



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

STATE SURVEY REPORT

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NAME OF FACILITY: **Emeritus at Dover**

DATE SURVEY COMPLETED: **April 5, 2012**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p><b>3225.0</b></p> <p><b>3225.9.0</b></p> <p><b>3225.9.5.2</b></p>	<p>An unannounced annual and complaint survey was conducted at this facility beginning March 27, 2012 and ending April 5, 2012. The facility census on the entrance day of the survey was 72 residents. The survey sample was composed of 8 residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures</p> <p><b>Assisted Living Regulations</b></p> <p><b>Infection Control</b></p> <p><b>Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on review of facility documentation and staff interview, the facility failed to ensure that seven (7) of 14 sampled staff had received the pre-employment base line two step tuberculin skin test. Findings</p>	<p>3225.0/3225.9.0/3225.9.5.2</p> <ol style="list-style-type: none"> <li>1.) E50 – two step PPD will be completed by 5/25/12,E51- 2 step PPD completed 5/15/2012 and was negative.,E52- Provided a copy of his 2-step PPD from other employer,E53- 2 step PPD completed on 4/2/12 and was nrgative,E54- 2 step PPD completed 5/26/12 and was negative,E55 – Completed annual screening form 3/29/12.,E56- will complete 5/25/12.</li> <li>2.) An audit of employee PPD's will be conducted by the ED to ensure all employees have received their new hire and annual PPD by 6/15/12.</li> <li>3.) New hire employees will receive their PPD or be able to show proof of a recent PPD at new hire orientation to the hiring manager. This process will be maintained by the Business Office Director monthly. Department Directors will be in-serviced on Emeritus TB Test Policy (Attachment A) Completion date 5/25/12</li> <li>4.) An audit will be conducted quarterly to ensure employees have received their PPD by the ED. This will continue until substantial compliance is met. Completion date 6/15/12</li> </ol>

Provider's Signature Mary F. D... [Signature] Title Executive Director Date 5/22/12



