



**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

Page 1 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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<p>3225.0</p> <p>3225.8.0</p> <p>3225.8.1</p> <p>3225.8.1.4</p>	<p>An unannounced annual survey was conducted at this facility beginning August 3, 2011 through August 4, 2011. The resident census on the entrance day of the survey was twelve (12). The survey sample totaled 9 open records.</p> <p>Assisted Living Regulations</p> <p>Medication Management</p> <p>An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:</p> <p>Administration of medication, self-administration of medication, assistance with self administration of medication, and medication management by an adult family member/support person.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, record review, interview, and review of the facility's policy and procedures it was determined that the facility failed to follow their policy and procedures for administering/assisting with medications for six (R1, RSS4, RSS5, RSS6, RSS8, RSS9) out of 9 sampled residents. Findings include:</p> <p>The facility's policy and procedure for Medication Assistance/Administration stated 4. Do not leave medication with resident unless there is a physician order to</p>	<p><u>3225.8.1.4 Medication Self-Administration</u></p> <p>The center has reviewed their medication administration practice. Residents shall be monitored during administration of medications.</p> <p>In-servicing shall be completed on or before September 15, 2011, for staff administering medications on the unit.</p> <p>Random audits shall be completed to confirm compliance with center practice, for the next 90 days. This shall be the responsibility of the ALF Director and DON. 9/15/2011</p> <p>The ALF Director and DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance 9/15/2011</p>
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Provider's Signature  NHA Title Administrator Date 9/11/2011



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STATE SURVEY REPORT

Page 2 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

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<p>3225.8.1.5</p> <p>3225.8.1.5.3</p>	<p>do so.</p> <p>On 8/4/11, a medication pass observation was observed with E3 (GNAS-Geriatric Nursing Assistant Specialist) that began at approximately 7:05 AM.</p> <p>Residents were observed sitting in a room outside the medication room waiting for their medications.</p> <p>In the medication room, E3 prepared the medications for RSS9. E3 delivered the medications to RSS9 then left the medications with RSS9 and returned to the medication room. E3 did not stay with RSS9 to ensure all the medications were consumed.</p> <p>E3 continued to administer medications to R1, RSS4, RSS5, RSS6, and RSS8 using the same process and leaving the residents alone with their medications. Review of all six residents' physician order sheets failed to reveal an order from their physicians indicating their medications were to be left alone with these residents.</p> <p>On 8/4/11 at 7:55 AM review of the observation with E4 (GNAS) confirmed the surveyor's observation. This information was also reviewed with E3 (RN) on 8/4/11 at approximately 8:15 AM.</p> <p>Provision for a quarterly pharmacy review, which shall include:</p> <p>Review of each resident's medication regimen with written reports noting any</p>	<p>LEFT BLANK INTENTIONALLY</p>



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STATE SURVEY REPORT

Page 3 of 11

NAME OF FACILITY: Seaford Center Assisted Living

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	<p>identified irregularities or areas of concern.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to identify a medication omission for one (RSS5) out of 9 sampled residents. Findings include:</p> <p>Review of RSS5's record revealed she was admitted to the facility on 4/27/11 with a physician order for Calcium with vitamin D by mouth twice daily and Vitamin D3 1000 i.u. (international units) by mouth daily.</p> <p>Review of RSS5's July 2011 monthly physician order sheet revealed that the admission physician order for the Calcium with Vitamin D was not carried on to the physician order sheet.</p> <p>Review of RSS5's pharmacy review sheet revealed a pharmacy review was completed on 7/20/11. The pharmacy review failed to identify this omission order for Calcium with Vitamin D.</p> <p>On 8/4/11 at 8:50 AM E5 (RN) contacted the physician who stated RSS5 was suppose to be receiving Calcium with Vitamin D3 by mouth twice a day and Vitamin D3 1000i.u. by mouth once a day. E5 continued to confirm that the staff should have identified this omission during the 24-hour chart check and/or during the change over.</p>	<p><u>3225.8.1.5.3 Pharmacy Review of Medication Regimen</u></p> <p>Resident RSS5 remains in the center and continues to receive medications as directed by the physician. An audit has been completed on all residents on the unit to determine accuracy with physician orders. <i>9/15/2011</i></p> <p>Staff will be in-serviced on or before September 15, 2011, on 24 hour chart checks and transcription of physician orders. <i>9/15/2011</i></p> <p>Random audits shall be completed over the next 90 days to determine compliance. This shall be the responsibility of the ALF Director and DON. <i>9/15/2011</i></p> <p>The ALF Director and DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. <i>9/15/2011</i></p>
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STATE SURVEY REPORT

