STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** Based on record review and interview, it was determined that the facility failed to ensure information was provided to the receiving provider for four (R1, R2, R3, and R5) out of four sampled residents investigated for hospitalization s. The facility failed to include resident care plan goals in the transfer/discharge information. Findings include: 1. Review of R1's clinical record revealed the following: 1/9/20 and 2/22/2020 - R1 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R1. 2. Review of R2's clinical record revealed the following: 1[DATE]19 and 12/9/2019 - R2 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R2. 3. Review of R3's clinical record revealed the following: 1/16/20 - R3 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R3. 4. Review of R5's clinical record revealed the following: 10/19/2019 - R5 was transferred to the hospital. There was no evidence in the record to indicate that care plan goals were sent to the receiving facility for R5. During an interview on [DATE] at approximately 1:30 PM, E1 (ED) confirmed the facility documentation lacked evidence that the required care plan goals accompanied the residents when transferring R1, R2, R3, and R5 to another provider. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on [DATE] during the exit conference beginning at 2:50 PM.
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** Based on record review and interview, it was determined that, for three (R1, R2, and R3) out of four sampled residents reviewed for hospitalization , the facility failed to provide written notice to the resident and/or the resident's representative of the resident's transfer or discharge to another facility. Findings include: 1. Review of R1's clinical record revealed: 2/22/2020 - R1 was transferred to the hospital. There was no evidence in the clinical record to indicate that a written notice was given to the resident or resident representative for R1. 2. Review of R2's clinical record revealed: 1[DATE]19 and 12/9/2019 - R2 was transferred to the hospital. There was no evidence in the clinical record to indicate that a written notice was given to the resident or resident representative for R2. 3. Review of R3's clinical record revealed: [DATE] - R3 was transferred to the hospital. There was no evidence in the clinical record to indicate that a written notice was given to the resident or resident representative for R3. During an interview on [DATE] at approximately 1:30 PM, E1 (ED) confirmed the facility documentation lacked evidence that the facility provided written notice to the residents and/or the resident's representatives of the resident's transfer or discharge to another facility for R1, R2, and R3. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on [DATE] during the exit conference beginning at 2:50 PM.
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** Based on record review and interview, it was determined that for three (R1, R2 and R3) out of four sampled residents reviewed for hospitalization , the facility failed to provide written bed-hold notice to the resident and/or the resident's representative when R1, R2 and R3 were transferred to the hospital. Findings include: 1. Review of R1's clinical record revealed: 2/22/2020 - R1 was transferred to the hospital. There was no evidence in the record to indicate that the bed-hold notice was given to the resident or resident representative. 2. Review of R2's clinical record revealed: 1[DATE]19 and 12/9/2019 - R2 was transferred to the hospital. There was no evidence in the record to indicate that the bed-hold notice was given to the resident or resident representative. 3. Review of R3's clinical record revealed: 1/16/20 - R3 was transferred to the hospital. There was no evidence in the record to indicate that the bed-hold notice was given to the resident or resident representative. During an interview on [DATE] at approximately 1:30 PM, E1 (ED) confirmed that the bed-hold notice was not provided to the residents or the resident's representatives when R1, R2, and R3 were transferred to the hospital. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on [DATE] during the exit conference beginning at 2:50 PM.
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.** Based on record review and interview, it was determined that, for one (R1) out of three sampled residents reviewed for falls, the facility failed to complete neurological evaluations after a fall. Findings include: Review of R1's clinical record revealed: A Facility policy entitled Neurological Evaluation (last revised 1/31/2020) included: Neurological evaluation will be performed as indicated or ordered. When a patient sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: - Every 15 minutes x two hours, then - Every 30 minutes x two hours, then - Every 60 minutes x four hours, then - Every eight (8) hours until at least 72 hours has elapsed. The standard of care in nursing home facilities includes: A fall that is unwitnessed, or in which the head is struck, requires neurological checks. Any change in resident condition requires a phone call to the primary care physician. (The assessments should include): Initial assessment (baseline); followed by q15 min x 4; q30 min x 2; every hour x 2; once per shift for 72 hours. (https://healthinsight.org/Internal/assets/Nursing Home/FALLS-PR - Post fall 72 hour .) 2/16/2020 6:55 PM - A facility event summary for an unwitnessed fall included: This nurse and his (R1's) primary nurse were notified patient found on floor. Patient sitting up with back against bed, legs in front of him, abductor pillow was in place. Patient

