STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085040	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lofland Park Center	715 E. King Street Seaford, DE 19973

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, it was determined that for one (R79) out of five residents sampled for medication review, the facility failed to discuss the risk and benefits of proposed care. Findings include: Review of R79's clinical record revealed: 9/12/24 - R79 was admitted to the facility. 9/18/24 - An admission MDS documented R79 was a BIMS of 6 indicating severe cognitive impairment. 2/13/25 - A physician's order was written for buspirone (anti-anxiety) 5 mg give one tablet by mouth every morning and and at bedtime for anxiety. 3/3/25 - A physician's order was written for lorazepam (anti-anxiety) 0.5 mg give one tablet by mouth every six hours for generalized anxiety disorder for 14 days. 3/9/25 - A physician's order was written for haloperidol (anti-psychotic) 5 mg/mL inject 5 mg/mL intramuscularly every four hours as needed for agitation. 6/11/25 1:41 PM - During an interview, E11 (RN) stated the expectation is to review each new medication (psychotropic) risk versus benefits with the resident if cognitively intact or with the resident's representative. E11 also stated the facility had a form that would be completed when discussing the treatment options. 6/12/25 10:19 AM - During an interview, E6 (RN) confirmed that R79's medical record lacked evidence of a Psychotropic Medication Administration Disclosure for the buspirone, haloperidol, and ativan medication. E6 also confirmed that the physician's progress notes lacked evidence of the risk versus benefit documentation regarding the aforementioned medications. 6/12/25 12:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate).

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, it was determined that for one (R79) out of five residents sampled for medication review, the facility failed to limit a PRN psychotropic medication to 14 days. Findings include: Review of R79's clinical record revealed: 9/12/24 - R79 was admitted to the facility. 3/6/25 - A quarterly MDS assessment documented that R79 was a BIMS of 9 indicating that R79 was moderate cognitively impaired. 3/9/25 - A physician's order was written for haloperidol (anti-psychotic) 5 mg/mL inject 5 mg/mL intramuscularly every four hours as needed for agitation with an indefinite stop date. 3/31/25 - A physician's order was written for lorazepam (anti-anxiety) 0.5 mg give one tablet by mouth every six hours as needed for generalized anxiety disorder for 180 days. 6/12/25 10:19 AM - During an interview, E6 (RN) stated the expectation for PRN medications have a 14 day stop date so the provider can evaluate resident for usage of the medication. E6 confirmed that the lorazepam and haldol did not have the 14 day stop date. E6 also confirmed the physician's progress note did not have a rationale to extend the lorazepam order for 180 days. 6/12/25 11:15 AM - During an interview, E1 (NHA) stated that the expectation was a 14 day stop date on PRN medication and the provider will evaluate the usage. E1 confirmed that the lorazepam order was written for 180 days. 6/12/25 12:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate). 6/13/25 9:25 AM - During an interview, E1 confirmed that R79 was evaluated for use of PRN lorazepam and confirmed the physician's progress notes lacked evidence of rationale to extend medication for 180 days. E1 stated that R79 was not using the lorazepam consistently and would discuss with the provider about discontinuing medication.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review it was determined that for two (R9 and R58) out of two residents reviewed for bowel and bladder, the facility failed to initiate antibiotic therapy for signs and symptoms of a UTI. For R9 with a urinary catheter who met criteria of a positive urine culture and for R58 without a urinary catheter who met criteria of a positive urine culture. Findings include: 1. Review of R9's clinical record revealed: 10/4/18 - R9 admitted to the facility with diagnoses including, but not limited to, thoracic spinal cord injury. 2/25/25 - An annual MDS documented R9 having an indwelling urinary catheter. 4/11/25 11:31 PM - A nursing note documented Obtain UA [urinalysis] and C&S [culture and sensitivity] for urinary discomfort .reported done on day shift. 4/11/25 11:50 AM - A specimen tracking report provided by E9 (Hospital Lab Supervisor) revealed the urine sample for UA and C&S was obtained. 4/11/25 3:38 PM - A specimen tracking report provided by E9 revealed the urine sample for UA and C&S was received from the facility and a urinalysis and urine culture was completed. 4/12/25 1:56 PM - A lab report in the hard copy medical record revealed abnormal UA results with cloudy clarity, 2+ [moderate] blood, positive nitrates, and 3+ [large] white blood cells and an E. Coli count > 100,000 cfu/ml indicating a positive urine culture. 4/12/25 1:56 PM - A specimen tracking report provided by E9 revealed the abnormal UA and the preliminary positive urine culture results were filed to R9's chart. 4/13/25 7:04 AM - A specimen tracking report provided by E9 revealed susceptibility results from the positive urine culture was filed to R9's chart. 4/14/25 5:50 PM - An order documented: Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth every 12 hours for UTI for 5 days . 