Page 4 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3225.8.4	<p>Residents who self-administer medication shall be provided with a lockable container or cabinet. This requirement does not apply to medications which are kept in the immediate control of the individual resident, such as in a pocket or in a purse. Facility policies must require that medications be secured in a locked container or in a locked room.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to ensure medications were properly stored for two (RSS4 and RSS3) out of 9 sampled residents. Findings include:</p> <ol style="list-style-type: none"> On 8/4/11 at 9:40 AM RSS4 was in his room and showed E3 (RN) and surveyor his medications. RSS4 medications were not in a locked box. RSS4 stated he gave his locked box away a while ago. On 8/4/11 at 10:00 AM RSS3 was in her room and showed E3 her medications that were located in her top draw and not in the locked box. 	<p><u>3225.8.4 Self-Administer Medications/Secured in Locked Container</u></p> <p>Residents RSS4 and RSS3 remain in the center and have been given lock boxes for their medications. Any resident doing self administration of medications shall be given a lock box for their medications. <i>9/15/2011</i></p> <p>Random rounds shall be completed to determine compliance with proper storage of medication in resident apartments. This shall be the responsibility of the ALF Director and DON. <i>9/15/2011</i></p> <p>The ALF Director and DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. <i>9/15/2011</i></p>
3225.8.6	<p>Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance</p>	



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STATE SURVEY REPORT

Page 5 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>with or staff administration of medication.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to follow their policy and procedure for monitoring one (RSS7) out of 9 sampled residents who self-administered her medication. Findings include:</p> <p>The facility's policy and procedures for Medications: Self-Administration stated: "Residents who request to self-administer medications will be evaluated per state regulations and at least prior to admission, every six months, and with change of status for capability... Procedure 5. Monitor resident to assure medication is administered as ordered and for effectiveness and/or side effects of medication."</p> <p>On 8/4/11 during the medication pass RSS7 gave E4 (GNAS) a bottle of Tramadol. Review of RSS7's clinical record revealed RSS7 was not ordered Tramadol.</p> <p>Review of RSS7's UAI and Service Agreement revealed she was assessed to self-administer her medications.</p> <p>Review of this information with E3 (RN) on 8/4/11 at 8:15 AM revealed that RSS7 had not had an on-site medication review to ensure she was taking medications as ordered by the physician and to review and assess the resident's cognitive and physical</p>	<p><u>3225.8.6 On-Site Review by RN of Self Administration</u></p> <p>Resident RSS7 remains in the center and has been reassessed for self administration of medications. Current residents have been reviewed to determine assessments are current per state regulations. <i>9/15/2011</i></p> <p>The ALF Director and DON shall track assessments to determine completions in a timely manor. <i>9/15/2011</i></p> <p>The ALF Director and DON shall notify the Administrator and QA committee of any variances identified monthly. The QA committee shall make recommendations to obtain and maintain compliance. <i>9/15/2011</i></p>



