



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

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

1-2-13
Amended Pac received via e-mail
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STATE SURVEY REPORT

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NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: November 15, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3225.0</p> <p>3225.5.0</p> <p>3225.5.2</p>	<p>An unannounced annual and complaint survey was conducted at this facility beginning November 4, 2012 and ending November 15, 2012. The resident census on the entrance day of the survey was 98. The survey sample was composed of 9 residents. The survey process included observations, interviews, review of residents' records, facility documents and facility policies and procedures.</p> <p>Assisted Living Regulations</p> <p>General Requirements</p> <p>All records maintained by the assisted living facility shall at all times be open to inspection and copying by the authorized representatives of the Department, as well as other agencies as required by state and federal laws and regulations. Such records shall be made available in accordance with 16 Del.C. Ch. 11, Subchapter I., Licensing by the State.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review, observation and staff interview it was determined that the facility failed to make available for inspection the entire closed clinical record of one resident (Resident #4) out of nine sampled. Findings include:</p> <p>In an interview conducted on 11/8/2012 with E1 (facility administrator) she revealed that the facility was unable to locate forms and notes missing from Resident #4's closed clinical record and</p>	<p>{F 000}</p> <p>Preparation and execution of this plan of correction in no way constitute an admission or agreement by Rockland Place of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Rockland Place reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance.</p> <p>This statement of deficiencies will be taken to Rockland Place's Quality Assurance/Assessment Committee on January 17, 2013.</p> <p>An all staff in-service will be held on January 16, 2013 to review the statement of deficiencies and corresponding plan of correction. Compliance with all aspects of this Plan of Correction will be achieved by 2/14/2013.</p> <p>3225.5.2</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice.</p> <p>The medical records were reorganized and filed in a separate, locked room. Closed records were organized in alphabetical order and in the corresponding year of discharge.</p> <p>How the facility will identify other residents having the potential to be affected by the same practices.</p> <p>All closed medical records will be stored in one secure location, alphabetically, by year which mirrors the medical records procedure.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur.</p> <p>The administrative and nursing teams have been educated on the medical records policy and closed chart procedure. Closer supervision is encouraged to ensure appropriate storage of medical records.</p>

Provider's Signature Rita Doherty Title Executive Director Date 12/29/2012



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<p>3225.0</p> <p>3225.5.0</p> <p>3225.5.2</p>	<p>An unannounced annual and complaint survey was conducted at this facility beginning November 4, 2012 and ending November 15, 2012. The resident census on the entrance day of the survey was 98. The survey sample was composed of 9 residents. The survey process included observations, interviews, review of residents' records, facility documents and facility policies and procedures.</p> <p>Assisted Living Regulations</p> <p>General Requirements</p> <p>All records maintained by the assisted living facility shall at all times be open to inspection and copying by the authorized representatives of the Department, as well as other agencies as required by state and federal laws and regulations. Such records shall be made available in accordance with 16 Del.C. Ch. 11, Subchapter I., Licensing by the State.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review, observation and staff interview it was determined that the facility failed to make available for inspection the entire closed clinical record of one resident (Resident #4) out of nine sampled. Findings include:</p> <p>In an interview conducted on 11/8/2012 with E1 (facility administrator) she revealed that the facility was unable to locate forms and notes missing from Resident #4's closed clinical record and</p>	<p>{F 000}</p> <p>Preparation and execution of this plan of correction in no way constitute an admission or agreement by Rockland Place of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Rockland Place reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance.</p> <p>This statement of deficiencies will be taken to Rockland Place's Quality Assurance/Assessment Committee on January 17, 2013.</p> <p>An all staff in-service will be held on January 16, 2013 to review the statement of deficiencies and corresponding plan of correction. Compliance with all aspects of this Plan of Correction will be achieved by 2/14/2013.</p> <p>3225.5.2</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice.</p> <p>The medical records were reorganized and filed in a separate, locked room. Closed records were organized in alphabetical order and in the corresponding year of discharge.</p> <p>How the facility will identify other residents having the potential to be affected by the same practices.</p> <p>All closed medical records will be stored in one secure location, alphabetically, by year which mirrors the medical records procedure.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur.</p> <p>The administrative and nursing teams have been educated on the medical records policy and closed chart procedure. Closer supervision is encouraged to ensure appropriate storage of medical records.</p>

Provider's Signature

Rita Doherty

Title

Executive Director

Date

12/29/2012



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3225.11.0	<p>requested by this surveyor on 11/7/2012 and 11/8/2012.</p> <p>These findings were reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p>	<p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Closed medical records will be audited monthly by the Residential Services Director for compliance. Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p>
3225.11.2	<p>Resident Assessment</p>	<p>The Residential Services Director will report weekly to the Administrator of any areas of concern.</p>
	<p>A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on review of the clinical record and staff interview it was determined that the facility failed to ensure that an initial UAI-based assessment was completed prior to admission of one resident (#6) out of 9 residents sampled. The facility also failed to ensure that an assessment was performed within thirty days after admission of one resident (Resident #6) out of nine residents sampled. Findings include:</p> <p>1. Review of the clinical record revealed</p>	<p>The Administrator assumes full responsibility for ensuring the community maintains medical records per policy by 2/15/13.</p> <p>3225.11.2</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice.</p> <p>Residents #6, UAI has been reviewed to ensure its on-going accuracy and compliance.</p> <p>How the facility will identify other residents having the potential to be affected by the same practices.</p> <p>The facility assumes that all resident have the potential to be affected by this practice.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur.</p> <p>The existing scheduled will be reviewed to include all residents being assessed with the approved DE UAI assessment tool; no more than 30 days prior to admission. A new tracking tool will be implemented to ensure UAI's are completed per DE regulation. As concerns or problems arise, the Resident Services Director will implement remedies to ensure compliance.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Resident Services Director in conjunction with the Marketing Director will review all admissions monthly and results will be documented. Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director will report weekly to the Administrator of any areas of concern.</p> <p>The Administrator assumes full responsibility for ensuring UAI are completed per DE regulation 2/14/2013.</p>



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3225.11.4	<p>that Resident #6 was admitted to the assisted living facility on 4/11/2012. Further review of the clinical record also revealed the initial UAI assessment completed for Resident #6 was dated 5/29/2012 approximately two and one-half weeks after admission.</p> <p>These findings were reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>2. Review of the Initial UAI assessment dated 5/29/2012 also revealed the absence of an assessment completed within thirty days of the admission of Resident #6 to the assisted living facility on 4/11/2012.</p> <p>These findings were reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>The resident assessment shall be completed in conjunction with the resident.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review it was determined that the facility failed to complete UAI assessments with dates and signatures in conjunction with seven residents (Resident #1, #2, #3, #5, #7 and #8) out of 9 sampled. Findings include:</p> <p>1. Review of the annual UAI dated 7/25/2012 revealed the absence of the date and signature of Resident #1 or her representative.</p>	<p>3225.11.4</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice. Residents #1, #3, #7 and #8, UAI's have been reviewed with the resident or DPOA and facility staff to ensure its accuracy and compliance. Residents #2 and #5 are closed records How the facility will identify other residents having the potential to be affected by the same practices. The facility assumes that all residents have the potential to be affected by this practice. What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur. All current residents UAI's will be evaluated, signed and dated by facility staff and reviewed with the resident or DPOA per regulation by 2/13/13. In addition a tool has been established to track UAI compliance for all</p>