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<p>3225.9.5.2.2</p>	<p>include:</p> <ol style="list-style-type: none"> <li>1. E50 was hired 7/28/2011. Review of documentation revealed that a step one TST was placed and read. However step 2 result was not available.</li> <li>2. E51 was hired 4/7/2011. Review of documentation revealed that a step one TST was placed and read. However step 2 result was not available.</li> <li>3. E52 was hired 2/9/2012. Review of documentation revealed that a step one TST was placed and read. However step 2 result was not available.</li> <li>4. E53 was hired 8/28/2011. Review of documentation revealed that no tuberculin skin test results were available.</li> <li>5. E54 was hired 5/26/2011. Review of documentation revealed that a step one TST was placed and read. However step 2 result was not available.</li> <li>6. R55 was hired 7/29/2008. Review of documentation revealed that no tuberculin skin test results were available.</li> <li>7. E56 was hired 8/25/2011. Review of documentation revealed that a step one TST was placed and read. However step 2 result was not available.</li> </ol> <p>Staff confirmed the above findings.</p> <p><b>Any person having a positive skin test but a negative X-ray shall receive an annual evaluation for sign and symptoms of active TB if they cannot provide documentation of completion of treatment for LTBI (latent TB infection).</b></p>	<p>3225.9.5.22</p> <ol style="list-style-type: none"> <li>1.) E57&amp;E58 will complete the Annual evaluation for signs and symptoms for TB by 5/25/12.</li> <li>2.) An audit of employees will be conducted by the ED to ensure employees who require an annual evaluation for signs and symptoms of TB will be completed by 6/15/12.(attachment B)</li> <li>3.) The Business Office Director will be in-serviced to monitor the PPD process by 5/25/12.</li> <li>4.) An audit will be conducted quarterly by the ED to ensure employees who require and annual evaluation for signs and symptoms of TB has been completed. Completion date 5/25/12.</li> </ol>
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<p>3225.12.0</p> <p>3225.12.1</p> <p>3225.12.1.3</p>	<p><b>This requirement is not met as evidenced by:</b></p> <p>Based on review of facility documentation and staff interview, the facility failed to ensure that two (2) of four sampled staff had completed an annual evaluation for sign and symptoms of active TB. Findings include:</p> <ol style="list-style-type: none"> <li>1. E57 was hired 1/25/2011. An annual evaluation for sign and symptoms of active TB was not available after the chest X-ray dated 11/2/2010.</li> <li>2. E58 was hired 6/25/2009. Latest annual evaluation for sign and symptoms of active TB was dated 3/23/2011.</li> </ol> <p>Staff confirmed the above findings.</p> <p><b>Services</b></p> <p><b>The assisted living facility shall ensure that:</b></p> <p><b>Food service complies with the Delaware Food Code</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on observations and interview during the tour of the kitchen on 3/27/2012, it was determined that the facility failed to comply with section 3-305.11 (A) (2) of the State of Delaware Food Code.</p> <p><b>3-3 Protection From Contamination After Receiving</b></p> <p><b>3-305 Preventing Contamination from</b></p>	
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	<p><b>the Premises</b></p> <p><b>3-305.11 Food Storage</b></p> <p><b>(A) Except as specified in ¶¶ (B) and (C) of this section, food shall be protected from contamination by storing the food:</b></p> <p><b>(2) Where it is not exposed to splash, dust, or other contamination.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Observations at 12:15 PM with E59 (Dining Services Director) revealed that two trays of desserts were stored uncovered in the McCall refrigerator.</p> <p>This finding was confirmed by E59.</p>	<p>3-305.11</p> <ol style="list-style-type: none"> <li>1.) The desserts were covered by parchment paper at the time it was brought to the attention of the Dietary Services Director by the surveyor.</li> <li>2.) All residents will be considered at risk</li> <li>3.) The Dietary Services Director will in-service dietary staff to ensure all desserts are covered and maintain cover by 5/30/12.</li> <li>4.) The Dietary Services Director/designee will monitor the refrigerator daily to ensure all desserts are covered until substantial compliance is met. Any deficient practice will be reported to the ED. 5/30/12</li> </ol>
<p><b>3225.13.0</b></p>	<p><b>Service Agreements</b></p>	
<p><b>3225.13.5</b></p>	<p><b>The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on clinical record review and staff interviews it was determined that the facility developed service agreements that failed to include goals with time frames and specific interventions to address the actual falls sustained by two residents (Resident #1 and Resident #5) out of eight sampled. Findings include:</p> <p>1. Cross refer 16 Del., Chapter 11, Subchapter III, §1131.</p>	<p>3225.13.5</p> <ol style="list-style-type: none"> <li>1.) R1's service agreement will be updated to include fall interventions from 7/6/11, 7/15/11, and 8/4/11 by 6/25/12</li> </ol> <p>R5 no longer resides in our community.</p> <ol style="list-style-type: none"> <li>2.) An audit of residents who are at high risk for falls service agreement will be conducted by the RCD/ARCD to ensure the agreement includes goals that are specific to interventions developed to address falls by 6/25/12.</li> </ol>



