. In addition, for one (R75) out of one three (3) residents reviewed for urinary catheter/UTI, the facility failed to ensure that an appropriate antibiotic was administered to treat R75's urinary tract infection (UTI) and the facility failed to ensure timely scheduling of an appointment for recurrent UTI. Findings include: 1. Review of R87's clinical records revealed: 5/17/22 - R87 was admitted to the facility. 5/17/22 - The following Physician's orders were written for three laxative medications: - Milk of Magnesia as needed for constipation, give at bedtime if no BM in three days. - Dulcolax Suppository as needed for constipation if no result from Milk of Magnesia by next shift. - Fleet Enema as needed for constipation if no result from Dulcolax within 2 hours. If no result from Fleet enema call MD/advanced practice provider for further orders. 5/17/22 (Most recent revision date of 6/10/22) - A care plan stated that R87 exhibited or was at risk for gastrointestinal symptoms or complications related to constipation and the goal was that the resident would not have complications. Interventions included to monitor and record BMs, encourage resident to consume all fluids during meals, document the frequency and consistency of stools, and offer and encourage fluids of choice. 5/26/22 through 5/31/22 - CNA documentation titled Toilet/Bowel/Bladder revealed that R87 had a large BM on 5/26/22 at 2:14 PM and the next BM was a small BM on 5/31/22 4:00 PM. There was lack of evidence that the facility assessed for signs or symptoms of constipation and/or administered medications as ordered for no BM in three (3) days. 2. Review of R75's clinical records revealed: a. 2/10/22 - R75 was admitted to the facility. 2/10/22 - The following Physician's orders were written for three laxative medications: - Milk of Magnesia as needed for constipation, give at bedtime if no BM in three days. - Dulcolax Suppository as needed for constipation if no result from Milk of Magnesia by next shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Fleet Enema as needed for constipation if no result from Dulcolax within 2 hours. If no result from Fleet enema call MD/advanced practice provider for further orders. 2/10/22 - A care plan stated that R75 exhibited or was at risk for gastrointestinal symptoms or complications related to constipation, nausea/vomiting and the goal was that R75 would pass a soft formed stool every 3 days. Interventions included to administer medications as ordered and observe for effectiveness and side effects and report to MD as indicated, monitor and record BMs, provide bowel regimen, utilize pharmacological agents as appropriate, i.e. stool softeners, laxatives, etc, document effectiveness, assess for signs and symptoms of constipation, i.e. nausea, vomiting, headache, abdominal distention and cramping 3/1/22 through 6/15/22- CNA documentation titled Toilet/Bowel/Bladder was provided by E2 (DON) which revealed: - 3/27/22 at 10:31 PM, R75 had a large BM and the next BM was documented on 4/3/22 at 10:53 PM. There was lack of evidence that the facility assessed for signs or symptoms of constipation and/or administered medications as ordered for no BM in three (3) days. - 5/31/22 at 2:59 PM, R75 had a large BM and the next BM was documented on 6/4/22 at 2:48 PM. There was lack of evidence that the facility assessed for signs or symptoms of constipation and/or administered medications as ordered for no BM in three (3) days. 6/15/22 12:30 PM - During an interview with E7 (RN), E7 stated that a resident's BM activity was communicated during the nursing shift to shift report. E7 also stated that the computer system used for resident care documentation has a clinical report titled Alert Listing which describes the date of the last BM for each of the facility's residents. E7 stated that the ordered bowel protocol should be initiated if a resident does not have a bowel movement in three days 6/17/22 10:45 - During an interview, E5 (RN UM) confirmed there were no bowel protocol interventions for R75 during the time periods 3/28/22- 4/2/22 and 6/1/22-6/3/22. Cross-refer F881 b. 2/10/22 - R75 was admitted to the facility. 4/30/22 3:55 PM - A Nursing Progress Note stated R75 complained of being dizzy and a Physician's order was obtained to transfer R75 to the emergency room (ER). 4/30/22 10:15 PM - The Nursing Progress Note stated R75 returned from the ER with a diagnosis of UTI. 4/30/22 - The ER visit summary listed a diagnosis of UTI and a progressive urinalysis (UA) was initiated with results of the culture and sensitivity (C&S) pending. R75 was ordered Augmentin (an antibiotic) for 10 days. 5/3/22 8:17 AM - The result of the UA/C&S was requested by the Surveyor during the survey and provided by E2 (DON) on 6/15/22 at 12:15 PM. The UA/C&S results indicated that Augmentin was not on the list of antibiotics that was sensitive to the organism to treat R75's UTI. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/3/22 through 5/9/22 - Review of the MAR revealed R75 was administered 10 doses of Augmentin, an antibiotic which was not on the C&S report as being sensitive to treat R75's UTI. 5/8/22 - A Physician's order was written by E43 (MD) for Cefdinir (a different antibiotic and sensitive to R75's UTI) by mouth for 10 days. 5/9/22 - A Progress Note by E4 (NP) stated, .Patient report (sic) burning with urination is slowly improving. Urine sensitivity results received and no sensitivity to Augmentin. Stop Augmentin twice daily for 10 days, start Cefdinir 300 mg twice daily for 10 days. Will continue to monitor closely. 6/7/22 - A Physician order was written for a urogynecology consultation for recurrent UTI and to please schedule the consult. There was lack of evidence that the urogynecology consultation was scheduled until inquiry by the Surveyor on 6/13/22 with E5 (RN UM) at approximately 12:30 PM. 6/17/22 12:01 PM - During an interview with E28 (UC) to inquire about the urogynecology consultation, E28 stated that R75 has an appointment scheduled for 8/1/22. There was a delay of approximately six (6) days in scheduling the above consultation. 6/21/22 11:45 AM - During an interview with E4 (NP), E4 stated a Physician from the hospital called E43 (MD) on 5/8/22 to report the result of the 4/30/22 UA/C&S and E43 discontinued the Augmentin and ordered Cedifnir on 5/8/22. E4 confirmed that if the results were available to E4 on 5/3/22, the Augmentin would have been discontinued and the treatment plan would have been reevaluated at that time. Due to the above failure to obtain the results of the urine C&S timely, R75 continued to receive an inappropriate antibiotic (Augmentin) for 6 days and there was a delay in starting an antibiotic that was sensitive to the bacteria. In addition, there was a delay in arranging for a urogyenocology consultation due to the order not being carried out for five (5) days.