



**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: Peach Tree Acres Assisted Living

DATE SURVEY COMPLETED: July 19, 2013

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3225</p> <p>3225.8.0</p> <p>3225.8.1</p> <p>3225.8.8.2</p>	<p>An unannounced annual survey was conducted at this facility from July 17, 2013 through July 19, 2013. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 19. The survey sample included 4 active residents.</p> <p><b>Assisted Living Facilities</b></p> <p><b>Medication Management</b></p> <p><b>An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:</b></p> <p><b>Each resident receives the medications that have been specifically prescribed in the manner that has been ordered.</b></p> <p><b>This requirement is not met as evidenced:</b></p> <p>Based on record review, observation and interview it was determined that the facility failed to obtain a medication that was ordered by the physician and discontinued a medication without a physician order for one (R3) out of 4 sampled residents. Findings include:</p> <p>The facility's policy and procedure for <u>Medication Administration-Self Administration</u> stated that, a registered nurse will ensure that the resident is receiving the medications that have been specifically prescribed...</p>	

*Ch Malaney*

*Director*

819-13



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1a. R3 had a physician's order dated 1/14/13, for Azelastine 0.1% Spray Instill one to two sprays in each nostril twice daily as needed for allergic rhinitis.

On 1/14/13, R3 was assessed using the Medication Self-Administration Assessment by the Director of Nursing and deemed able to safely administer his own medications.

On 7/17/13 at approximately 2:15 PM, R3 showed the surveyor medications that he was self-administering. Review of the medications revealed he did not have the Azelastine spray as ordered by the physician.

On 7/18/13 at 7:30 AM, R3's clinical record and the observation made on 7/17/13 revealed that R3 did not have the Azelastine in his possession, for self-administration.

E3 confirmed on 7/18/13 that the facility failed to fill the physician's order for Azelastine that had been written on 1/14/13.

1b. R3 had a physician order; dated 11/26/12, for Nasonex Nasal Spray 17 grams instill 2 sprays in each nostril daily as needed for allergic rhinitis.

Review of R3's medications revealed he had Nasonex Nasal Spray available to him for self-administration.

**3225.8.8.2**

- A. The order was clarified for Azelastine 0.1% Nasal Spray with ordering physician on 1/14/13. A discontinued order was received by ordering Physician for Azelastine 0.1% and a new order was obtained for the Nasonex Nasal Spray 17gm. to instill 2 sprays in each nostril daily as needed. Resident has Nasonex Nasal Spray available to him for self-administration.
- B. An RN will review all medication orders prescribed by the other nursing staff and sign all orders after verification of completion for all residents.
- C. An RN will verify all medication orders. Quarterly pharmacy reviews will include physical inspection of R3's medication box with specific attention to medication orders/discontinuations to prevent recurrence.
- D. A monthly medication review of all charts will be performed and monitored for Quality Assurance by the RN and reviewed at quarterly QA Meetings. (See attachment # 1).  
The policy and procedure for Physicians Orders was revised and reviewed with all nurses for transcribing physicians orders. (See attachments # 1, 2 & 3).

Completed: 8/25/13

Provider's Signature *C. Maloney* Title Director Date 8-19-13



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<p>3225.12.0</p> <p>3225.12.1.3</p>	<p>Review of R3's Medication Administration Record (MAR) revealed the Nasonex Nasal Spray was discontinued for the months of June and July 2013.</p> <p>On 7/18/13 at 7:30 AM, R3's clinical record and observation were reviewed with E3, Licensed Practical Nurse. E3 stated that the facility discontinued the Nasonex without a physician order. E3 immediately notified R3's physician for clarification of the orders for R3's nasal sprays.</p> <p><b>Services</b></p> <p><b>Food service complies with the Delaware Food Code;</b></p> <p><b>2011</b> <b>4-703.11 Hot Water and Chemical.</b> After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (A) Hot water manual operations by immersion for at least 30 seconds and as specified under § 4-501.111; P (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under §§ 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71°C (160°F) as measured by an irreversible-registering temperature indicator; The findings were reviewed with the Administrator and the Maintenance Director.</p> <p><b>This requirement is not met as evidenced by:</b></p>	