6/10/25 11:36 AM - During an interview, E16 (RN) stated that when a resident shows symptoms of a UTI, the nurse will take vital signs to check for fever, assess urine color and clarity, note any foul odor, and notify the physician of the findings. The facility does not perform in-house urine dipstick tests; instead, urine specimens are sent to the hospital lab. Lab results are faxed back to the facility, and any nurse on the unit can contact the physician with the results. Some physicians initiate prophylactic antibiotics immediately, while others prefer to wait for susceptibility and sensitivity results before starting treatment. 6/11/25 1:24 PM - During an interview, (E9) confirmed the accuracy of the data in the specimen tracking report provided. E9 further explained that upon receipt of a specimen by their laboratory, a urinalysis and preliminary urine culture are performed and the results are uploaded to R9 ' s chart. If further testing is indicated, such as susceptibility testing for a positive urine culture, the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urine specimen is then shipped to a larger reference laboratory, where it is plated and incubated for susceptibility analysis and the are results uploaded to R9's chart. R9 had a positive urine culture and met the minimum criteria for initiating antibiotic therapy as a resident with a urinary catheter. However, the facility failed to initiate antibiotics on 4/12/25 when R9 met the criteria of a positive urine culture. 2. Review of R58's clinical record revealed: 7/7/22 - R58 admitted to the facility with diagnoses including, but not limited to, spastic quadriplegia cerebral palsy. 5/13/25 2:30 PM: An order documented, Obtain UA [urinalysis] /C&S [Culture and Sensitivity] for altered mental status. 5/13/25 2:15 PM - A lab report in the EMR revealed that a urine sample for urinalysis (UA) and culture and sensitivity (C&S) was obtained, and at 3:56 PM, the same report showed that the sample was received by the laboratory. 5/14/25 3:36 PM - A faxed lab report in the hard copy medical record revealed a Poteus mirabilis colony count >100,000 cfu/ml indicating a positive culture. 5/15/25 7:17 AM - A faxed lab report in the hard copy medical record revealed culture sensitivity results were reported to facility. 5/15/25 - 11:40 AM - An order documented: Amoxicillin-pot Clavulanate 875/125mg. Give one tablet by mouth BID [two times daily] x 10 days for UTI .[administration times 9 PM and 9 AM R58 had a positive urine culture and met the minimum criteria for initiating antibiotic therapy as a resident without a urinary catheter. However, the facility failed to administer antibiotics on 5/14/25 after R58 met the criteria of a positive urine culture. 6/12/25 12:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on interview, observation and record review, it was determined that for one (R346) out of one residents reviewed for respiratory care, the facility failed to change oxygen tubing weekly per plan of care. Findings include: 1. Review of R346's clinical record revealed: 7/20/24 - R346 admitted to the facility with diagnoses including but not limited to COPD and Centrilobular Emphysema. 7/20/24 4:05 PM - An order documented, Oxygen tubing change weekly on 11-7 [PM] Wednesdays .Label each component with date and initials. 6/5/25 10:34 AM - Observation of R346's continuous oxygen tubing label was dated Saturday, May 24, 2025 and nebulizer tubing dated Thursday, May 29, 2025. 6/5/25 3:15 PM - A subsequent observation of R346's continuous oxygen tubing label dated Thursday, June 5, 2025. 6/5/25 3:18 PM - During an observation interview E8 (LPN) confirmed that she changed R346's continuous oxygen tubing at the start of their shift [3 PM to 11 PM] on Thursday, June 5, 2025 and that R346's nebulizer tubing was dated Thursday, May 29, 2025. E8 further stated that R346's nebulizer tubing should have been changed and that she would change the nebulizer tubing. The facility changed R346's oxygen tubing after 11 days, failing to follow the physician's order for weekly oxygen tubing changes. 6/12/25 12:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on interview and record review, it was determined that for one (R98) out of six residents reviewed for unnecessary medications, the facility failed to ensure a resident on insulin had adequate monitoring of blood sugar levels R98. Findings include: A review of R98's clinical record revealed: 11/25/24 - R98 was admitted to the facility, with diagnoses including diabetes mellitus. 11/25/24 - A physician's order for Humalog solution 100 unit /mL Inject 5 units subcutaneously in the evening for diabetes mellitus. 12/5/24 - A physician's order for Insulin glargine subcutaneous solution pen-injector 100 unit/mL, inject 15 units subcutaneously one time a day for diabetes mellitus. 6/9/25 - The EMR lacked evidence of a physician's order for blood sugar monitoring for R98. 6/9/25 11:48 AM, an interview with E6 (RN) confirmed that when a resident is receiving insulin, E6 obtains a physician's order to monitor a resident's finger stick blood sugar level. 6/9/25 1:10 PM - An interview with E4 (RN) confirmed that upon resident admission, finger stick blood sugars are monitored for three days if blood glucose levels exceed 200. The physician is notified, and E4 would obtain an insulin order and enters it into the computer system, which then prompts a choice between sliding scale or non-sliding scale insulin. However, E4 confirmed that the EMR did not include an order for finger stick blood sugar monitoring for resident R98. 6/10/25 10:45 AM - An interview with E5 (NP) confirmed that if a resident is receiving insulin on admission, finger sticks are ordered for three days in the AM to monitor the finger stick blood sugar level. If the resident is controlled, then the order would be discontinued. E5 confirmed it would be a separate order. 6/12/25 12:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate).