

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 086027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2015
NAME OF PROVIDER OR SUPPLIER SILVER LAKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1080 SILVER LAKE BLVD DOVER, DE 19904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from June 17, 2015 through June 24, 2015. The deficiencies cited in this report are based on record reviews, staff interviews, family interviews, and review of other facility documentation as indicated. The census the first day of the survey was 113. The sample size included two (2) active and one (1) closed records. Abbreviations used in this report are as follows: -DON - Director of Nursing; -ADON - Assistant Director of Nursing; -NHA- Nursing Home Administrator; -SW- Social Worker; -MDS- Minimum Data Set-standardized assessment form used in nursing homes; -UM- Nurse Unit Manager	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and family interview, it was determined that for one (1) of three (3) residents reviewed (R1) the facility failed to provide medically related social services to the resident to maintain the highest practicable mental and psychosocial well-being. The facility identified that R1 had multiple, ongoing social	F 250	1. Resident R1 no longer resides in the center. 2. Any resident in the facility may be in need of medically related social services. 3. (new change)The Social Work department staff will be assigned permanent rooms to develop relationships, facilitate interactions, and provide individualized engagement for	7/29/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

Rather B. Duce, Administrator 7/17/15

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.

Rather B. Duce

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F 250	<p>Continued From page 1</p> <p>service needs, however, there was a lack of evidence that the facility's social worker was actively involved with R1 and his family to meet his identified social services needs for R1's highest practicable well-being. Findings include:</p> <p>A care plan developed by E4 (SW) on 10/9/14 identified that R1 had a distressed mood as evidenced by sadness. Other social service related issues identified in the care plan for R1 included:</p> <ul style="list-style-type: none"> -combative / physically abusive behaviors by R1 towards staff (identified on 7/8/14); -verbal aggression by R1 such as yelling at and threatening staff (identified on 9/18/14); and -resisting care / treatment by R1 (identified on 9/18/14). <p>Despite multiple identified social service needs, the clinical record for R1 lacked evidence of any active participation by facility social services staff (two full time social workers, E4 and E5). When E4 was asked for any social services documentation for R1, the surveyor was provided with three brief notes documented by E5 (a second facility SW at the time) dated 6/26/14, 7/23/14, and 8/6/14 which were unrelated to the ongoing social service issues identified in R1's care plan.</p> <p>The facility's Social Services job description provided to the surveyor by E4 upon request identified that the facility social worker "works with patients / residents and their family members / significant others within the facility through the use of the psychosocial perspective identifying their strengths, social, emotional, and mental health needs along with providing, developing, and/or aiding in the access of services to meet</p>	F 250	<p>both immediate and/or ongoing Social Service needs. Each Social Worker will be required to document resident interactions utilizing a Social Services progress note to capture and verify evidence of their involvement with meeting or attempting to meet social service needs.</p> <p>4. Social Services notes will be audited weekly for 4 weeks, then monthly for 3 months or until evidence that substantial compliance has been obtained and maintained. This will be the responsibility of the Administrator/Designee. The audits will be shared with the QAPI Committee for further review and recommendations.</p>		

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F 250	Continued From page 2 those needs". Interview with E4 on 6/24/15 at approximately 3:15 PM confirmed a lack of involvement with R1 and his family with E4 stating that the bulk of her time was spent completing assessment forms, assisting with discharge planning, and attendance at care plan meetings. The facility lacked an effective system for planning for and providing active, on-going social services to meet the identified needs of R1. Interview with E6 (daughter of R1) on 6/24/15 at 12:30 PM revealed that the family had experienced much concern and frustration related to R1's care and his declining condition and also confirmed a lack of assistance and involvement from either of the facility's two social workers (E4 and E5). These findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 6/24/15 at 6 PM.	F 250			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	1. Resident R2 care plan reflects an appropriate comprehensive plan of care to include fall prevention services and interventions and has been communicated to the staff responsible for care. 2. An audit by the nursing leadership team will be performed on each current care plan for residents identified as high risk for falls	7/29/2015	

