DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center

DATE SURVEY COMPLETED: May 24, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted on May 22, 2023 through May 24, 2023. The deficiencies contained in this report are based on interviews, review of residents' clinical records and review of other facility documentation records as indicated. The facility census the first day of the survey was 95. The survey sample size was eleven (11) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	Scope		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 24, 2023: F550, F656, and F677.		

Provider's Signature _____ Title Administrator Date 6/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from May 22, 2023 through May 24, 2023. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records and review of other facility documentation. The facility census on the first day of the survey was ninety-five (95). The survey sample totaled eleven (11) residents. Abbreviations/definitions used in this report are as follows: Cerebral Palsy - a disorder that affects muscle tone, movement and motor skills; DON - Director of Nursing; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; UM - Unit Manager.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/30/23

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

Electronically Signed | 06/21/2023

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that for one (R4) out of four resident's reviewed for abuse, the facility failed to promote dignity when a staff member spoke to R4 in a raised voice. Findings include: 2/9/23 - An allegation of verbal abuse was reported to the State Agency from the facility. The report alleged, "According to the Unit Manager, resident and CNA came up the hallway, and heard both resident and a CNA raising their voices. Resident complained to Unit Manager that	F 550	A: The CNA involved was immediately suspended pending investigation and terminated at the conclusion of the investigation. B: All residents had the potential to be affected, however the incident was addressed immediately at the time of the event and the CNA involved never returned to the facility. Resident Council meetings cover Resident Rights every month, as well as told who the Ombudsman is and how to contact the Ombudsman. All staff receive Resident	

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F 550	Continued From page 2 CNA was yelling to resident." During an interview on 5/22/25 at 1:56 PM, E5 (RN) stated that on 2/9/23, "E4 (CNA) came in and told me that she said [to R4] you can't be rude to staff members. E4 told me then went to the desk and for 2-3 minutes I heard yelling from R4 and E4 yelling back." E5 confirmed that E4 was "yelling" at R4, but stated the language was not abusive. During an interview on 5/23/23 at 9:26 AM with R4, the resident confirmed that E4 (CNA) spoke in a raised voice, "yelled" at her on 2/9/23. R4 stated, "She [E4] yelled at me and I yelled back. I had yelled at another CNA for turning my light on and so she [E4] yelled at me saying that I am scaring the staff away and they wont have help if I'm rude to people. I left my room to go to the nurses station and she was too and we continued yelling, we were yelling back and forth." R4 then confirmed that E4 did not threaten or intimidate her at any point. These findings were reviewed during the exit conference on 5/24/23 at 12:30 PM with E1 (NHA) and E2 (DON).	F 550	Right education upon hire & annually. We did staff education immediately with all staff following this incident. C: A root cause analysis was completed which determined that clinical staff required additional education on Resident Right. After the event occurred, the unit manager removed the CNA immediately and placed her on suspension. Unit manager began investigation that included staff statements, statements from residents with BIMS above 8 and total assessment of all residents housed on the same unit. NPE will complete monthly education, attached A, to ensure all new staff are educated properly on Resident Rights. D: NHA/designee will complete weekly audits, attachment B, for 10% of the resident population until 4 audits consecutively achieve 100% compliance. Audits will occur monthly thereafter until 3 consecutive reviews achieve 100% compliance. Results of audits will be presented at the monthly QAPI for review and recommendations.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		6/30/23

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F 656	Continued From page 3 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 656	A: Resident R6 care plan was	