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 20835 Based on interview, review of the clinical record, review of the facility's guideline and review of professional clinical resources as indicated, it was determined that for one (F87) out of five (5) sampled residents for pressure ulcer (PU) reviews, the facility failed to ensure that the resident received the necessary treatment and services, consistent with professional standards of practice, to prevent new pressure ulcers (PU's) from developing. R87 was admitted to the facility with no PU, was assessed as being at risk for the development of PU's, yet the facility failed to develop and implement preventative measures, including an individualized turning and repositioning (T&R) program that resulted in R87 acquiring an avoidable unstageable PU of the sacrum on 6/1/22. Findings include: According to the National Pressure Ulcer Advisory Panel (April 2016), the stages of pressure injuries/ulcers (categorization system used to describe the severity of PUs) included: Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin. Undermining may occur. Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints. Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage is more severe than slough in the wound bed). Review of the facility's undated guidelines revealed the following: Pressure Ulcer Prevention Guidelines. Basic Prevention Interventions for all patients at risk. Perform daily observation of the skin . Apply moisturizer daily. Apply moisture barrier to high risk areas such as heels, elbows, etc . Encourage frequent repositioning/weight shifting . Utilize pressure redistributing surface . Risk Factor Impaired/Decreased mobility/function. Example of Intervention . Individualized positioning and repositioning schedule . refer to rehabilitation for seating/positioning/interventions to increase mobility and function . turning and repositioning plans are implemented regardless of bed surface . Guidelines: Turning and Repositioning . Provide turning and repositioning to individuals at risk for pressure ulcers; specifically, those who have impaired mobility and/or impaired sensation. Turning and repositioning plans are implemented regardless of bed surface. Schedules are based on individual needs, risks, tissue tolerance . Cross-refer F697 Review of R87's clinical records revealed the following: 5/17/22 3:24 PM - A Nursing Documentation Note (Progress Note) documented that R87 was admitted for pain management and therapy. The Admission Nursing Skin Assessment documented the presence of three (3) small scabs on top of the right foot, however, R87 was not admitted with a PU. R87 was documented as having pain during T&R with a pain rating of 10 and at rest, a 7 (Pain Scale of zero (0) to 10 with 0 being no pain and 10 being the worst pain imaginable). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/17/22 - The care plan stated that R87 required assistance with ADLs and interventions included one staff person to provide extensive assistance with bed mobility. 5/17/22 - The Braden Scale (completed by facility Nurse's) was completed with a score of 15 or that R87 was at mild risk for the development of PU's. There was lack of evidence that the facility developed and initiated an individualized T&R program when R87 was assessed as being at risk for the development of a PU. 5/17/22 through 5/24/22 - CNA Documentation Survey Report stated R87 required total assistance of staff on two (2) out of 17 shifts documented, required extensive assistance of staff for 13 out of 17 shifts and limited assitance of staff for two (2) out of 17 shifts. 5/24/22 - A weekly skin check documented no new skin injury/wounds. 5/24/22 - The 5 day Admission MDS Assessment documented that R87 required extensive assistance of two plus staff for bed mobility and transfers, required extensive assistance of one person for toileting, was frequently incontinent of urine and bowel, had no PU's, and R87 was not on a T&R program. 5/24/22 - R87's Braden score was 16 or at mild risk for the development of PU's. 5/30/22 (initial date and revised on 6/8/22) - A care plan stated that R87 was at risk for skin breakdown related to assistance needed with bed mobility and urinary incontinence. Resident has an actual unstageable pressure ulcer (identified on 6/1/22) that included the following interventions: - Pat (do not rub) skin when drying. - Provide preventative skin care (i.e. lotions, barrier creams as ordered). - Assist resident in turning and repositioning every 2 hours (intervention was created on 6/1/22). - Observe skin condition daily with ADL care and report abnormalities. - Offload/float heels while in bed with use of pillows (created on 6/1/22). - Obtain RD consult (created on 6/1/22). - Pressure redistribution surface to bed per guideline. 5/17/22 through 5/31/22 - CNA documentation stated that the following interventions were completed for the prevention of skin breakdown: - Preventative skin care - float heels with use of pillows in bed: For 13 out of 42 shifts, there was lack of evidence that this intervention was implemented. - Preventative skin care - lotion/cream apply barrier cream to buttocks with incontinence care: For 13 out of 42 shifts, there was lack of evidence that this intervention was implemented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There was no evidence that an individualized T&R plan was developed and implemented although R87 was assessed for being at risk for the development of PU's. 5/31/22 - R87's Braden score was 15 or at mild risk for the development of PU's. 6/1/22 1:58 PM - A Wound Assessment by E24 (RN WCN) documented a sacral unstageable PU measuring 1.5 cm L x 3 cm W x 0.1 cm D with 20% granulation, 60% slough, and 20% necrotic. The wound was reported by the CNA who was providing personal care to R87. The NP was notified, care plan updated and orders updated. E24 instructed R87 on the importance of repositioning every two (2) hours to assist with wound healing and to prevent further skin breakdown and R87 verbalized understanding. 6/2/22 - CNA documentation stated that a new intervention to assist R87 to T&R and check skin every 2 hours was initiated, however, there was lack of evidence that this intervention was completed. 6/2/22 2:00 AM - A Nursing Progress Note stated, .sacral wound dressing in place .Resident refused to stay on side even after education. C/O (complaint of) anxiety not relieved by non pharmacological measures . 6/2/22 8:00 AM - A Nursing Progress Note stated, .treatment completed to sacrum (sic) wound. turned and repositioned every 2 hours side to side . 6/3/22 -6/5/22 - CNA documentation revealed that R87 was assisted to T&R and skin was checked every 2 hours as ordered. 6/8/22 12:40 PM - An interview with E24 (RN WCN) revealed that she performed weekly wound rounds and reported any updates to E2 (DON) and the Medical Practitioner. E24 stated that R87's new skin impairment was identified by the CNA providing care to R87 on 6/1/22, however, E24 did not recall the name of the CNA. 6/10/22 3:30 PM - An interview with E24 in the presence of E3 (RNC) was conducted. E24 stated that she recalled initially when R87 was admitted to the facility, R87 was able to T&R independently, however, R87 had difficulty due to pain in the lower part of her body. E3 related that according to the MDS (dated 5/24/22), R87 required assistance of staff with bed mobility. The Surveyor identified there was lack of developing and implementing an individualized T&R program for R87 and E3 related to the Surveyor to follow-up with E2 (DON). 