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	<p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>2a. Review of the initial UAI dated 4/29/2011 revealed the absence of the date and signature of the facility staff member and Resident #2 or his representative.</p> <p>These findings were reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>2b. Review of the above referenced UAI also revealed development of a UAI dated 5/13/2011 for a significant change in Resident #2's condition. However further review of the UAI dated 5/13/2011 revealed the absence of the date and signature of the facility and Resident #2 or his representative.</p> <p>These findings were reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>3. Review of the annual UAI completed 3/19/2012 revealed the absence of the date and signature of Resident #3 or his representative.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>4. Review of the initial UAI dated 11/14/2011 revealed the absence of the date and signature of Resident #5 or her representative.</p>	<p>residents' to ensure compliance with DE regulations. As concerns or problems arise, the Resident Services Director will implement remedies to ensure compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Resident Services Director will review all resident UAI's monthly and results will be documented. Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director will report weekly to the Administrator of any areas of concern.</p> <p>The Administrator assumes full responsibility for ensuring all UAI are completed per DE regulation by 2/14/2013.</p>



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3225.11.5	<p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>5: Review of the annual UAI dated 10/15/2012 revealed the absence of the date and signature of Resident #7 or her representative.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>6. Review of the annual UAI dated 9/28/2012 revealed the absence of the date and signature of Resident #8 or her representative.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>The UAI developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review it was determined that the facility failed to ensure that an assessment was performed within 30 days after admission for one resident (Resident #9) out of nine residents sampled. Findings include:</p>	<p>3225.11.5</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice. Residents #9, UAI has been reviewed to ensure its accuracy and compliance. How the facility will identify other residents having the potential to be affected by the same practices. The facility assumes that all residents have the potential to be affected by this practice. What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur. A schedule has been developed to include all residents being assessed with the approved DE UAI assessment tool, at a minimum 30 days after admission, annually and with a significant change by 2/28/13. A tracking tool has been established to track UAI schedules for all residents' to ensure compliance with DE regulations. As concerns or problems arise, the Resident Services Director will implement remedies to ensure compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Resident Services Director in conjunction with the Pathways Director will review all resident UAI assessments monthly to ensure updates occur and are in compliance; results will be documented. Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director will report weekly to the Administrator of any areas of concern.</p> <p>The Administrator assumes full responsibility for ensuring all UAI are completed per DE regulation by 2/14/2013</p>



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3225.13.0	<p>Review of Resident #9's clinical record revealed the absence of an updated assessment within 30 days of admission to the assisted living facility on 4/11/2012.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>Service Agreements</p> <p>13.1 A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record reviews and staff interviews it was determined that the facility failed to ensure that service agreements were signed by three residents (Resident #2, Resident #5 and Resident #6) out of nine sampled. Findings include:</p> <p>1. Review of the service agreement attached to the initial UAI dated 4/29/2011 revealed the absence of the date and the signature of Resident #2 or his representative.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3</p>	<p>3225.13.0</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice. Residents #2, #5 and #6, are all closed records. How the facility will identify other residents having the potential to be affected by the same practices. The facility assumes that all residents have the potential to be affected by this practice. What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur. The existing scheduled will be reviewed and adapted to include all residents being assessed with the approved DE UAI assessment tool and a service plan completed prior to admission. In addition, all service plans will be reviewed, dated and signed by the resident or DPOA prior to admission. As concerns or problems arise, the Resident Services Director will implement remedies to ensure compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Resident Services Director in conjunction with the Pathways Director will ensure all residents have a support plan that follows the UAI prior to admission. Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director will report weekly to the Administrator of any areas of concern.</p> <p>The Administrator assumes full responsibility for ensuring all UAI are completed per DE regulation by 2/14/2013</p>



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3225.13.2	<p>(staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>2. Review of the initial service agreement dated 11/14/2011 revealed the absence of the signature of Resident #5 or his representative.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>3. Review of the initial service agreement dated 4/11/2012 revealed the absence of the signature of Resident #6 or his representative.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:</p> <p>These requirements are not met as evidenced by:</p> <p>Based on clinical record review and staff interview it was determined that the facility developed service agreements that failed to describe all the services to be provided, failed to identify the providers of the unidentified services and to determine when and how these services would be provided for three (Residents #2, Resident #6 and Resident #9) out of nine sampled. Findings include:</p> <p>1. Review of Resident #2's closed clinical record revealed the service agreement</p>	<p>3225.13.2</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice.</p> <p>The Service Agreements of resident #9 have been reviewed to ensure they meet the physical, medical, and psychosocial services for each individual resident. Resident #2, #6, are closed records</p> <p>How the facility will identify other residents having the potential to be affected by the same practices.</p> <p>The facility assumes that all residents have the potential to be affected by this practice.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur.</p> <p>New Service Agreements will be created individually for all current/new residents based on the residents physical, medical and psychosocial service needs to include indicators such as environmental services, transportation services, furniture and assistive devices by 2/14/13.</p>