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F 279	<p>Continued From page 3</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that for one (1) of three (3) residents reviewed (R2), the facility developed a care plan that failed to identify a supervision plan to maintain the highest practicable physical well-being of a resident identified by facility staff as at risk for falls. The facility then failed to revise the care plan to address supervision after R2 experienced actual falls in the facility. Findings include:</p> <p>Cross-refer F323. The facility initiated a care plan on 2/20/14 to address R2's risk for falls due to impaired mobility and lack of safety awareness. The care plan developed by the facility lacked an established plan for providing adequate supervision of R2 to address her fall risk. According to a care plan evaluation nursing note dated 2/28/15 and timed 5:42 PM, R2 had two falls with no injury in the previous three months. The facility failed to have an effective system to ensure that revisions to address R2's need for supervision were added to the care plan (for example, to address supervision) for R2's safety and highest practicable well-being.</p> <p>These findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 6/24/15 at 6 PM.</p>	F 279	<p>to identify any need for revisions necessary for fall prevention. Identified revisions will be communicated to the staff responsible for care of the resident.</p> <p>3. (new practice) The facility will initiate a fall committee to meet weekly to review current falls and care plan revisions. This will be the responsibility of the DON/Designee.</p> <p>4. The DON/Designee will report falls at morning meetings and communicate any revisions related to the care plan for 4 weeks. The DON/Designee will report to the QAPI committee monthly for 3 months the number of falls and care plan revisions to evaluate the effectiveness of the system changes and for further recommendations to obtain and maintain substantial compliance.</p>		

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility incident reports and follow-up documentation, it was determined that for one (1) of three (3) residents reviewed (R2), the facility failed to plan for and provide adequate supervision to prevent accidents. R2 was identified by facility staff as being at risk for falls, however, the facility failed to establish any supervision plan for staff to follow. With no established supervision plan, the facility then had no plan to review and revise as falls occurred and also failed to recognize the need to plan for R2's supervision after each fall occurred. The facility lacked an effective process for establishing a supervision plan for residents who were identified by facility staff as at risk for falls. In addition, the facility lacked an effective process for developing and implementing supervision plans for residents who experienced falls. Findings include:</p> <p>A care plan initiated on 2/20/14 identified that R2 was at risk for falls due to impaired mobility and a lack of safety awareness. This care plan was in effect for over one year at the time of the survey and had some changes made in the past year, however, none of the changes addressed staff</p>	F 323	<p>1. R2 remains in the facility with adequate supervision with evidence of needed supervision in the medical record as appropriate.</p> <p>2. An audit by the nursing leadership team will be performed on each current care plan for residents identified as high risk for falls to identify any need for revisions necessary for fall prevention to include specific supervision/monitoring as appropriate for the individual resident.</p> <p>3. Incident and accidents will be reviewed at each morning meeting for 4 weeks, then monthly for 3 months by the interdisciplinary team for root cause analysis and to develop appropriate interventions to prevent incident and accidents to the extent possible and to obtain and maintain substantial compliance.</p> <p>4. The interdisciplinary team will meet weekly for 4 weeks, then monthly for 3 months to review/audit a minimum of 20% of incidents and</p>	7/29/2015	

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F 323	<p>Continued From page 5</p> <p>supervision, failed to revise and failed to implement new intervention for R2. The care plan lacked an identified plan for staff to follow to ensure that R2 received adequate supervision to prevent accidents.</p> <p>According to an MDS assessment dated 11/26/14, R2 required extensive assistance of staff (meaning staff had to provide support for R2 to bear her weight) to move from one position to another (for example, from the bed to the wheelchair) and also required extensive assistance of staff for using the toilet. The assessment further indicated that R2 was not steady and was unable to stabilize herself without staff assistance when moving from a seated position to a standing position or when using the toilet. There was no plan for routine supervision of R2 developed by the facility following this assessment.</p> <p>According to incident report documentation dated 12/22/14, R2 fell while attempting to walk to the bathroom with her walker without staff assistance. The corrective action documented on the incident report was to add an alarm device to alert staff when R2 tried to get up from the bed or chair unassisted. There was no evidence found in the clinical record or provided to the surveyor upon request made to E2 (DON) on 6/24/15 at 2:30 PM that a supervision plan was established for routine staff monitoring of R2 following this fall.</p> <p>According to incident report documentation dated 1/11/15, R2 was assisted by staff to the toilet in her bathroom and left alone. R2 then fell to the floor while trying to get back into her wheelchair without staff assistance. The corrective action</p>	F 323	accidents and determine that the system is working to obtain and maintain substantial compliance.	