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STATE SURVEY REPORT

Page 6 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3225.8.8.2	<p>ability to self-administer medication or the need for assistance with or staff administration of medication.</p> <p>Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, observation and interview it was determined the facility failed to ensure that four (RSS4, R1, RSS5, and RSS7) out of 9 sampled residents received all and only the medications as ordered by the physician. Findings include:</p> <p>1. On 8/4/11 at approximately 7:20 AM during the medication observation it was observed that RSS4 was provided medications. Review of the physician order sheet revealed RSS4 had a physician order for Tobramycin 0.3% drops instill one drop in right eye four times a day for prophylactic treatment and Sustane 0.3%-0.4% drop to instill one drop in each eye at bedtime for dry eyes.</p> <p>Review of RSS4's MAR revealed documentation that indicated that for the aforementioned medications "Does Self (self-administer)".</p> <p>Review of RSS4's annual UAI dated 5/6/11 revealed he was assessed under the section for Medication Management as needing to have his medications administered to him.</p>	<p><u>3225.8.8.2 Receiving Meds as Prescribed/Ordered</u></p> <p>Current residents have had a medication review completed to determine the accuracy of medications. <i>9/15/2011</i></p> <p>Audits shall be completed monthly to determine medication orders are accurate. This shall be the responsibility of the ALF DON. <i>9/15/2011</i></p> <p>The ALF DON shall report monthly to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. <i>9/15/2011</i></p>



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	<p>On 8/4/11 at 9:40 AM E3 (RN) asked RSS4 if we could see his medications in his room. Upon E3 questioning RSS4 about his medications, he stated he stopped taking his eye drops about 2 months ago.</p> <p>2. On 8/4/11 at 7:25 AM during the medication observation pass, E4 (GNAS) was observed handing R1 her Sprivia 18 mcg inhaler. E4 then left R1 alone and went back into the medication room. E4 began preparing medications for the next resident. R1 came into the medication room and stated the inhaler was not working. E4 took the capsule out of the inhaler and replaced it with a new one. E4 then told R1 to push the button then inhale. R1 pushed the button on the inhaler then took 2 puffs from the inhaler containing the Sprivia instead of one puff as ordered.</p> <p>Review of R1's physician order sheet revealed an order for Spiriva 18 mcg cap with hand inhaler one puff every morning.</p> <p>On 8/4/11 at 10:20 AM E3 (RN) asked R1 if she could see the medications she took. R1 gave E3 permission to see her medications. E3 found several medication cups with medications in them. R1 stated they were her pills she took at night to help her sleep. E3 also found a bottle of multivitamins, Milk of Magnesium, Prevision multivitamins. E3 asked R1 if she took these multivitamins and milk of magnesium R1 stated that she did.</p> <p>Upon matching, the medications found in R1's room with the medications ordered by her physician the following medications</p>	<p>LEFT BLANK INTENTIONALLY</p>
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STATE SURVEY REPORT

Page 8 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	--	--

	<p>were identified: 9-Tylenol tablets, 9-Meloxicam 7.5 mg tables and one Fosmax 70 mg tablet. These medications were documented on the MAR as being administered by staff to R1; however, it appeared that R1 was not consuming the medications when they were provided to her by staff.</p> <p>R1 was taking them back to her room and saving them instead consuming them as documented.</p> <p>The above incident was immediately reviewed after leaving R1's room with E3 and revealed that R1 was starting to decline.</p> <p>3. On 8/4/11 at 7:35 AM during the medication pass E3 (GNAS) was observed providing RSS5 with her medications. RSS5 was administered five medications. One of the medications she received was Calcium with vitamin D one tablet.</p> <p>Review of RSS5's physician order sheet for August 2011 revealed an order for Vitamin D3 1000 i.u. (International Units) tablet one by mouth every day. There was no physician order for the Calcium with Vitamin D.</p> <p>Review of RSS5's admission physician order dated 4/27/11 revealed an order for Calcium with Vitamin D and Vitamin D3 1000 i.u. by mouth daily.</p> <p>Review of RSS5's MAR revealed E4 (GNAS) signed off that she administered the Vitamin D3 1000 i.u. and the Calcium with Vitamin D tablet. However, E4 was</p>	<p>LEFT BLANK INTENTIONALLY</p>
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STATE SURVEY REPORT