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	<p>without a date and the resident's signature, failed to include and to address all services described in 13.2.4 (Environmental services including housekeeping, laundry, and trash removal); 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>2. Review of Resident #6's closed clinical record revealed that the service agreement dated 4/11/2012 failed to include and failed to address all services described in 13.2.4 (Environmental services including housekeeping, laundry, and trash removal); 13.2.7 (transportation services); 13.2.8 (Individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); and 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on</p>	<p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Resident Services Director in conjunction with the Pathways Director will ensure all residents have a support plan that follows the UAI and meets the physical, medical and psychosocial service needs.</p> <p>Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director will report to the Administrator of any areas of concern.</p>



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3225.13.5	<p>11/15/2012.</p> <p>3. Review of Resident #9's clinical record revealed that the service agreement dated 10/13/2011 failed to include and failed to address all services described in 13.2.3 (Food, nutrition, and hydration services); 13.2.4 (Environmental services including housekeeping, laundry, safety, trash removal); 13.2.7 (transportation services); 13.2.8 (individual living unit furnishings); 13.2.9 (notification procedures when an incident occurs or there is a change in the health status of the resident); 13.2.10 (assistive technology and durable medical equipment); 13.2.11 (Rehabilitation services); 13.2.13 (reasonable accommodations for persons with disabilities as defined by applicable state and federal law), 13.2.12 (Qualified interpreters for people who have a hearing impairment or do not speak English; and) 13.2.13 (Reasonable accommodations for persons with disabilities as defined by applicable state and federal law) and 13.3 (the resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number) as required in this section of the regulations.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>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.</p>	



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	<p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review and staff interviews it was determined that the facility developed service agreements that failed to include interventions specific to either behavior resistant to care, elopement risk or actual elopements or falls exhibited by six residents (Resident #2, Resident #5, Resident #6, Resident #7, Resident #8 and Resident #9) out of nine residents sampled. Findings include:</p> <p>1. Review of an initial service agreement dated 4/29/2011 revealed it was absent behavior resistant to care as exhibited by Resident #2.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>2. Review of the service agreement dated 11/14/2011 revealed that it was absent the risk for elopement and actual elopements exhibited by Resident #5. Additionally the facility failed to develop and implement goals and interventions that addressed the risk of elopement and/or to address actual elopements committed by Resident #5.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>3. Review of the service agreement dated 4/11/2012 revealed that it was absent the development of time frames for goals and specific interventions to address falls</p>	<p>3225.13.5</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice.</p> <p>The Service Agreements of residents #7, #8 and #9 were reviewed to ensure they meets the resident's unique physical and psychosocial needs with recognition of their capabilities and preferences. Residents #2, #5, and #6, are closed records.</p> <p>How the facility will identify other residents having the potential to be affected by the same practices.</p> <p>The facility assumes that all residents have the potential to be affected by this practice.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur.</p> <p>New Service Agreements will be created individually for all residents based on the residents UAI which highlights each resident's unique physical and psychosocial needs along with recognizing their capabilities and preferences by 2/14/13. Service plans will be specific to each risk factor and have goals, timeframes and interventions to address the risks involved. Service plans will be updated on an as needed basis as the resident's clinical condition changes. Additionally, service plans will be created annually based on the UAI schedule to reflect the resident's current physical and psychosocial needs along with risk factors.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Resident Services Director in conjunction with the Pathways Director will ensure all residents have a support plan that follows the UAI and meets the physical and psychosocial service needs which also address risk factors. Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director will report to the Administrator of any areas of concern.</p>



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	<p>sustained by Resident #6.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>4. The facility failed to develop an annual service agreement for Resident #7 in conjunction with the annual UAI dated 10/15/2012 to address multiple falls with goals and interventions.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>5. Cross refer 16 Del., C., Chapter 11, Subchapter III, Section 1131. The facility failed to develop an annual service agreement for Resident #8 in conjunction with the annual UAI dated 9/28/2012 to address elopement risk and an actual elopement with goals and interventions.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>6. The facility failed to develop an annual service agreement for Resident #9 in conjunction with the annual UAI dated 3/19/2012 to address elopement risk and an actual elopement with goals and interventions.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p>	



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3225.13.6	<p>The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on record review and staff interview it was determined that the facility failed to execute a revised service agreement in conjunction with changes addressed in the UAI assessment for five residents (Resident #1, Resident #2, Resident #7, Resident #8 and Resident #9) out of nine residents sampled. Findings include:</p> <p>1. Review of the clinical record revealed that Resident #1 was absent a service agreement developed in conjunction with an annual UAI assessment dated 7/25/2012.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>2. Review of the clinical record revealed the absence of a service agreement developed in conjunction with a UAI dated 5/13/2011 and identified as a significant change in the condition of Resident #2.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p>	<p>3225.13.6</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice.</p> <p>The Service Agreements of residents #1, #8 and #9 were reviewed to ensure they meet the resident's needs. Residents #2, #6, are closed records. How the facility will identify other residents having the potential to be affected by the same practices.</p> <p>The facility assumes that all resident have the potential to be affected by this practice.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur.</p> <p>Service Agreements will be reviewed individually for all residents when the needs of the residents change or within ten days of the UAI assessment by 2/13/2013. As concerns or problems arise, the Resident Services Director will implement remedies to ensure compliance. Training has been provided to the care team on support plans and needed changes based upon resident condition.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Resident Services Director in conjunction with the Pathways Director will ensure all residents have a support plan that follows the UAI assessment within 10 days or when there is a significant change. Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director will report to the Administrator of any areas of concern.</p>



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	<p>3. Review of the clinical record revealed that Resident #7 was absent a service agreement developed in conjunction with an annual UAI assessment dated 10/15/2012.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>4a. Review of the clinical record revealed that an annual UAI completed for Resident #8 was dated 9/28/2012. However review of the clinical record also revealed that Resident #8 was absent a service agreement developed in conjunction with the annual UAI assessment dated 9/28/2012.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>4b. Review of the clinical record revealed that Resident #8 was absent a service agreement developed in conjunction with a UAI assessment completed for a significant change in condition and dated 12/20/2011.</p> <p>This finding was reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>5. Review of the clinical record revealed the absence of a service agreement developed in conjunction with a UAI dated 3/19/2012 and identified as a significant change in the condition of Resident #9.</p> <p>This finding was reviewed with E1 (facility</p>	