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F 323	<p>Continued From page 6</p> <p>documented on the incident report was to not leave R2 alone on the toilet. This instruction, however, was not added to R2's care plan to ensure that all staff was aware of and followed this directive. As of the time of the survey (5 months later), this instruction was still not included in R2's care plan. Again there was no evidence found in the clinical record or provided to the surveyor upon request made to E2 on 6/24/15 at 2:30 PM that a supervision plan was established for routine staff monitoring of R2 following this fall.</p> <p>According to an MDS assessment dated 2/26/15, R2 continued to require extensive assistance of staff to move from one position to another (for example, from the bed to the wheelchair) and also required extensive assistance of staff for using the toilet. This assessment indicated that R2 continued to be unsteady and was unable to stabilize herself without staff assistance when moving from a seated position to a standing position or when using the toilet. There was no plan for routine supervision of R2 developed following this assessment as was also the case following the 11/26/14 assessment.</p> <p>According to incident report documentation dated 3/3/15, R2 was eating lunch while seated on the side of her bed when she unclipped her alarm and tried to stand. R2 then fell to the floor hitting her face on a chair sustaining facial abrasions (scrape like injuries) and bruising to the right side of her face.</p> <p>Despite ongoing assessment of R2's fall risk factors such as unsteadiness and a known lack of safety awareness (as identified in a care plan initiated on 2/20/14), the facility lacked evidence</p>	F 323			

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F 323	Continued From page 7 that staff supervision was planned for and provided to minimize R2's fall risk and prevent accidents. R2 experienced three falls (12/22/14, 1/11/15, and 3/3/15) with no corresponding review, new interventions and revision of her care plan to address supervision. This indicates that the facility lacked an effective process for utilizing assessment data to develop plans to meet the supervision needs of residents. Interview with E7 (UM) on 6/24/15 at 3:30 PM revealed a lack of understanding of how the facility made changes in a resident's care and supervision following falls. The facility lacked an effective process for using assessment information, incident report documentation, and post-fall analysis to plan for and provide adequate supervision to R2 to prevent accidents.	F 323			



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-8661

STATE SURVEY REPORT

NAME OF FACILITY: Silver Lake Center

DATE SURVEY COMPLETED: June 24, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from June 17, 2015 through June 24, 2015. The deficiencies cited in this report are based on record reviews, staff interviews, family interviews, and review of other facility documentation as indicated. The census the first day of the survey was 113 . The sample size included two (2) active and one (1) closed records.</p> <p>Abbreviations used in this report are as follows: -DON - Director of Nursing; -ADON - Assistant Director of Nursing; -NHA- Nursing Home Administrator; -SW- Social Worker; -MDS- Minimum Data Set-standardized assessment form used in nursing homes; -UM- Nurse Unit Manager</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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</p>	<p>Cross Refer to CMS 2567-L Plan of Correction submitted July 17, 2015</p>	<p>7/29/15</p>

Provider's Signature Kathleen M. Gibson Title Administrator Date 7/17/15



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DHSS - DLTCRP
3 Mill Road, Suite 308
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(302) 577-6861

STATE SURVEY REPORT

NAME OF FACILITY: Silver Lake Center

DATE SURVEY COMPLETED: June 24, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed June 24, 2015 F250, F279, and F323</p>		

Provider's Signature: [Signature] Title: Administrator Date: 7/17/15