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	<p>Clinical record review revealed that the service agreement dated 5/10/2010 was absent goals with time frames and specific interventions to address the fall risk assessed for Resident #1. Additionally the service agreement dated 11/2011 revealed failure of the facility to address actual falls sustained by Resident #1 on 7/6/2011, 7/15/2011 and 8/4/2011 with time frames for goals and specific interventions.</p> <p>These findings were reviewed with E1 (executive director), E2 (regional RN) and E3 (resident service coordinator) on 4/5/2012.</p> <p>2. Clinical record review revealed that Resident #5 was admitted to the facility 3/22/2010 with diagnoses that included dementia, degenerative joint disease, hypertension, COPD and osteopenia. According to the UAI completed for a significant change on 3/4/2011 Resident #5 was disoriented to person, place and time and exhibited short-term memory and long-term memory problems. Further review of the UAI dated 3/4/2011 revealed that Resident #5 was independent with an assistive device for mobility although she was also assessed as a fall risk due to confusion and falling in the last 30 days.</p> <p>However review of the service agreement dated 3/6/2011 revealed the absence of goals with time frames and specific interventions developed to address actual falls sustained by Resident #7 on 7/5/2011, 7/10/2011 and 8/4/2011.</p> <p>These findings were reviewed with E1 (executive director), E2 (regional RN) and E3 (resident service coordinator) on 4/5/2012.</p>	<p>3.) The RCD will be in-serviced on service agreement updates regarding falls and appropriate interventions by 6/1/12.</p> <p>4.) Residents who are at risk for falls will be audited quarterly by the RCD to ensure the service agreements reflect the interventions that are in place. This will continue until substantial compliance is met. Completion date 6/25/12 and ongoing.</p>
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<p><b>3225.17.0</b></p> <p><b>3225.17.2</b></p> <p><b>3225.17.1</b></p> <p><b>3225.17.2</b></p> <p><b>3225.17.2.2</b></p>	<p><b>Environment and Physical Plant</b></p> <p><b>Assisted living facilities shall:</b></p> <p><b>Be in good repair.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on observations on 4/4/2012, during the environmental tour with E60 (Maintenance Director), it was determined that the facility failed to provide maintenance services necessary to maintain an orderly interior. Findings include:</p> <p>The following equipment was in disrepair:</p> <ol style="list-style-type: none"> <li>1. Dining room carpet had a tear of approximately four feet in length.</li> <li>2. Stained flooring by the urinal, damaged walls, missing baseboard and scratched stall door were observed in the men's restroom.</li> <li>3. Wooden door jamb to the crafts room was damaged.</li> <li>4. Resident room doors and metal door jams were scratched.</li> <li>5. Hallway walls and baseboards were scratched.</li> <li>6. Repaired wall was unpainted in the Capitol Drive hallway.</li> </ol> <p><b>Assisted living facilities shall:</b></p> <p><b>Be clean.</b></p> <p><b>This requirement is not met as</b></p>	<p>3225.17.0/3225.17.2/3225.17.1</p> <ol style="list-style-type: none"> <li>1.) The dining room carpet will be replaced by 6/25/12. (Attachment C)</li> </ol> <p>The flooring in the men's room will be replaced, baseboards will be placed, and stall doors will be painted by 6/25/12</p> <p>The wooden door jams in the crafts room was repaired on 4/6/12.</p> <p>Resident room doors and metal door jams will be repaired and painted by 6/25/12.</p> <p>Hallway walls will be painted and/or repaired by 7/1/25.12</p> <p>Repaired unpainted walls on Capitol Drive hallway were painted on 4/13/12.</p> <ol style="list-style-type: none"> <li>2.) All residents are considered affected.</li> <li>3.) The Maintenance Director will be in-serviced on the Fire, Safety, and Maintenance task sheet. (Attachment D)</li> <li>4.) Quarterly Rounds will be conducted by the Maintenance Director and the Executive Director to ensure the physical plant is properly maintained. This will continue until substantial compliance is met. 7/1/12.</li> </ol>



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		3225.17.2.2
	<p><b>evidenced by:</b></p> <p>Based on observations on 4/4/2012, during the environmental tour with E60 (Maintenance Director), it was determined that the facility failed to provide housekeeping services necessary to maintain a clean interior. Findings include:</p> <p>1. Soiled carpet was observed in the TV room, hallway by the restrooms, dining area, and hallways of Boulevard and Capitol wings.</p>	<p>1.) The Carpet in the dining room, lobby, hallways, TV room, is being replaced by 6/25/12.</p> <p>2.) All residents are considered to be affected.</p> <p>3.) New carpet will be installed by 6/25/12.</p> <p>4.) The new carpet will be cleaned and on an ongoing basis per manufacturer recommendations.</p>
3225.18.0	<p><b>Fire Safety and Other Emergency Plans</b></p>	
3225. 18.1	<p><b>The assisted living facility shall comply with all applicable state and local fire and building codes. All applications for license or renewal of license shall include a letter certifying by the Fire Marshal having jurisdiction. Notification by the Fire Marshall of non-compliance with the Rules and Regulations of the State Fire Prevention Commission shall be grounds for enforcement remedies in 16 Del. C Ch. 11, Subchapter 1, Licensing By The State.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>An interview with E60 (Maintenance Director) confirmed that there was no evidence of the annual certification letter by the Fire Marshal.</p>	<p>3225.18.0 3225.18.1</p> <p>1.) The City of Dover Fire Marshall will be contacted to complete and inspection by 5/25/12.</p> <p>2.) All residents will be considered affected.</p> <p>3.) The Maintenance Director will be in-serviced to maintain a Fire Marshall inspection log and notify the Fire Marshall when an inspection is due.5/25/12</p> <p>4.) This practice will be monitored monthly by the Safety Committee until substantial compliance is met. 5/25/12</p>
3225.18.0	<p><b>Fire Safety and Other Emergency Plans</b></p>	
3225.18.4	<p><b>The assisted living facility shall promote staff knowledge of fire and other emergency safety by:</b></p>	