Page 9 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

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<p>3225.13.0</p> <p>3225.13.1</p>	<p>observed providing only the Calcium with Vitamin D tablet to RSS5.</p> <p>Review of the medications with E3 (RN) and E5 (RN) on 8/4/11 at 8:10 AM confirmed that the 24-hour chart check missed this medication omission for over a 3 month period of time. It was also missed during the changeover. E5 called the physician and clarified the order. The physician stated he wanted RSS5 to be administered both the calcium with vitamin D and the Vitamin D3 1000 i.u. by mouth daily.</p> <p>4. During the medication pass observation with E4 (GNAS) on 8/4/11 at approximately 7:40 AM, RSS7, who was assessed for self-administration of medications, approached E4 and handed her a bottle of medications. RSS7 told E4 to take the pills as they did not take away her pain. Later it was reported to the surveyor the medication bottle handed to E4 by RSS7 contained Tramadol (Ultram).</p> <p>Review of RSS7's physician orders revealed RSS7 did not have a physician order for the Tramadol.</p> <p>On 8/4/11 at 12:45 PM this information was reviewed with E1 (Administrator) E2 (AI Director) E3 (RN), R6 (DON-SNF) and R7 (Corporate RN)</p> <p>A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of</p>	<p>LEFT BLANK INTENTIONALLY</p>



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STATE SURVEY REPORT

Page 10 of 11

NAME OF FACILITY: Seaford Center Assisted Living

DATE SURVEY COMPLETED: August 4, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	--	--

	<p>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 was not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to ensure the service agreement reflected the needs found in the UAI for one (RSS4) out of 9 sampled residents. Findings include:</p> <p>Review of RSS4's UAI dated 5/6/11 revealed he was assessed under 10. Medication Management as "D. Administration of medication" (indicating a licensed person).</p> <p>Review of RSS4's Service Agreement dated 5/11/2011 documented under Medication Management in the intervention section it stated, "Staff performs and Can self administer medication with assistance in offering meds at prescribed times" (indicating an AWSAM staff member) .</p> <p>Upon observation of the medication administration on 8/4/11 at 7:20 AM, revealed E4 (GNAS) who was AWSAM trained provided RSS4 his medications.</p> <p>Review of RSS4s UAI and Service Agreement with E3 (RN) on 8/4/11</p>	<p><u>3225.13.1 Resident Participation in UAI</u></p> <p>Current residents UAI's and service plans will be reviewed with resident participation and corrections made to the service plans as necessary to reflect the resident's current level of care. 9/15/2011</p> <p>Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the ALF Director and DON. 9/15/2011</p> <p>The ALF Director and DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. 9/15/2011</p>
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STATE SURVEY REPORT

Page 11 of 11

NAME OF FACILITY: Seaford Center Assisted Living

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3225.16.11	<p>confirmed that RSS4's UAI assessment and Service Agreement were not consistent. E3 continued to state she would reassess RSS4 and ensure that his UAI assessment would be correctly reflected on his Service Agreement</p> <p>Every assisted living facility shall have a Director of Nursing who is a registered nurse. Facilities licensed for 25 assisted living beds or more shall have a full-time Director of Nursing. Facilities licensed for 5 through 24 assisted living beds shall have a part-time Director of Nursing on-site and on-duty at least 20 hours a week. The nursing director of a facility for 4 assisted living beds or fewer shall be on-site at least 8 hours a week.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to have a designated Director of Nursing for this facility. Findings include:</p> <p>Review of the licensed staff with E1 (administrator) on 8/5/11 at approximately 1:35 PM revealed the facility failed to have one person designated as the Director of Nursing for this 19 licensed bed facility. Review of the DLTCRP facility maintenance system failed to reflect the name of the person designated as the DON for the A/L facility.</p>	<p><u>3225.16.11 Every AL licensed for 5 to 24 beds shall have a part-time DON</u></p> <p>The assisted living facility contends that their failure to comply with this standard is in name only. The duties and responsibilities associated with the role, responsibility and title of Director of Nurses are and were being met by a designated and readily identified Registered Nurse, however, she did not carry the title of Director of Nurses, ALF. <i>9/15/2011</i></p> <p>The ALF Administrator shall designate the person fulfilling this role and as the Director of Nurses, ALF referred to herein as ALF DON. <i>9/15/2011</i></p>