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<p>3225.11.0</p> <p>3225.11.4</p>	<p>Based on policy review and temperature readings made inside the Hobart-brand dish machine on 07/17/13, it was determined that the facility failed to properly sanitize food ware. Findings include:</p> <p>At 12:50 PM, the internal temperature achieved by the Hobart-brand dish machine was 157.9°F. This was 2.1 degrees below the minimum temperature required to properly sanitize food ware. E8, maintenance director was present during the review of the dish machine.</p> <p>The Peach Tree Acres, Assisted Living Policy Manual 2003 indicated for the Dining Service, #4.11 Heat Sanitizing, "...2. In a dishwashing machine, a good rule of thumb is: wash at 150 °F and rinse at 180 °F. But, remember temperature may vary depending on the type of machine used. To ensure proper water temperature monitor and record dish machine temperature on the Dish Machine Temperature log." The findings were reviewed with E1, Administrator and E8.</p> <p><b>Resident Assessment</b></p> <p><b>The resident assessment shall be completed in conjunction with the resident.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on record review and interview it was determined for three (R1, R2 and R4) out of 4 sampled residents the facility failed to have evidence that the UAI</p>	<p><b>3225.12.1.3</b></p> <p>A. The Service company came out on 7/20/13 and adjusted the washing/sanitizing machine to reach the proper temperature.</p> <p>B. There are no other residents impacted.</p> <p>C. A temperature log was created (see attachment #4). The food service manager will make kitchen staff aware and will spot check this log to assure temperatures are appropriate and staff are actually monitoring dish machine temperatures (See attachment #5).</p> <p>D. The Director of Maintenance will audit weekly and document his findings.</p> <p style="text-align: right;"><b>Completed: 7/23/13</b></p>



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	<p>(Uniform Assessment Instrument), was completed in conjunction with the residents' legal representative Findings include:</p> <p>1. R1 was admitted to the facility with diagnosis that included a traumatic brain injury.</p> <p>On 2/16/12, a significant change UAI was developed for R1. On 6/18/12 and 6/18/13, annual UAIs were developed for R1. Review of these three UAIs revealed the facility failed to have evidence that these assessments were completed in conjunction with R1's legal representative/ responsible party.</p> <p>2. R2 was admitted to the facility with diagnoses that included traumatic brain injury.</p> <p>On 6/10/13, an annual UAI was developed for R2 and there was no evidence that this assessment was completed in conjunction R2's legal representative.</p> <p>3. R4 was admitted to the facility with diagnoses that include traumatic brain injury.</p> <p>On 5/23/13, an annual UAI was developed for R4 and there was no evidence that this assessment was completed in conjunction R4's legal representative.</p> <p>On 7/18/13 at approximately 9:35 AM, review of the UAIs with E2, Director of</p>	<p><b>3225.11.4</b></p> <p>A. Unable to correct deficiency.</p> <p>B. All of the UAI's up until this point have not been signed by the guardian/responsible party. We considered the UAI a nursing assessment tool used in order to complete the Service Agreement. We did, however, have the guardian/responsible party sign the Service Agreement. The Service Agreement/UAI policy has been updated to reflect this change. (Attchment #9)</p> <p>C. All future UAI's will be reviewed with the guardian/responsible party in conjunction with the Service Agreements. Both documents will be signed by The guardian/responsible party and the resident (when appropriate) and given a copy of both documents.</p> <p>D. The Administrator will review all UAI's and Service Agreements quarterly, for the previous quarter, at the QA meetings.</p> <p style="text-align: right;"><b>Completed: 8/1/13</b></p>
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<p>3225.13.0</p>	<p>Nursing, confirmed she signed these assessments however, the facility failed to evidence that R1, R2 and R3's UAI assessments were completed in conjunction with their legal representative.</p> <p><b>Service Agreements</b></p> <p><b>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:</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on record review and interview, it was determined that for one resident (R1) out of 4 sampled residents who was not able to comprehend and perform the obligations of the service agreement failed to have evidence this assessment was completed in conjunction with R1's responsible party. Findings include:</p> <p>R1 was admitted to the facility with diagnoses that included traumatic brain injury.</p> <p>R1 had a Service Agreement developed on 6/5/13 (13 days before the UAI was</p>	<p><b>3225.13.0</b></p> <p>A. Unable to correct deficiency.</p> <p>B. All of the UAI's up until this point have not been signed by the guardian/responsible party. We considered the UAI a nursing assessment tool used in order to complete the Service Agreement. We did, however, have the guardian/responsible party sign the Service Agreement. The Service Agreement/UAI policy has been updated to reflect this change. (Attchment #9)</p> <p>C. All future UAI's will be reviewed with the guardian/responsible party in conjunction with the Service Agreements.</p> <p>D. The Administrator will review all UAI's and Service Agreements quarterly, for the previous quarter, at the QA meetings.</p> <p style="text-align: right;"><b>Completed: 8/1/13</b></p>