6/13/22 2:30 PM - An interview with the assigned CNA (E25) revealed that R87 was T&R every 2 hours with skin checks during the shift and stated that R87 has not refused to be T&R every 2 hours. 6/14/22 2:45 PM - An interview with the assigned CNA (E42) revealed that R87 was T&R every 2 hours with skin checks during the shift and stated that R87 has not refused to be T&R every 2 hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6/14/22 1:50 PM - An interview with E2 (DON) in the presence of E1 (NHA) was conducted. E2 confirmed prior to the identification of the sacral PU on 6/1/22, R87 scored as being at mild risk for the development of a PU on the Braden Scale and R87 required assistance of staff for bed mobility as R87 was unable to perform this without staff assistance. At the conclusion of the interview, the Surveyor requested evidence of whether the facility developed and implemented an individualized T&R program. After the interview, E2 stated that T&R was documented in the resident's clinical record and the Surveyor informed E2 that the Surveyor had reviewed R87's clinical records, including Nursing progress notes and there was lack of evidence of an individualized T&R plan. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 and E2.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32810 Based on observation and interview, it was determined that for one (R67) out of one resident reviewed for tube feeding, the facility failed to ensure placement of the tube feeding according to current standards of practice during a medication administration. Findings include: Review of the following current standards of practice for a gastric tube (tube used to feed resident directly into the stomach and/or to administer medications) placement verification revealed that auscultation (listening) was no longer recommended: - Auscultation verification of gastric tube placement solely by auscultation, which involves instillation of air into the tube while simultaneously listening with a stethoscope over the epigastric (abdominal) region for the sound of air, is no longer recommended. (Emergency Nurses Association, Clinical Practice Guidelines: Gastric Tube Placement Verification, 2017). - Nurses should not use the auscultatory (air bolus) . (American Association of Critical-Care Nurses updates Practice Alert on feeding tube placement 4/1/16). The Facility policy for enteral (via the stomach) medication administration, last updated 6/1/21, directed staff to measure the tube from the point of entry into the skin to the end of the tube to determine whether the catheter has migrated. 11/18/19 - The following physicians order was written for R67: every shift check feeding tube for proper placement, tube length 23 CM, prior to each feeding, flush, or medication administration by measuring the length of the tube. 6/9/22 11:23 PM - A nursing progress note documented, Every shift Check tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube, tube length 15 cm newly placed. 6/10/22 - R67's physicians order for the feeding tube was updated to check every shift for placement and tube length 15 CM, check feeding tube for proper placement prior to each feeding, flush, or medication administration by measuring the length of the tube. 6/10/22 at 10:46 AM - During an observation of medication administration through the feeding tube, E7 (RN) was observed checking for placement of R67's feeding tube by injecting 10 ml of air via a syringe connected to the feeding tube while listening with a stethoscope to R67's abdomen, then pulling back the plunger of the syringe to look for the presence of stomach contents. E7 stated, I heard the [NAME], far as I know that is the way to check. During an interview on 6/10/22 at 2:26 PM, E7 (RN) confirmed that R67's feeding tube placement was not checked in accordance with the current physicians order. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/22/22 at 3:15 PM.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20835 Based on observation, clinical record review, interviews, review of the facility's policies and procedures, and review of other facility documentation as indicated, it was determined that the facility failed to ensure that emergency equipment was available for potential accidental dislodgement for two (R7 and R67) out of two active residents in the facility reviewed for tracheostomy (trach) related care. The lack of available emergency equipment, in addition to the lack of competent trained staff in trach care posed an immediate jeopardy (IJ) situation to the residents with tracheostomies. The IJ was identified on 6/8/22 at 6:05 PM and was abated on 6/9/22 at 1:55 PM. Additionally the facility failed to ensure tracheostomy supplies were available for ordered treatments for R67. Lastly, during a random trach care observation of R7, the facility failed to ensure auscultation of R7's breath sounds at the conclusion of trach care. Findings include: EMERGENCY EQUIPMENT (SUPPLIES): Review of the facility's policy and procedure titled Tracheostomy Emergency Bedside Supplies, with a revision date of 6/1/21, stated the following emergency supplies will be kept at the resident's bedside and nursing is responsible for maintaining the supplies. Supplies include a spare trach tube with obturator (device that closes or blocks up an opening) of the same manufacturer brand and size currently used or one size smaller if the same size is not available, syringe for cuff inflation/deflation, manual resuscitation (Ambu) bag with any necessary connectors to fit the resident's trach tube. 1. Review of R7's clinical record revealed the following: 8/6/21- R7 was admitted to the facility with a trach. 8/6/21 - A Physician's order stated to change the trach tube monthly with a Shiley #6 XLT size and as needed. 6/8/22 beginning at 2:29 PM - A joint observation with E5 (RN UM) was done of the emergency supplies that must be at the bedside. All supplies were observed with the exception of a replacement Shiley #6 XLT cuffless trach tube. Upon confirmation of the lack of replacement trach tube at the bedside, E5 left R7's room and returned to the room at 2:42 PM, approximately 13 minutes later with a replacement trach tube with the obturator. 6/8/22 2:39 PM - During an interview with the assigned LPN (E39), the Surveyor asked if the emergency supplies at the bedside was previously checked during the day shift and E39 stated it was not done. E39 was able to locate all of the emergency supplies and confirmed the replacement trach tube and obturator were not at the bedside. E39 proceeded to leave the room and stated she will locate E5 (RN UM). 6/8/22 3:45 PM - An interview with E12 (NPE) revealed for a resident with a trach, emergency supplies that must be at the bedside for potential accidental decannulation of a trach tube included a spare trach tube with obturator or one size smaller and a syringe. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of R67's clinical record revealed the following: 7/5/18 - R67 was admitted to the facility with multiple diagnoses including persistent vegetative state, brain damage, chronic respiratory failure, and a tracheostomy. a. 8/4/21- A physician's order was written for R67 to have a tracheostomy tube and Ambu bag [manual respirator] at the bedside to be checked every shift. R67's care plan for tracheostomy, last updated 5/9/22, had a goal that the resident would have no complications developed by the trach for 90 days. Some of the interventions included in the care plan included to keep the Ambu bag and extra trach tube in the resident's room. 6/8/22 2:45 PM - During screening of R67 for the initial pool, E32 (RN) was asked to show the Surveyor the emergency supplies for R67. On R67's wall near the bedside was a bag with a replacement trach tube, however, there was no Ambu bag present. From 2:45 PM to 2:48 PM, E32 searched R67's room for an Ambu bag and after three minutes, located it on the far side of R67's room in a cardboard box. E32 then stated, There was new equipment delivered, someone must have moved it by accident. b. 2/15/22 - An order was implemented for R67's trach tube to be changed monthly and as needed. R67's care plan for tracheostomy, last updated 5/9/22, had a goal that the resident would have no complications developed by the trach for 90 days. Some of the interventions included in the care plan were as follows: tracheostomy tube changed every 30 days. R67's care plan for alteration in respiratory status related to tracheostomy, last updated 5/9/22, included the intervention that the trach tube be changed per physician order. 2/9/22 11:11 AM - A note in R67's clinical record documented, eMAR progress note: change tracheostomy tube monthly .every 1 month(s) starting on the 1st for 28 day(s). Tracheostomy tube size not available at this time. Ancillary [staff] made aware to reorder. NP made aware. Will reschedule for 2/11/2022, pending delivery. [R67's] (mother) made aware as well. No respiratory distress observed. 2/11/22 2:53 PM - A note in R67's clinical record documented, Residents tracheostomy tube changed today as per physicians orders per monthly. 5/1/22 5:26 PM - A note in R67's clinical record documented, No inner cannula (smaller tube for insertion into the trach tube) available to change. Trach care provided. 5/15/22 2:36 PM - A note in R67's clinical record documented, Tracheostomy care including inner cannula and drain sponge every day and evening shift inner cannula has been cleansed none available to replace. Drain sponge changed. 5/16/22 2:57 PM - A note in R67's clinical record documented, No inner cannula available to exchange. 5/18/22 8:57 PM - A note in R67's clinical record documented, No inner cannula available to exchange. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/19/22 12:59 PM - A note in R67's clinical record written by E49 (RT) documented, Talked with patients RN about tracheostomy inner cannula supply issue. No current trach inner cannula's available, but we do have [other sized] inner cannula's that fit and will not cause a patient safety concern. Discussed usage with RN and I will speak with materials manager regarding current solution. Review of the May 2022 TAR revealed the changing of R67's inner cannula was incorrectly documented as completed on 5/1/22. 6/1/22 12:06 PM - A note in R67's clinical record documented trach care including inner cannula was changed by respiratory therapist. 6/13/22 at 11:35 AM - During an observation of trach care with E32 (RN), E32 was asked if the facility always has trach supplies for R67, E32 replied, No, but before Surveyor's came the respiratory therapist changed the order so we would have the supplies. During an interview on 6/14/22 at 9:52 AM, E6 (RN UM) confirmed that R67's tracheostomy supplies were not always available. During an interview on 6/14/22 at 10:11 AM with E51 (supply staff), it was confirmed that at times R67's trach supplies were unavailable. E51 stated it was due to Back order because of COVID. During an interview on 6/14/22 at 10:55 AM, E2 (DON) reported that when R67's supplies are unavailable she Will drive to our other center. Then we will call our provider and they will give us an order to change the date. E2 attributed the facility's lack of supplies for R67's trach care to back orders and one product was discontinued, we couldn't order it. 6/16/22 11:08 AM - An interview with E50 (Supervisor) for respiratory contract service it was reported that From time to time there have not been inner cannula's. COMPETENT TRAINED STAFF: 3. 6/8/22 3:45 PM - An interview with E12 (Nurse Practice Educator - NPE) revealed that all licensed nurses at the time of orientation training and validation completed trach care and documented on the facility's Clinical Competency Validation for Tracheostomy Care documentation. E12 confirmed that this document did not include the steps to take during a trach dislodgement. E12 stated the last training and competency validation for trach dislodgement was conducted by a previous Contracted Respiratory Therapist and E12 would provide this information to the Surveyor as soon as possible. 6/8/22 4:45 PM - During an interview with E12 in the presence of E1 (NHA), E12 provided evidence of inservice and competency validation conducted for trach dislodgement on 6/3/21. Review of the list revealed that three (3) RNs (E5, E31 and E32) out of 15 current RNs completed training and competency validation. E12 confirmed the facility was unable to provide evidence for the remaining 12 RNs. 6/8/22 6:05 PM - During an interview with E1 and E12 (NPE), the parties were advised that the lack of emergency equipment and lack of competent trained staff for dislodgement of a trach was an Immediate Jeopardy. Findings were confirmed with E1 and E12. E1 stated that the facility began the training and competency validation process within the past hour. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6/8/22 6:30 PM - The facility had evidence of training for a total of (7) RNs, including retraining of the three (3) previously trained RNs (E5, E31 and E32). 6/8/22 7:36 PM - The facility's abatement plan included: - Proper emergency trach supplies have been placed at both trach patients bedside as of approximately 3:15 PM on 6/8/22. - Out of 15 RN's on staff, 7 (seven) have already been educated on decannulation and emergency trach care. The remaining RNs will be educated on the topic prior to the start of their next scheduled shift. Any newly hired RN's or agency RN's will be educated upon starting employment at the center. - Orders were placed to ensure emergency trach supplies (i.e. Ambu bag and replacement trach supplies) are checked by nursing and tracked on the Medication Administration Record (MAR) each shift as of 3:45 PM on 6/8/22. - The facility will develop a policy and procedure for emergency decannulation by 6/9/22. 