| 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 _____ | **04/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **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) |
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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br><br>Based on observations, interviews and review of CDC (Centers for Disease Control) COVID-19 guidelines and facility policies it was determined that the facility failed to follow COVID-19 precautions to isolate and cohort six (R1, R4, R6, R8, R10, and R12) out of six residents on the long term care section and three (R14, R17 and R18) out of three residents on the rehabilitation section by placing asymptomatic and presumptive positive COVID-19 residents in shared rooms. On the locked dementia unit, an asymptomatic resident (R21) was a roommate with a COVID-19 positive resident (R20). Additionally, the facility failed to follow proper infection control practice when staff stated that they used the same personal protective equipment (PPE) when providing care to COVID positive/presumptive residents and three asymptomatic residents (R21, R22 and R23) in the locked dementia unit. These failures put the residents at risk for contracting COVID-19. An immediate jeopardy (IJ) was called on 4/17/2020 at 7:10 PM and was abated on 4/17/2020 at 10:59 PM. Findings include: 3/27/2020 - The facility's COVID-19 policy included: In addition to Standard Precautions, Contact and Droplet Precautions will be implemented for patients suspected or confirmed to have COVID-19 based on the Centers for Disease Control (CDC) guidance. Follow local public health and state regulations when applicable. This policy refers to a document called Special Circumstance COVID-19 Outbreak Intervention Tiers for confirmed patients or employees with COVID-19 which included to: Ensure patient has been placed in a private room with the door closed .Care for these patients with dedicated healthcare personnel (cohort staff) to minimize the risk of transmission and exposure to other patients and other health care workers, as much as able. 4/2/2020 - The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) issued COVID-19 Long-Term Care Facility Guidance that included: Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status .When possible, facilities should exercise consistent assignment, or have separate staffing teams for COVID-19-positive and COVID-19-negative patients. 4/15/2020 - The Governor of Delaware's Eleventh Modification State of Emergency Declaration included: All nursing facilities, assisted living facilities, rest residential facilities, and intermediate care facilities for persons with intellectual disabilities shall immediately implement, to the best of their ability, the following personnel practices: Establish a cohort of staff who are assigned to care for residents with known or suspected COVID-19. Designate a room, unit, or floor of the facility as a separate observation area where newly admitted and readmitted residents are kept for 14 days on contact and droplet precautions while being observed every shift for signs and symptoms of COVID-19. Designate a room, unit, or floor of the facility to care for residents with known or suspected COVID-19. Documentation review and observation revealed: 4/17/2020 2:20 PM - Review of the current facility line listing and resident census revealed there were ten residents (R2, R3, R5, R7, R9, R11, R13, R15, R16, and R19) that the facility identified as presumptive positive for COVID-19 that were in the same rooms as asymptomatic residents. There was also one COVID-19 positive resident (R20) in the same room as an asymptomatic resident (R21). 4/17/2020 2:30 PM - The following nine asymptomatic residents (R1, R4, R6, R8, R10, R12, R14, R17, and R18) were not identified on the line listing as having COVID-19 or presumptive COVID-19. These residents were observed to have roommates that were identified by the facility to be presumptive positive for COVID-19. 4/17/2020 2:30 PM to 4:10 PM - During staff interviews on the locked dementia unit, several staff (E9 (CNA), E10 (CNA), E10 (Activity Aide), E7 (LPN) and E8 (RN)) stated they were told by the facility's supervisors and administrators to consider all of the residents on this unit as COVID-19 positive, so staff all stated that they wore the same gown and mask for their entire eight hour shift while providing care to all residents on the unit. 4/17/2020 2:45 PM - E12 (locked dementia unit manager) confirmed that R21, R22 and R23 were the only aymptomatic residents on the locked dementia unit and that R20 tested COVID-19 positive and R20 and R21 are roommates. 4/17/2020 6:42 PM - During an interview with E5 (Corporate Nurse), it was confirmed that nine asymptomatic residents (R1, R4, R6, R8, R10, R12, R14, R17, and R18) were sharing a room with one or two of the 10 facility identified presumptive positive COVID-19 residents (R2, R3, R5, R7, R9, R11, R13, R15, R16, and R19) and that one COVID-19 positive resident (R20) was in the same room as an asymptomatic resident (R21). While the facility maintains an infection prevention and control program they failed to adhere to and implement standard and transmission based precautions to prevent the spread of infection there by jeopardizing the safety and well fare of residents. The facility failed to isolate the ten residents (R2, R3, R5, R7, R9, R11, R13, R15, R16, and R19) that were identified as presumptive positive for COVID-19 and one resident (R20) positive for COVID-19. Additionally, the facility failed to follow proper infection control practice when staff stated they used the same PPE on COVID-19 positive/presumptive residents and asymptomatic residents and failed to provide dedicated health care personnel for COVID-19 positive and presumptive positive residents. These failures put twelve residents (R1, R4, R6, R8, R10, R12, R14, R17, R18, R21, R22, and R23) who were asymptomatic for COVID-19 at risk for contracting COVID-19. 4/17/2020 7:10 PM - E1 (NHA) was notified by the surveyor that an IJ was identified when the facility failed to properly isolate and cohort positive and presumptive COVID-19 residents. The facility had one positive resident (R20) positive resident in the same room with an asymptomatic resident (R21). The facility cohorted 10 (R2, R3, R5, R7, R9, R11, R13, R15, R16, and R19) presumptive COVID positive residents with nine (R1, R4, R6, R8, R10, R12, R14, R17, and R18) asymptomatic residents. Additionally, the facility failed to follow proper infection control practice when staff stated they used the same PPE on COVID-19 positive / presumptive residents and three (R21, R22 and R23) asymptomatic residents on the locked dementia unit. These failures put residents at risk for contracting COVID-19. 4/17/2020 10:45 PM - E1 (NHA) provided the abatement plan for the IJ. 4/17/2020 10:59 PM - The IJ was abated after the following was completed: the facility corrected the improper isolation and the improper infection control techniques to prevent the spread of infection in the facility by moving asymptomatic residents to rooms without COVID-19 positive / presumptive residents and developed an appropriate plan to cohort staffing and provide staff education. 4/22/2020 3:10 PM - Findings were reviewed with E1 (NHA), E2 (Assistant Director of Nursing) and E4 (Corporate Nurse) during an exit teleconference. |

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.