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<p>3255.13.3</p>	<p>developed). R1 was not able to comprehend the obligations under this agreement. Review of this form revealed the facility failed to have evidence this assessment was completed in conjunction with R1's legal representative/responsible party.</p> <p>Review of R1's Service Agreement on 7/18/13 at 9:35 AM with E2, Director of confirmed the facility failed to have evidence this assessment was completed in conjunction with R1's legal representative.</p> <p><b>The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on record review and staff interviews, it was determined that for four (R1, R2, R3, and R4) out of four sampled residents, the facility failed to ensure that the residents' personal attending physician's information was documented in the service agreement (SA). Findings include:</p> <p>Review of the four sampled residents' Service Agreements revealed the facility failed to include documentation of the residents' personal attending physician's name, address, and telephone number. An interview with E2, Director of Nursing, on 7/18/13 at approximately 9:35 AM, confirmed that the facility failed to include</p>	<p>3225.13.3</p> <p>A. R1's service agreement did include the physician's name, however, we updated the agreement to include the physician's address and phone number. R2's service agreement did include the physician's name, however, we updated the agreement to include the physician's address and phone number. R3's service agreement did include the physician's Name, however, we updated the agreement to include the physician's address and phone number. R4's service agreement did include the physician's Name, however, we updated the agreement to include the physician's address and phone number.</p> <p>B. All the other Service Agreements for the remaining residents were reviewed and the address's and phone numbers were added.</p> <p>C. The Service Agreement was revised and an address and phone number line were added under the physician's name.</p> <p>D. The Administrator will review all Service Agreements completed within the quarter for completion of physician's address's and phone number.</p> <p style="text-align: right;"><b>Completed: 7/31/13</b></p>
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<p>3225.13.6</p>	<p>this information on the following service agreements for:</p> <ol style="list-style-type: none"> <li>1. R1's service agreements dated 6/5/13 and 6/11/12</li> <li>2. R2's service agreement dated 6/10/13</li> <li>3. R3's service agreements dated 6/3/12 and 5/31/13</li> <li>4. R4's service agreement dated 5/24/13</li> </ol> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on clinical record review and interview it was determined that the facility failed to develop a service agreement for one (R1) out of 4 sampled residents who had a UAI developed for a significant change. Findings include:</p> <p>On 2/16/12, the facility developed a significant change UAI for R1 after she returned from the hospital. Review of R1's Service Agreements revealed the facility failed to develop a new service agreement to correspond with R1's significant change and UAI.</p> <p>On 7/19/13 at 9:45 AM, review of R1's clinical record with E2, Director of Nursing, confirmed the facility failed to develop a service agreement for R1's, 02/16/12 significant change UAI.</p>	<p>3225.13.6</p> <ol style="list-style-type: none"> <li>A. Unable to correct deficiency for R1.</li> <li>B. All future significant change in UAI's will coincide within 10 days of such assessment to execute and revise the Service Agreement if indicated.</li> <li>C. All UAI's with a significant change will have a newly revised, if indicated, Service Agreement. A Service Agreement/UAI Policy and Procedure has been updated to reflect this change. (Attachment #9)</li> <li>D. QA Review Committee will review quarterly, all Service Agreements/UAI's for the previous quarter, to monitor for compliance.</li> </ol> <p style="text-align: right;"><b>Completed: 8/1/13</b></p>
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3225.17.0	<b>Environment and Physical Plant</b>	
3225.17.1	<b>Each assisted living facility shall comply with applicable federal, state and local laws including:</b>	
3225.17.2.4	<p><b>Have an effective pest control program.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on record review and observations made in the dietary area, resident rooms, and common areas on 07/17/13 and 07/18/13, it was determined that the facility failed to have an effective pest control program. Findings include:</p> <ol style="list-style-type: none"> <li>1. On 07/17/13 at 12:50 PM, six (6) flies were observed flying around the kitchen and landing on multiple surfaces.</li> <li>2. On 07/17/13 at 10:15 AM, two (2) flies were observed flying around and landing on the receptionist area.</li> <li>3. On 07/18/13 at 09:45 AM, one (1) fly was observed in the administrator's office.</li> <li>4. On 7/18/13 at 12:00 PM flies were observed in the dining room.</li> </ol> <p>The Peach Tree Acres, Assisted Living Policy Manual 2003 indicated for the Dining Service, #4.34 Physical Barriers, "...10. Keep all exterior openings closed tightly. Check them for proper fit as part of your cleaning and maintenance program. 11. Install air curtains (also called air doors or fly fans) that blow a steady stream of air, creating a shield around doors that are</p>	