6/9/22 10:00 AM - Interviews were conducted with current nursing staff to determine they received training as outlined in the written plan. 6/9/22 10:00 AM - The facility provided a copy of the policy and procedure for emergency decannulation. 6/9/22 1:55 PM - The facility provided evidence that all current RNs completed their training and the IJ was abated. Review of the facility's policy and procedure titled Tracheostomy Care, with a revision date of 7/15/21, stated upon completion of trach care, .33. Evaluate patient's respiratory rate, heart rate, breath sound, pulse oximetry, and cough effort. 4. 6/13/22 beginning at 11:00 AM - During a random trach care observation, E21 (RN) performed routine trach care, including suctioning of R7. E21 evaluated R7's respiratory rate, heart rate, pulse oximetry, and cough effort, however, failed to evaluate R7's breath sounds post trach care. 6/13/22 1:45 PM - An interview with E12 (NPE) confirmed that R7's breath sounds should have been auscultated after routine trach care. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference 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. 20835 Based on record review and interview, it was determined that for one (R1) out of three (3) residents reviewed for pain investigation, the facility failed to provide R87 with services consistent with professional standards of practice, the comprehensive person-centered care plan and R87's goals. Findings include: The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. The facility's Pain Management policy, revised on 6/1/21, stated, . Policy. Patients will be evaluated as part of the nursing assessment process for the presence of pain upon admission/re-admission, quarterly, with change in condition or change in pain status . Pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the patient's goals . Purpose. To maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain . PRACTICE STANDARDS: . 8. Patients receiving interventions for pain will be monitored for effectiveness and side effects . 8.2 Effectiveness of PRN medications. 8.3 Ineffectiveness of routine or PRN medications including interventions, follow-up, and physician notification . Review of R87's clinical records revealed the following: 5/17/22 3:24 PM - A Nursing Progress Note documented that R87 was admitted for pain management and therapy. R87 was documented as having pain during turning and repositioning with a pain rating of 10 out of 10 and at rest, seven (7) out of 10 (Zero (0) is no pain and 10 is the worst imaginable pain). 5/17/22 - The Admission Nursing Pain Assessment documented that R87 had severe pain in her lower back and right hip areas which were acute and R87 described the pain as aching and moves down the leg or arm. R87's acceptable pain goal was 4 and her current pain level was a 7. 5/17/22 - The Physician's Orders for pain management included the following: - Morphine Sulfate (MS) ER (Extended Release) tablet 15 mg by mouth two times daily. - Acetaminophen (ACTM) ER 650 mg by mouth every 8 hours as needed for mild to moderate pain 1/7. - Acetaminophen (ACTM) 650 mg by mouth every 4 hours as needed for mild pain. - Pain monitor every shift. - Baclofen Tablet 10 mg three times a day for muscle spasms. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lidocaine 5% topical patch to lower back daily. 5/18/22 - Review of the admission history and physical completed by E43 (MD) stated during E43's evaluation, R87 was found to be in mild acute distress due to uncontrolled diffuse achiness secondary to chronic pain. 5/18/22 through 5/24/22 - The MAR revealed the following: - 5/18/22 7:00 AM - 3:00 PM shift, Pain Monitoring documented a pain rating of 10. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors and including, what interventions, if any were implemented. - 5/18/22 9:00 PM, there was a lack of evidence that the scheduled narcotic, MS ER 15 mg was administered. - 5/21/22 7:00 AM - 3:00 PM shift, Pain Monitoring documented a pain rating of 9. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors and including, what interventions, if any were implemented. - 5/23/22 3:23 PM, R87 had a pain level of 7 and was administered ACTM 650 mg ordered for mild pain and E for effective was documented. The post pain rating of 4 was documented at 10:08 PM, approximately nine (9) hours after the pain medication was administered. - 5/24/22 7:00 AM - 3:00 PM shift, Pain Monitoring documented pain rating of 9. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors and including, what interventions, if any were implemented. 5/24/22 - The Admission 5 day MDS Assessment stated R87 was independent with decision making, was receiving both scheduled and PRN (as needed) pain medication and had pain at the time of the assessment. In addition, the pain was experienced frequently, had no affect on sleep, have to limit day to day activities due to the pain and experienced severe pain within the past 5 days of this assessment. 5/30/22 - The care plan for alteration in comfort related to chronic pain caused by spinal stenosis of the lumbar region of the spine had a goal that R87 would have an acceptable level of pain control. Interventions included to evaluate pain characteristics: quality, severity, location, precipitating/relieving factors, utilize pain scale, medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects and report to physician as indicated, monitor frequency of episodes of breakthrough pain to determine the need for pain med adjustment, complete pain assessment per protocol, assist resident to a position of comfort, utilizing pillows and appropriate positioning devices, and monitor for nonverbal signs of pain: increase in agitation, grimace, resistance to care. 5/30/22 through 6/8/22 - The MAR revealed the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/30/22 3:04 PM, R87 was administered ACTM arthritis pain ER 650 mg. The clinical records lacked evidence of an evaluation of pain characteristics including quality, severity, location, precipitating/relieving factors prior to the administration of the medication. In addition, a post pain evaluation was lacking. - 6/4/22 12:47 AM, R87 was administered ACTM arthritis pain ER 650 mg for hip pain 8/10. The Nursing Progress Note documented Effective at 11:10 AM, approximately 10 hours after the medication was administered. The clinical records lacked evidence of a post pain assessment utilizing the pain scale. - 6/9/22 2:55 PM, R87 complained of generalized pain 8/10 and it was documented that the pharmacological intervention was effective. The clinical records lacked evidence of a post pain assessment utilizing the pain scale. 6/8/22 11:39 AM - During an interview, R87 stated she was experiencing pain in her lower back and right hip with a pain level of 8/10. The Surveyor immediately informed E5 (RN UM) of R87's complaint of pain. 6/8/22 - A new Physician order for a different narcotic pain medication, Oxycodone 15 mg by mouth every 6 hours as needed for moderate to severe pain was ordered after the Surveyor informed E5 (RN UM) of R87's pain rating of 8/10. 