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3225.18.4.5	<p><b>Maintaining records for two years of facility fire and other emergency drills/training sessions.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Review of the fire drill records on 3/29/2012 revealed that the fire drill reports for the first and second quarter shifts of 2010 were not available. Additionally, the fire drill reports for the third shift of the first quarter and the second shift of the fourth quarter of 2011 were not available. E60 (Maintenance Director) confirmed the findings.</p>	<p>3225.19.0 3225.19.6</p> <p>1.) Resident #7 incident was reported on 1/16/12. Resident no longer resides in community.</p> <p>Resident #8 incident was reported on 4/2/12.</p>
3225.19.0	<p><b>Records and Reports</b></p>	<p>2.) All residents are affected. In accordance with this regulation, all reports of abuse will be reported to DLTCRP by the LPN, RN, ED, or Department Director. And event management report will be completed by the LPN, RCD or ED as per policy.</p>
3225.19.6	<p><b>Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be directed by the Division.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on clinical record review and staff interview it was determined that the facility failed to immediately report an incident of alleged abuse sustained by one resident (Resident #8) and an incident of alleged neglect sustained by one resident (Resident #7) out of eight sampled within 8 hours to the Division of Long Term Care Residents Protection. Findings include:</p> <p>1. Cross refer 16 Del., C., Chapter 11, Subchapter III, § 1131. Review of a facility incident report submitted to the Division on 1/16/2012 at 17:35 PM revealed it was received approximately 32 and ½ hours following an</p>	<p>3.) Licensed nursing staff and Department Directors will be in serviced on requirements to the DLTCRP. Licensed nurses and Department Director training on this topic will additionally occur on hire, annually and as needed.</p> <p>4.) Review of event reports will be conducted by the ED/RCD/Department Director's daily to ensure that all reportable events have been reported to the DLTCRP. Completion date 6/15/11</p>



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	<p>allegation of neglect directed toward Resident #7 that occurred on 1/15/2012 during the morning shift. According to the incident report Resident #7 did not receive breakfast on 1/15/2012.</p> <p>The facility failed to immediately report an incident of substantiated neglect within 8 hours to the Division. This finding was reviewed with E1 (executive director), E2 (regional RN).</p> <p>2. In an interview conducted with E1 (facility administrator) on 4/5/2012 it was stated that an incident of alleged abuse toward Resident #8 that occurred on 4/1/2012 was received and reported to the Division on 4/2/2012. During this same interview E1 (facility administrator) confirmed that the above referenced incident should have been reported to the Division within 8 hours of the occurrence of the incident.</p> <p>According to the incident report dated 4/1/2012 and timed 6:00 AM "(Resident #8) reported to (caregivers) that he was upset and crying because the (staff) nurse in the white coat yelled at him when he went to hug her". Further review of this incident report of alleged abuse revealed it was reported to the Division on 4/2/2012 at 4:16 PM, approximately 34 hours after its occurrence on 4/1/2012 at 6:00 AM. The facility failed to immediately report an incident of alleged abuse within 8 hours of its occurrence to the Division. The facility policy "Abuse Prevention, Identification &amp; Reporting" states "... Community employees are mandated reporters so may report any known or suspected resident abuse, neglect or exploitation... alleged or suspected abuse, neglect or exploitation should be</p>	