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	<p>left open.”</p> <p>The pest control vendor contract, dated 04/18/07, did not include flies in the scope and nature of work section. An air curtain had been installed above one side of the kitchen exit doors, leading to the screened in porch area. One of the interior front doors was held open and there was no pest control devise located in the entry doors area.</p> <p><b>16 Del. C. Chapter 11, Subchapter III Definition (9) Neglect (c) Failure to carry out a prescribed treatment plan for a patient or resident.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Based on clinical record review, observation and interview it was determined that the facility failed to follow the speech therapist's dysphagia (difficulty swallowing) recommendations for one (R1) out of four sampled residents. Findings include:</p> <p>R1 had diagnoses that included traumatic brain injury and dysphagia.</p> <p>On 8/2/12, E7, the Speech Therapist, documented an initial evaluation summary that R1 was demonstrating oropharyngeal dysphagia characterized by coughing and possible aspiration with thin liquids. E7 recommended a regular diet with nectar thick liquids and that R1 also required cueing by the staff that included reminders to eat slowly and to take small sips of</p>	<p><b>3225.17.2.</b></p> <ul style="list-style-type: none"> <li>A. Installed Pheremone baited fly traps outside exterior doors of the building.</li> <li>B. There are no other residents impacted.</li> <li>C. We will have Orkin install 3 UV insect attracting devices on the rear porch, front foyer and kitchen area.</li> <li>D. The electronic lights will be monitored by the maintenance man on his daily rounds and monthly by the pest control company.</li> </ul> <p style="text-align: right;"><b>Completed: 9/5/13</b></p>
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liquid while eating. E7 documented that R1 was able to drink nectar thick liquids, needed to sit up tall and to take small sips and bites. E7 also documented that R1 was observed placing heaping utensils full of food in her mouth, on more than one occasion and oral spillage was noted. E7 documented that she spoke with E2, Director of Nursing and recommended using smaller utensils to help with bolus size control.

Further review of the speech therapist's notes revealed that on 10/9/12, E7 had documented an observation that during dinner R1 had used a smaller fork with a decreased amount of food on the utensil. E7 also documented that R1 had slight difficulty scooping food due to spillage and suggested possible use of a plate guard.

Review of R1's, 06/18/13 UAI revealed for meals that R1 required observation during meals due to chewing, swallowing and eating difficulties. However, this UAI failed to document R1 required her food to be cut up, was on choking precautions and required nectar thick liquids. The UAI also failed to include that R1 required a special plate and small utensils.