6/14/22 1:35 PM - An interview with E2 (DON) in the presence of E3 (RNC) was conducted. The above dates and times of lack of evidence was reviewed and additional evidence was provided, however, E2 stated that it was her understanding that the utilization of a consistent pain scale for evaluation of pain pre and post intervention was not required, thus, E or effective was an acceptable standard for pain management. E2 further stated that the facility monitors pain every shift at any time during the shift and does not require documentation of what interventions were implemented and the outcome of the intervention. Thus, for the day shifts in which R87 reported a pain level of 10 on 5/18/22, 9 on 5/21/22, and 9 on 5/24/22, E2 confirmed that there was no requirement for the staff to comprehensively assess the pain. E2 confirmed that R87 was not administered the scheduled routine narcotic on 5/18/22. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA) 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. 40264 Based on clinical record review, interview and review of facility documentation, it was determined that for one (R100) out of 39 sampled residents, the facility failed to accurately monitor the targeted behaviors for psychotropic medications (any medication capable of affecting the mind, emotions and behavior). Findings include: Review of R100's clinical record revealed the following: 3/16/20 - R100 was admitted to the facility with diagnoses that included dementia with behavioral disturbance and major depressive disorder. 8/25/20 - R100 was care planned for being at risk for distressed/fluctuating mood symptoms related to major depressive disorder. R100's goal was to exhibit decreased episodes of agitation. The care plan interventions included, but were not limited to: - observing for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation; and - observing for signs/symptoms of new psychiatric disorder (e.g .frequent mood swings). 9/11/21 - R100's Quarterly MDS (Minimum Data Set) Assessment revealed that R100 had severe cognitive impairment and was able to ambulate or walk independently, requiring set up help only. In addition, R100 was exhibiting daily wandering behaviors during the review period. 9/12/21 - A progress note documented by E37 (Nurse Practitioner- NP) stated, .(R100) seen for weight loss . agitation, tearful . she just wants to see her husband and she wishes she would just die . 9/22/21 - A progress note documented by E37 stated, .(R100) seen today for worsening agitation .per staff she continues with agitation, seems to be getting worse. Tried earlier this week to get out the side of the door .anxious walking the halls per staff. The assessment included: Dementia with behavioral disturbance .with worsening agitation recently and has been slowly progressing with her dementia, confusion and behaviors . will add Depakote (used as a mood stabilizer) .she has been exit seeking will continue to follow closely. 9/22/21 - An order summary report indicated that R100 was ordered Depakote 125 mg two times a day for dementia with behavioral disturbance. 6/21/22 at 9:00 AM - Review of R100's September 2021 Medication Administration Record revealed a lack of evidence of the targeted depression symptoms and exit seeking behavior. 6/21/22 at 1:02 PM - An interview with E37 (NP) revealed symptoms of depression: tearfulness, wanting to to see her husband (who passed away), wishing to die, increased agitation and exit seeking behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence that the facility was monitoring the targeted behaviors associated with using antipsychotic medication, including tearfulness, wanting to to see her husband (who passed away), wishing to die, increased agitation and exit seeking behavior. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/22/22 at approximately 3:15 PM.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 40264 Based on observation, interview and record review, it was determined that for one (R111) out of two residents reviewed for food preferences, the facility failed to accommodate R111 's food preferences. Findings include: 2/21/20 - R111 was admitted to the facility. 6/8/22 at 12:24 PM - During a dining observation, R111's food tray was sitting on the overbed table untouched. 6/8/22 at 12:25 PM - When asked about her lunch, R111 shook her head and pointed at the toasted sandwich and potato salad on her tray. R111 attempted to slice the piece of toasted bread, but was not able to slice through it. R111 held her fork to pick up a cubed potato from her salad, but was not able to pierce the fork through the potato. R111 was pointing at the food and stated, See that? The bread is so hard and it has a yellowish filling on it, I don't even know what's in it. The cubed potatoes are so hard like a rock. How do you think I can eat that? R111 asked the Surveyor what's in the sandwich. This Surveyor read the meal ticket, Tuna Salad for Sandwich, Potato Salad .Advance Dysphagia (difficulty swallowing) diet - chopped meats. R111 stated that she already told them (staff) that she can not eat tuna. R111 said she was upset that they were still sending her a tuna sandwich. 6/8/22 at 12:39 PM - The Surveyor notified E35 (LPN), who in turn sent E38 (CNA) to Find out what the resident wants. E38 confirmed the bread was hard to cut as it was toasted. He further confirmed that the cubed potatoes in the salad were also hard. E38 stated, The resident can not eat the food on her tray. She can only eat soft food. I'll call the kitchen for a substitute and I will let the nurse know. 6/8/22 at 12:40 PM - In an interview, E35 stated that R111 was on an advanced dysphagia diet and could only eat soft consistency food. E35 added that she saw R111 and offered her a soft sandwich which R111 agreed to and notified the kitchen staff that R111 does not like tuna on any of her meals. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/22/22, at approximately 3:15 PM.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 sanitary storage of food, clean and sanitized surfaces on food preparation equipment, and maintain the correct concentration of sanitizing solution. During multiple kitchen tours on 6/7/22, the Surveyor observed the following: - 8:57 AM - A rectangular plastic food storage canister containing deli sliced ham, which was partially covered preventing protection from dust, debris, and other contaminants. - 9:05 AM- E30 (Cook) tested the sanitizer level of the solution in a red sanitizing bucket. When E30 tested the sanitizing solution, the test strip indicated that the level of chemical concentration in the bucket was not sufficient to provide proper sanitization. - 9:47 AM- Dried food debris on the blade and other areas of a meat slicer. - 9:52 AM- A large amount of loose dry cereal on a tray of covered cereal bowls stored in the pantry. - 10:03 AM- A large clear plastic food storage bucket containing liquid tea, which was completely uncovered preventing protection from dust, debris, and other contaminants. - 10:27 AM- An interview with E30 (Cook) revealed that none of the staff members working in the kitchen including E30, who was the designated PERSON IN CHARGE, during multiple tours of the kitchen, possessed a current Food Protection Manager Certification. 