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<p>3225.19.7</p> <p>3225.19.7.2</p>	<p>immediately reported to the required state agencies...".</p> <p>These findings were reviewed with E1 (executive director), E2 (regional RN) and E3 (resident service coordinator) on 4/5/2012.</p> <p><b>Reportable incidents include:</b></p> <p><b>Neglect as defined in 16 Del. C. 1131.</b></p> <p><b>16 Del. C., Chapter 11, Subchapter III</b></p> <p><b>Subchapter III. Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients</b></p> <p><b>Section 1131. Definitions.</b></p> <p><b>When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.</b></p> <p><b>(9) "Neglect" shall mean:</b></p> <p><b>a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on review of the clinical record, facility documents and staff interviews it was determined that the facility failed to provide transfer assistance for one resident (Resident #1) out of 8 sampled in accordance with her service agreement. The facility also failed to ensure that one</p>	<p>3225.19.7</p> <p>3225.19.72</p> <ol style="list-style-type: none"> <li>1.) Resident #1 had no injury from fall. Resident #7 no longer resides in the community.</li> <li>2.) An audit will be conducted on residents requiring stand by assist for transfer to ensure all interventions on the service agreement are listed on the Resident Care sheet. 6/30/12.</li> <li>3.) Nursing staff will be in-serviced on following resident service agreements and Resident Care Sheets. 6/30/12.</li> <li>4.) RCD will monitor the Resident Care sheets to ensure pertinent information from the Service Agreement is accessible to staff until substantial compliance is met. 6/30/12</li> </ol>
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	<p>resident (Resident #7) out of eight sampled was free from substantiated neglect. Findings include:</p> <p>1. Clinical record review revealed that Resident #1 was admitted to the assisted living facility on 4/10/2008 with diagnoses that included dementia, Alzheimer's type, hypertension and hyperlipidemia. According to the annual UAI dated 5/10/2010 Resident #1 was oriented to person only and exhibited short-term memory and long-term memory loss. Further review of the above referenced UAI revealed that Resident #1 was assessed for "standby assistance during transfers" and needed "observation/standby/transfer assist during toileting.". Additionally the UAI dated 5/14/2010 revealed that Resident #1 was identified as having a gait problem, impaired balance and confusion, all factors increasing her risk for falls. Another UAI completed 11/1/2011 revealed that Resident #1 was assessed for "one person physical assistance" during transfer and was at risk for falls due to the above referenced factors and additional factors of "unstable transition from seated to standing position, balance problems when standing and falls in the last 30 and 31 – 180 days".</p> <p>The clinical record review also revealed a nurse's note dated 7/6/2011 and timed 2:28 PM that stated "(Resident #1) had a fall ...while E6 (CNA) was toileting her. E6 (CNA) had (Resident #1) hold onto grab bar, but resident let go of grab bar and fell...". According to the facility incident report dated 7/6/2011 and timed (1:30 PM) "(Resident #1) fell while E6 (CNA) was toileting her. (Resident #1) was holding onto grab bar when she tried to lower</p>	



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	<p>herself to floor and then let go of bar.” However review of an attached statement to the above referenced incident report completed by E6 (CNA) on 7/6/2011 and without a specific time stated “We were in the bathroom, when I asked (Resident #1) to stand up (and) hold on to the pole (grab bar), When she did she kept scooting to the floor. I told her (Resident #1) to stand up while I go get the wheelchair. When I came back to the bathroom, she started scooting to the floor again. That’s when she let go the pole and fell to the floor...”.</p> <p>Review of the service agreement dated 5/10/2010 revealed the intervention “Standby assistance during transfers” was developed to address the transfer of Resident #1. However standby assistance was unavailable while Resident #1 was left unattended in the bathroom and fell while waiting to transfer. The facility failed to ensure the safety of Resident #1.</p> <p>These findings were reviewed with E1 (executive director), E2 (regional RN) and E3 (resident service coordinator) on 4/5/2012.</p> <p>2. Resident #7 had diagnoses that included debility, left above knee amputation, right below the knee amputation, rheumatoid arthritis with contractures of both hands and fingers, depression, hypertension and CAD (Coronary Artery Disease). According to the initial UAI dated 12/27/2011 Resident #7 was alert and oriented to time, place and person. The UAI dated 12/27/2011 also revealed that Resident #7’s short-term memory and long-term memory were intact. Although the above referenced UAI revealed that Resident #7 was independent in eating meals, it also</p>	



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

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**STATE SURVEY REPORT**

**NAME OF FACILITY: Emeritus at Dover**

**DATE SURVEY COMPLETED: April 5, 2012**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>indicated that Resident #7 was dependent for physical assistance with mobility and transfers.</p> <p>Further review of the clinical record revealed a nurse's note dated 1/16/2012 and timed (5:50 PM) that stated "Received complaint that (Resident #7) did not receive breakfast 1/15/2012...". Review of the facility incident report dated 1/16/2012 also revealed an allegation of neglect that stated "Received complaint that (Resident #7) did not get breakfast 1/15/2012". Review of the facility investigation of this incident revealed that although E7 (assigned CNA) stated that Resident #7 informed him that she wanted "to rest a while longer" when he entered her room at "10:00 AM or so", Resident #7 was shortly approached by another staff member, E8 (CNA). When E8 (CNA) asked if she was ready to get up, Resident #7 stated "yes, I (have been) waiting to get up". The investigation of the above referenced incident also revealed that Resident #7 acknowledged she received breakfast every morning except 1/15/2012 and further stated "They didn't come to get me up."</p> <p>Review of findings of the facility investigation of the above referenced incident revealed substantiated negligence resulting in the termination of E7 (assigned CNA) assigned to the morning shift on 1/15/2012. These findings were reviewed with E1 (executive director), E2 (regional RN) and E3 (resident service coordinator) at the exit conference on 4/5/2012.</p>	