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F 656	Continued From page 4 other facility documentation, it was determined that for one (R6) out of eleven residents reviewed for care plans, the facility failed to develop a comprehensive and personalized care plan for R6's dependence on facility staff for showers. Findings include: Cross refer F677. A facility policy entitled Person-Centered Care Plan (last revised 10/24/22) included that the purpose of the care plan was "to attain or maintain the patient's highest practicable physical, mental and psychosocial well being." Review of R6's clinical record revealed: 5/16/18 - R6 was admitted to the facility with Cerebral Palsy and severe cognitive impairment. 2/26/23 - A quarterly MDS assessment documented that R6 was severely cognitively impaired and dependent on two staff members for bathing. Review of R6's care plan lacked evidence of a personalized care plan for all ADL's (activities of daily living) including, but not limited to the amount of assistance R6 required for bathing/showers and R6's need for a shower stretcher. 5/23/23 9:45 AM - During an interview, E1 (NHA) and E2 (DON) confirmed that R6's comprehensive care plans were not personalized for her special needs. These findings were reviewed during the exit conference on 5/24/23 at 12:30 PM with E1	F 656	immediately corrected to reflect barriers to providing a safe shower process in order to have a detailed comprehensive care plan. B:The DON completed the initial audit of all non-verbal residents to ensure they have the appropriate detailed care plan. No other residents within the facility at that time had communication barriers. C: A root cause analysis was completed and determined that license nursing staff need education on proper comprehensive care planning. NPE/designee will provide education to licensed nurses that input information into the resident care plans to initiate a care plan for all residents with communication barriers to be detailed and patient specific. This will be completed by 6/30/23. D: DON/designee will complete audits, attachment C, on 100% of resident care plans with similar barriers in communication. Audits will be conducted weekly for 4 weeks or until 100% compliance is achieved and then monthly for 3 months or until substantial compliance is achieved. Results of audits will be presented at QAPI for review.	

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F 656	Continued From page 5 (NHA) and E2 (DON).	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that for one (R6) out of three residents reviewed for activities of daily living (ADL's), the facility lacked evidence that appropriate treatment and services were provided to a dependent resident which included showers for R6. Findings include: Cross refer F656. A facility policy entitled Activities of Daily Living (last revised 5/1/23) included: "A patient that is unable to carry out ADL's (Activities of Daily Living) will receive the necessary level of ADL assistance to maintain...grooming. ADL care is documented every shift by the nursing assistant." Review of R6's clinical record revealed: 5/16/18 - R6 was admitted to the facility with Cerebral Palsy (a disorder that affects muscle tone, movement and motor skills). 2/26/23 - A quarterly MDS assessment documented that R6 was severely cognitively impaired and dependent on two staff members for bathing.	F 677	A: Facility followed through with all individual employees for R6 at the time of the events to include counseling and education regarding ADLs. B: All residents had the potential to be affected by the deficient practice, however the facility followed with each employee at the time of the event. Other residents dependent for ADLs have been reviewed to ensure care provision. Clinical staff receive education upon hire about the importance for provision and documentation of care. Employees violating this area are addressed individually through our disciplinary process. C: A root cause analysis was completed that determined all clinical staff required education on the importance for the provision and documentation of ADL care. NPE/designee will complete education, attachment D, with nurses and CNAs by 6/30/23. D: DON/designee will complete weekly audits, attachment E, for 10% of the resident population until 3 consecutive reviews have achieved 100% compliance. Audits will occur bi-weekly until 3	6/30/23

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F 677	Continued From page 6 5/22/23 2:26 PM - During a random observation, R6 was noted in bed and her hair was disheveled and appeared greasy. Review of the CNA tasks for R6 to have a tub/shower/bath revealed that on 4/29/23, 5/13/23 and 5/17/23 R6 was documented to be not available. Review of the progress notes revealed that the resident had not been out of the facility on those dates and had not received a shower or a tub bath. 5/23/23 9:07 AM - During an interview, E3 (CNA) stated that if the resident is in the facility, the CNA task for bathing should not reflect that they are not available. E3 stated that R6 required staff to put her on a shower bed (a stretcher) to go into the shower room for bathing. 5/23/23 9:24 AM - During an additional observation and interview, E7 (CNA) and E8 (CNA) confirmed that R6's hair was disheveled and greasy and that R6 did not appear to have received a recent shower and hair wash. 5/23/23 9:32 AM - During an interview, E9 (Unit Manager) confirmed that R6 had not gone out to the hospital or was out of the facility during the aforementioned dates. E9 stated that sometimes R6 will get flustered, get a red face and "swing her arms and legs" when care was provided. 5/23/23 9:45 AM - During an interview, E2 (DON) confirmed that R6 was provided a shower after the Surveyor informed the staff that the resident appeared disheveled and had greasy hair. 5/23/23 approximately 10:15 AM - During an	F 677	consecutive reviews are achieved 100% compliance. Then audits will occur monthly until 3 consecutive reviews are achieved 100% compliant. Results of the audits will be presented to QAPI for review and recommendations.	

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F 677	Continued From page 7 observation, R6 was noted to be in bed, well groomed, with clean hair that had a pink bow in it. These findings were reviewed during the exit conference on 5/24/23 at 12:30 PM with E1 (NHA) and E2 (DON).	F 677		