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3225.19.7.2	<p>administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p> <p>Neglect as defined in 16 Del.C 1131.</p> <p>16 Del., C., Chapter 11, Subchapter III</p> <p>Subchapter III. Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients</p> <p>Section 1131. Definitions.</p> <p>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:</p> <p>(9) "Neglect" shall mean:</p> <p>a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on clinical record review and staff interviews it was determined that the facility failed to provide a safe environment for two residents (Resident #8 and Resident #9) out of nine sampled who eloped from the facility without the knowledge of staff. Findings include:</p> <p>1. Review of the clinical record revealed that Resident #8 was admitted to the assisted living facility on 9/28/2011 with diagnoses that included dementia, chronic atrial fibrillation, rheumatic heart</p>	<p>3225.19.7.2</p> <p>How the corrective action will be accomplished for those residents found to have been affected by this practice.</p> <p>Both residents #8 and #9 reassessed for wandering tendencies. In addition the community installed a new, comprehensive wanderguard system on 1/29/12 that attempts to prevent assessed residents who wear a wanderguard from exiting the facility without the knowledge of staff. Both Residents currently #8 and #9 wear wanderguards.</p> <p>How the facility will identify other residents to have the potential to be affected by the same practices.</p> <p>The facility assumes that all residents with dementia and wandering tendencies have the potential to be affected by this practice.</p> <p>What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur.</p> <p>All residents are assessed for elopement at the time of admission, annually or when a significant change occurs. Residents who are at risk for elopment are issued a wanderguard. Resident wanderguard devices are checked daily for operations as well as a weekly door audit to ensure the wanderguard system is operational. All staff has been in-serviced on the communities' elopement policy and Rockland's abuse and neglect policy as recently as 12/5/12. On-going training will be conducted in both areas to ensure on-going compliance.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Resident Services Director working with the Director of Plant Operations will make rounds to ensure the wanderguard is working properly and all residents are assessed annually or upon a change of condition. These rounds will be implemented daily times one month, weekly times four weeks and monthly thereafter.</p> <p>Trends will be reported, reviewed and discussed quarterly in the Quality Assurance meeting and action plans will be implemented as necessary.</p> <p>The Resident Services Director and the Director of Plant Operations will report weekly to the Administrator of any areas of concern.</p> <p>The Administrator is responsible for ensuring the facility providing attention to physical needs of the patient including but not limited to toileting, bathing, meals and</p>



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	<p>disease, hypertension and mild kidney disease. According to the annual UAI dated 9/28/2012 Resident #8 was disoriented to time, place and person. Additionally Resident #8 was assessed with short- term memory and long- term memory problems. Further review of the above referenced UAI indicated that Resident #8 was dependent on staff for toileting, grooming and bathing. Although Resident #8 required "supervision, set up, cuing and coaching" for eating, mobility and transferring, the physical assistance of staff was required for dressing. The annual UAI dated 9/28/2012 also revealed that Resident #8 had a history of wandering "inside" and "outside" the facility. Clinical record review revealed a nurse's note dated 12/17/2011 and timed (11:00 PM) that stated "At (approximately 5:30 PM) staff was alerted that (Resident #8) could not be found...searched the building...with no results. Family (and) police...notified. Police requested another search be performed...(Resident #8) was located (at approximately 7:45 PM)...at another location...brought back to the facility...family escorted him back to his room...". Review of the completed facility incident report dated 12/17/2011 and timed (5:45 PM) stated "...searches of building and area were made. Police, family and physician notified. (Resident #8) located (at department store on busy highway) returned safely to facility. No injury noted." An investigation conducted by the Division of Long Term Care Residents Protection learned that Resident #8 was found near the Sears store on Route 202, approximately 3 miles from the facility. It is unknown how the resident was able to reach that location.</p>	



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	<p>The facility failed to ensure that a safe environment was provided for Resident #8. These findings were reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012:</p> <p>2. Review of the clinical record revealed that Resident #9 was admitted to the assisted living facility on 10/13/2011 with diagnoses that included dementia, TIA (transient ischemic attack), hypertension, anemia, macular degeneration and osteoporosis. According to the initial UAI dated 10/13/2011 Resident #9 was oriented to self and place and experienced short-term memory problems. Additionally the above referenced UAI revealed Resident #9 was absent a history of wandering.</p> <p>Further review of the clinical record revealed a nurse's note dated 3/12/2012 and timed (3:30 PM) that stated "(Resident #9) went out front door unattended from facility...easily redirected (and) wanderguard now in place (right) wrist...". The facility failed to provide a safe environment for Resident #9. In an interview conducted with E3 (licensed staff member) on 11/15/2012 it was confirmed that Resident #9 eloped from the facility and was immediately redirected inside the facility by staff as soon as she exited through the front door.</p> <p>These findings were reviewed with E1 (facility administrator), E2 (director of nursing), E3 (staff nurse) and E4 (activities director) on 11/15/2012.</p>	