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) removed from the floor via Hoyer (hydraulic) lift per facility policy. Vital signs obtained. MD called. 2/16/2020 7:00 PM - R1's neurological evaluations were initiated. For the following dates and times R1's neurological evaluation flowsheet lacked evidence of a neurological assessment: 2/16/2020 11:05 PM; 2/17/2020 11:05 AM; 2/17/2020 7:00 PM; 2/18/2020 3:00 AM; 2/18/2020 11:00 AM; 2/18/2020 7:00PM; [DATE] 3:00 AM; [DATE] 11:00 AM; and [DATE] 7:00 PM. During an interview on [DATE] at approximately 1:00 PM E3 (ADON) confirmed that R1's neurological assessments from the 2/16/2020 fall were incomplete, and that R1's clinical record (including nursing progress notes) lacked evidence that every 8-hour neurological assessments were completed for 72 hours after R1 sustained a fall. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on [DATE] during the exit conference beginning at 2:50 PM.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of other facility documentation it was determined that the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through the facility assessment. The facility failed to ensure that training was conducted with licensed nursing staff on post-transfusion assessment of potential complications and the facility's policy on blood [MEDICAL CONDITION]. Findings include: 1/[DATE]6 (effective date) and 8/27/19 (effective date) - The facility's contracts with the vendor that administers the [MEDICAL CONDITION] in the facility included that the vendor will provide any necessary in-servicing and/or training to facility staff prior to the first transfusion. 11/1/19 (revision from the effective date 5/1/19) - The facility's policy entitled Blood/Blood Product Transfusion Provided by (vendor) included that: - (Vendor) RN will verify blood product to be transfused against the patient's identification band and the Center RN will verify identification of patient with patient identification band to verify dual nurse verification and document on the Dual Nurse Verification form. (This form includes visual inspection of the blood product/bag and expiration date.) - Post-Transfusion the Center licensed nurse will: Receives the 'Post Transfusion Vital Signs Form' and signs as understanding of the instructions; Observes the patient hourly for an additional five hours; Documents vital signs on the 'Post Transfusion Vital Signs Form'; Submits completed 'Post Transfusion Vital Signs Form' to (vendor). - In the event of a transfusion related incident during or within one-hour post-transfusion the, Center licensed nurse will: Document emergency protocol and/or additional physician orders; Communicate updates with patient representative. - In the event of a transfusion related incident after the vendor nurse has left the Center, the Center licensed nurse will: Immediately notify the patient's physician/(nurse practitioner) .and the (vendor) RN .; Notify the patient representative; Document notifications and orders. - For ten days post-transfusion, Center licensed nurse monitors patient for signs of transfusion associated graft vs host disease (TA-GVHD) and notifies patient's physician, patient representative and (vendor) upon suspicion of TA-GVHD; Document signs of TA-GVHD, treatment, effectiveness and notifications in the patient's medical record. 12/19/19 - The Facility Assessment contained a section entitled Special Treatments and Conditions included that the facility provides an average of one transfusion a month. The section entitled Staff Training/Education and Competencies did not include training on [MEDICAL CONDITION]. [DATE] 2:20 PM - During an interview, E4 (Nurse Educator) stated that the facility has no record of education being provided to their nurses on [MEDICAL CONDITION]. E4 added that the contracted vendor's nurse administers the [MEDICAL CONDITION] and monitors the resident for one hour after the transfusion; then, the facility nurses only take the resident's vital signs once an hour for the next five hours. [DATE] 8:30 AM - During an interview, E1 (NHA) stated that since 1/16/19 residents have received seven [MEDICAL CONDITION] in the facility, but is not aware of any education provided to the nurses except on the spot report from the vendor's nurse after the transfusion is complete. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on [DATE] during the exit conference beginning at 2:50 PM.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on review of facility documentation, review of cited deficiencies from the facility's annual survey of 6/25/19 and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. Findings include: During the QAPI interview on [DATE] at 2:40 PM with E1 (NHA), E2 (DON) and E3 (ADON) it was confirmed that the team meets at least quarterly and meetings include the required meeting members. During the same interview, E1 was made aware that the survey team identified deficiencies in the following areas: Transfer and Discharge Requirements, Notice Requirements Before Transfer/Discharge and Notice of Bed Hold Policy Before/Upon Transfer. Review of the facility's 6/25/19 annual survey identified deficiencies were cited for: Transfer and Discharge Requirements, Notice Requirements Before Transfer/Discharge and Notice of Bed Hold Policy Before/Upon Transfer. 1. Transfer and Discharge Requirements - The facility's plan of correction for a deficiency regarding Transfer and Discharge Requirements cited during the 6/25/19 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability. The results of the current survey cited under F622 revealed that the QAPI committee was ineffective in correcting this deficient practice. 2. Notice Requirements Before Transfer/Discharge - The facility's plan of correction for a deficiency regarding Notice Requirements Before Transfer/Discharge cited during the 6/25/19 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability. The results of the current survey cited under F623 revealed that the QAPI committee was ineffective in correcting this deficient practice. 3. Notice of Bed Hold Policy Before/Upon Transfer - The facility's plan of correction for a deficiency regarding Notice of Bed Hold Policy Before/Upon Transfer cited during the 6/25/19 survey revealed that the facility would complete audits and report the results of the audits to the QAPI committee to discuss progress and/or make recommendations to achieve sustainability. The results of the current survey cited under F625 revealed that the QAPI committee was ineffective in correcting this deficient practice. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on [DATE] during the exit conference beginning at 2:50 PM.