6/15/2022 8:11 AM - E1 (NHA) and E29 (Dining Services Manager) confirmed all findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 20835 Based on observation, interview and review of infection control guidelines, it was determined that the facility failed to ensure proper hand hygiene was completed to prevent the spread of infection. During random medication pass and tracheostomy (trach) care observations, the facility failed to perform appropriate hand hygiene when changing gloves. Lastly, the facility failed to ensure the laundry room adhered to recommended CDC guidelines to prevent infection. Findings include: Review of the CDC Hand Hygiene Guidance, last reviewed 1/30/2020, indicated the following: The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient; Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; Before moving from work on a soiled body site to a clean body site on the same patient; After touching a patient or the patient's immediate environment; After contact with blood, body fluids, or contaminated surfaces; Immediately after glove removal . Healthcare facilities should require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. Core Concepts for Hand Hygiene: Clean Hands for Healthcare Personnel, instructs HCP to perform hand washing as follows: 1. Wet hands with water; 2. Apply soap; 3. Rub hands together for at least 15 seconds, covering all surfaces, focusing on fingertips and underneath fingernails; 4. Rinse under running water and dry with disposable towel; 5. Use the towel to turn off the faucet; https://www.cdc.gov/handhygiene/providers/guideline.html. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled IC203 Hand Hygiene, with a revision date of 11/25/20 and last review date of 11/15/21, stated to perform hand hygiene .1.3 After any contact with blood or other body fluids, even if gloves are worn; 1.4 After patient care: . 1. During random medication pass observations on 6/10/22 revealed the following: a. 6/10/22 beginning at approximately 11:05 AM - During a random medication pass observation, E22 (RN) performed a finger stick blood sugar (FSBS) on R110. Upon completing the FSBS, E22 discarded the contaminated glove, washed her hands with soap and running water for eight (8) seconds and turned off the faucet with her left bare hand, thereby contaminating her hand. b. 6/10/22 beginning at approximately 11:15 AM - During a random medication pass observation, E22 (RN) performed a FSBS on R106. Upon completing the FSBS, E22 discarded the contaminated glove, washed her hands with soap and running water for 10 seconds and turned off the faucet with the left sleeve of her shift. 6/10/22 11:18 AM - Interview with E22 (RN) immediately after the above observations confirmed the above observations. Cross-refer F695, Example #3 2. During a random trach care observation on 6/13/22 beginning at approximately 11 AM and concluding at 11:20 AM on R7, E23 (RN) changed his gloves four (4) times, proceeded to wash his hands with soap and running water for five (5) seconds each time, then turned off the faucet with his left bare hand for two (2) out of the four (4) hand washings performed, thereby contaminating his hand. 6/13/22 11:40 AM - Interview with E23 (RN) immediately after the above observations confirmed the observations. 32810 3. Review of the CDC guidelines for Guidelines for Environmental Infection Control in Health-Care Facilities (last updated 2003) indicated, Laundry areas should have handwashing facilities readily available to workers. Laundry workers should wear appropriate personal protective equipment (e.g., gloves and protective garments) while sorting soiled fabrics and textiles. https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html. The facility policy for personal clothing handling, last updated 3/1/18, revealed the absence of required PPE to be worn while handling soiled clothing. 6/16/22 at 10:13 AM - During an observation of the facility laundry room the following was observed: - lack of available gowns for PPE, only one pair of goggles and gloves was available. - access to handwashing sink was obstructed by a tall drying rack with clothing hanging on it. - paper towel dispenser not functioning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately following the observation, E48 (laundry worker) confirmed the absence of gowns for PPE and stated, We don't use them, we just wear gloves. E48 then demonstrated that the paper dispenser was not functioning and stated, Sometimes it works, sometimes it doesn't, so I wash my hands in the bathroom on the floor (unit). 6/21/22 at 11:00 AM - During a second observation of the laundry accompanied by E19 (Environmental Supervisor) and E1 (NHA), it was confirmed that the laundry room did not have PPE/gowns available for use when staff handle resident laundry and the only PPE staff wear when handling laundry is gloves. The handwashing sink continued to be obstructed by the drying rack. E1 reported the batteries to the paper towel dispenser were replaced the previous Saturday, 6/18/22. These findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 6/22/22 at 3:15 PM.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 20835 Based on record review, facility policy, and interview, it was determined that for one (R75) out of two sampled residents reviewed for antibiotic stewardship, the facility failed to implement their antibiotic stewardship program protocol for antibiotic use. Findings include: Review of the facility's policy and procedure titled Antibiotic Stewardship, with a revision date of 5/11/22, stated, POLICY. Centers will implement an Antibiotic Stewardship Program that includes antibiotic use protocols and systems for monitoring antibiotic use .2.1.7 Infection Preventionist: 2.1.7.1 Monitors and supports antibiotic stewardship activities through rounds, review of provider orders, PCC (Point Click Care- an electronic system within the EMR) documentation and available PCC/pharmacy/lab reports; . Cross-refer F684, Example #3 2/10/22 - R75 was admitted to the facility. 4/30/22 3:55 PM - A General Note (Nursing Progress Note) stated that R75 complained of being dizzy and a Physician's order was obtained to transfer R75 to the emergency room (ER). 4/30/22 - R75 returned from the ER and the ER visit summary stated R75 was diagnosed with a UTI. While in the ER, a urinalysis (UA) was initiated with the results of the culture and sensitivity (C&S) pending. R75 was ordered Augmentin (an antibiotic) for 10 days. There was lack of evidence of the results of the urine C&S in R75's clinical records. 