The facility developed a service agreement for R1 on 6/5/13, which was 13 days prior to the completion of R1's UAI. The service agreement failed to document that R1 required adaptive equipment that included a special plate and small utensils.

Review of R1's Resident Weekly Care Log (Form used by the staff for documenting services that were provided), for July 14-20, 2013, documented under "things to do"



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was meal assistance and monitor during meals. Further comments documented that staff would provide small portion meals, nectar thickened liquids and the staff must stay with the resident during meals.

During the lunch observation on 7/17/13 at 12:15 PM, R1 was observed eating lunch, sitting in her wheelchair and leaning to the right side. R1 was not sitting up tall and no one addressed her posture while she was eating her lunch. R1 was eating a Pita pocket sandwich with tuna, tomatoes, onions, lettuce and mayonnaise. The pita pocket was not cut up into small bites. R1 was also eating veggie chips and grapes. R1 was observed coughing while eating a grape. Served to R1 by staff was water that she was drinking from a straw. The water was not thickened to a nectar consistency nor did she have a plate guard/scoop plate or small utensils, as recommended by the speech therapist. The facility failed to have a staff member remain with R1 throughout the meal.

During an interview on 7/17/13 at approximately 12:30 PM, E4, Certified Nursing Assistant, was asked why R1's water was not nectar thick. E4 stated she added thickener to R1's water and did not know why it did not "thicken up."

Review of R1's dining observation and clinical record with E2, Director of Nursing, on 07/18/13 at 7:50 AM confirmed R1's service agreement was correct. E2 confirmed that R1 needed her food cut up in small pieces due to choking precautions and her water should have been thickened to nectar thick. E2



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DATE SURVEY COMPLETED: July 19, 2013

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>continued to state a staff member should be in the dining area while R1 was eating.</p> <p>Review of R1's speech therapy report with E1, Administrator, and E2, Director of Nursing, on 7/18/13 at 11:15 AM confirmed R1 should have had a plate guard/scoop plate and smaller utensils. E1 also confirmed the lunch observation findings of 07/17/13 as she was also observing the same lunch meal. E1 and E2 also confirmed that R1's UAI assessment, service agreement and Resident Weekly Care Log contained inconsistent information that failed to document all of R1's necessary services listed on the service agreement.</p> <p>On 7/18/13 at 12:10 PM, E2 and the surveyor observed R1 eating her lunch. R1 had a scoop plate with regular size utensils. R1 also had water and juice that was not thickened sitting in front of her with E5, Certified Nursing Assistance, sitting beside her. E2 checked R1's fluid and realized they were not of a nectar thick consistency and R1 did not have small utensils. E2 immediately addressed these concerns.</p> <p>On 7/22/13 at 10:00 AM, E7 returned surveyors call and confirmed the above recommendations were given to the facility for R1's dysphagia.</p>	<p><b>16 Del. C. Chapter 11, Subchapter III</b></p> <p>A. Staff educated (Attachment #3) regarding policy and procedure on choking precautions (Attachment #6 ), specialized small utensils, scoop/guard bowl, smaller portions, food cut up into small pieces, correct posture, nectar thickened liquids, small sips, and that a staff member must sit with resident while eating and drinking.</p> <p>B. Staff re-educated to identify and report any changes with any resident, such as coughing, increased throat clearing, or choking while eating and drinking.</p> <p>C. Choking policy and procedure were reviewed and implemented. Documented education of all Staff. Speech Therapy evaluation ordered for dysphagia on 8/15/13. Physical therapy ordered to improve posture while Eating and drinking on 8/15/13. Wheelchair evaluated for any possible improvements to assist with better posturing on 7/22/13. Daily Care Log has been revised and implemented for Staff to follow on a daily basis. (Attachment #7 )</p> <p>D. Staff and resident observations will be made daily for 2 weeks and documented for adaptive measures. (Attachment #8 ) Results will be reported to Speech Therapist and utilized for QA.</p> <p style="text-align: right;"><b>Completed: 9/2/13</b></p>