5/3/22 8:17 AM - R75's UA/C&S results, dated 5/3/22, were in the Delaware Health Information Network (DHIN, a statewide health information exchange that registered healthcare providers can access). Lab results were requested by the Surveyor and provided by E2 (DON) during the survey on 6/15/22 at 12:15 PM. The UA/C&S results indicated that Augmentin was not on the list of antibiotics that was sensitive to the organism and to treat R75's UTI. 5/8/22 7:02 PM - A Physician's order by E43 (MD) was written for Cefdinir (a different antibiotic) by mouth for 10 days. 5/9/22 - A Progress Note by E4 (NP) stated, .Patient report (sic) burning with urination is slowly improving. Urine sensitivity results received and no sensitivity to Augmentin. Stop Augmentin .start Cefdinir . for 10 days. Will continue to monitor closely. 6/21/22 11:40 AM - During an interview, E12 (NPE) revealed that as the facility's Infection Control Preventionist, she has access to DHIN and was able to go into DHIN to check lab results. 6/21/22 11:45 AM - An interview with E4 (NP) confirmed that the 5/3/22 UA/C&S results revealed Augmentin was not on the list of antibiotics that were sensitive to R75's UTI and if E4 had checked the results on 5/3/22, she would have discontinued the Augmentin and reevaluated the treatment plan. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure monitoring of R75's antibiotic use resulting in R75 receiving an inappropriate antibiotic (Augmentin) for 5 days and a delay starting an antibiotic that was sensitive to the bacteria. 6/22/22 beginning at 3:15 PM - The above findings were reviewed during the Exit Conference with E1 (NHA and E2 (DON).

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. 32810 Based on record review and interview, it was determined that the facility failed to ensure employee's who were not up to date with COVID-19 vaccinations were tested in accordance with County positivity rates. Additionally, the facility failed to ensure testing for up to date employees every 3-7 days in accordance with outbreak testing recommendations. Findings include: Review of the QSO 20-38 memorandum by CMS, last revised 3/10/22, indicated that LTC facility testing requirements for staff and residents, minimum testing for staff who are not up to date is twice a week when in substantial or high positivity rates. Minimum Testing Frequency of Staff who are not up to date (up to date means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible) are as follows: Low (blue) not recommended; Moderate (yellow) once a week; Substantial (orange) twice a week; High (red) twice a week, staff who are up to date do not need to be routinely tested . The facility policy for screening test for coronavirus - Residents and staff, last updated 4/7/22, indicated, . Testing of staff, who are not up to date, should be based on the extent of the virus in the community . Facilities should use their community transmission level as a trigger for staff testing frequency .Substantial twice weekly. High twice weekly. Review of County positivity rates for the facility's location, indicated the area had a substantial positivity rate from 3/30/22 - 4/25/22 and a high positivity rate from 4/26/22 through the time of the exit on 6/22/22, which required testing twice a week. 1. Review of 2022 testing logs for the following employees who were not up to date with COVID-19 vaccinations revealed the following: - E7 (contract RN) was tested on ce a week for COVID-19 on the following dates: 4/5, 4/12, and 4/18. - E52 (contract CNA) was tested on ce a week for COVID-19 on the following dates: 4/6, 4/13, 4/20, 4/26. - E53 (contract CNA) was tested on ce a week for COVID-19 on the following dates: 4/5, 4/11, 4/25, 5/2, 5/9, 5/17, and 5/24. - E22 (RN) was tested on ce a week for COVID-19 on the following dates: 4/6, 4/12, 4/18, 4/26, 5/3, 5/9, 5/16, and 5/24. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- E56 (CNA) was tested on ce a week for COVID-19 the following dates 4/19, 4/26, 5/17, 5/24, 5/31, 6/7, and 6/13. During an interview on 6/22/22 at 1:06 PM with E1 (NHA) and E12 (ICP), it was confirmed that staff who were not up to date were not tested twice a week in accordance with COVID-19 infection positivity rates. 2. The CDC webpage entitled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes & Long Term Care Facilities, last updated February 2, 2022, indicated that when performing outbreak testing, perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but generally not earlier than 24 hours after the exposure, if known) and, if negative, again 5-7 days later. If additional cases are identified, testing should continue on affected unit(s) or facility wide every 3-7 days . until there are no new cases for 14 days. The facility policy for testing and management of symptomatic persons, close contacts and outbreaks, last updated 6/1/22, indicated, Centers should continue with broad based testing . Perform testing for all patients and HCP regardless of vaccination status immediately and if negative again 5-7 days later . If additional cases are identified, testing should continue on affected units or facility wide every 3-7 days . until there are no new cases for 14 days. E55 (CNA), a COVID-19 up to date vaccinated employee, worked in the facility several dates from 5/15/22 through 6/14/22 while the facility was in outbreak status. E55 was tested for COVID-19 on the following dates: 5/11 and 5/19, an 8 day span. 5/26 and 6/5, a 10 day span. 6/5 and 6/14, a 9 day span. During an interview on 6/21/22 at 12:47 PM, E12 (ICP) reported that the facility began outbreak status on 3/8/22 and We were never really out of outbreak. Outbreak testing was still in progress at the facility on June 22, 2022. During an interview on 6/22/22 at 10:06 AM, E12 (ICP) stated the facility was In an outbreak. We test all of the residents weekly. We test our staff too. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) 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	06/28/2022

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 44706 Based on review of facility documentation, it was determined that for two (E40 and E41) out of seventeen random sampled staff members, the facility failed to ensure that the required training on abuse, neglect, and exploitation was completed. Findings include: The facility policy on Abuse Prohibition, updated 5/1/22, indicated, The Center will implement an abuse prohibition program through the following: - Training of employees (both new employees and ongoing training for all employees). Training and reporting obligations will be provided to all employees . through orientation, Code of Conduct training, and a minimum of annually. Review of facility training records for abuse, neglect and exploitation revealed two staff members without evidence of training from March 2021 through June 2022 as follows: -E40 (CNA), E40's last training was completed on 3/1/21. -E41 (Agency CNA), E41's first day in the facility was 3/21/22. The facility lacked evidence of E41's training. Findings were reviewed during the exit conference on 6/22/22 at 3:15 PM with E1 (NHA) and E2 (DON). 6/27/22 2:03 PM - During an interview via telephone, E1 confirmed that annual training was offered during orientation and electronically for annual training that can be accessed at any time by employees.