



**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

NAME OF FACILITY: State Street Assisted Living

DATE SURVEY COMPLETED: September 22, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3225 3225.5.0 3225.5.5</p>	<p>An unannounced annual and complaint survey was conducted at this facility beginning on July 26, 2015 and ending on September 22 2015. The facility census on the entrance day of the survey was 85. The survey sample was composed of thirteen (13) residents. The survey process included observation, interviews, and review of resident clinical records, facility documents and facility policy/procedures.</p> <p>Abbreviations used in this state report are as follows:</p> <p>ED – Executive Director, =E1; DON – Director of Nursing, =E2; RN – Registered Nurse; LPN – Licensed Practical Nurse, =E3; CNA – Certified Nurse’s Aide; UAI – Uniform Assessment Instrument – a standardized resident assessment tool used in Assisted Living facilities; SD – Staff Development Nurse=E4; CM- Centimeter- a metric unit equal to less than half an inch;</p> <p>Stage II pressure sore- a shallow, open bed sore caused by pressure;</p> <p>Activities of Daily Living- usual activities such as bathing, dressing, grooming, and toileting;</p> <p>Dementia-brain disease that causes difficulty with memory and decision making.</p> <p>Regulations for Assisted Living Facilities</p> <p>General Requirements</p> <p>The assisted living facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. However, residents may be</p>	<p>Responses to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.</p> <p>3225 Regulations for Assisted Living Facilities 3225.5.0 General Requirements</p> <p>3225.5.5 The assisted living facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. However, residents may be permitted to wander safely within the perimeter of a secure unit.</p>	<p>11/23/15 RHS</p>
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Provider's Signature Lisa Hanelow Title Executive Director Date 11-18-2015



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	<p>permitted to wander safely within the perimeter of a secured unit.</p> <p>Based on record review, review of incident report, policy / procedure review and staff interview, it was determined that for two (2) of thirteen (13) residents reviewed (R8 and R11) the facility failed to adhere to established policies and procedures to prevent these residents with diagnosed memory impairment from wandering away from safe areas. The facility's "Risk Assessment: Elopement" policy / procedure required that if a resident's behavior warrants elopement prevention measures, an elopement prevention plan will be documented as part of their service agreement with changes made as needed based on staff observations of the resident. R8's and R11's service agreements lacked elopement prevention plans (such as supervision) for the times when R8 and R11 were outside of the facility although R8 and R11 both had dementia, adjustments (e.g. increasing supervision when outside) did not occur to the elopement prevention plans as required by facility policy / procedure to address R8's and R11's safety needs despite elopements by both residents.</p> <p>According to the policy / procedure, repeat elopement attempts required the facility's Director of Nursing to review the interventions with the team of caregivers to develop additional prevention measures and monitoring. Findings include:</p> <p>1. Cross-refer 16 Del. Code Chapter 11, Subchapter III, § 1131 (10)a, example 2.</p> <p>R8 failed to have an effective elopement prevention plan included in her service agreement as required by facility policy / procedure. Five (5) total Elopement Risk Evaluations completed by facility staff</p>	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. R8 elopement prevention plan has been reviewed and revised to include staff supervision when outside. R8 was moved to the secured memory care unit on 9/9/15. b. R11 elopement prevention plan has been reviewed and revised to include staff supervision when outside.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>a. All residents will have an elopement risk reassessment completed. Those identified at risk will have the elopement prevention plan reviewed and revised as needed to include staff supervision when outside. b. Elopement risk assessments will be completed on admission, quarterly and with a significant change in status. Elopement prevention plans will be implemented on residents identified at risk to include staff supervision when outside.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>a. The Elopement policy and procedure was reviewed and revised to include any resident at risk will have staff supervision when outside. (Attachment 1) b. The Wanderguard Door System was updated to include automatic self locking of the front door and parlor door when a resident with a wanderguard approaches. The Door System will be checked q shift for proper functioning. Residents at risk will have supervised staff time outside. c. Staff will be inserviced on the revised Elopement policy and procedure . (Attachment 2)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Executive Director and/or the Director of Nursing will monitor the Elopement Policy and procedure using the audit tool that includes date of assessment, prevention plan on UAI, service plan and implementation of service plan on CNA flow sheet and evaluate effectiveness weekly x 8 weeks, monthly x 3 months, then quarterly x 3 for compliance. (Attachment 3) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.</p>	<p>11/23/15 RAG</p>
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	<p>between 5/28/14 and 5/26/15 indicated that R8 was at high elopement risk. Although R8 wore an arm band to trigger a door alarm if she exited the building, it was the practice of facility staff to reset the alarm and allow R8 to remain outside without direct supervision. According to nursing note documentation, R8 was then able to wander off facility property on 6/21/15 and 7/28/15 without staff being aware. There was no elopement prevention plan established by the facility for R8 when she was outside the facility. On 8/12/15 at 1:40 PM, E4 (LPN) confirmed to the surveyor that it was the facility's practice to shut the door alarm off when R8 went outside and if the resident was out front on the porch the receptionist on-duty was to look out for R8 as best as she could although E4 acknowledged that the receptionist desk location does not allow for full and direct visualization of the facility's porch.</p> <p>2. Cross-refer 16 Del. Code Chapter 11, Subchapter III, § 1131 (10)a, example 4. R11, a resident with dementia, was assessed on 3/16/15 by facility staff to be at high risk for elopement. The service agreement for R11 indicated that R11 went out for a daily walk in the circular area in front of the facility (a porch, a sidewalk, and a parking lot with street access) and would let staff know when she (R11) was going out. The service agreement lacked a supervision plan to ensure that R11 did not wander away from facility property. According to an incident report dated 4/21/15 and timed 3:30 PM, a staff person observed R11 a block away from the facility talking to a man on the street. A change to R11's service agreement was dated 4/21/15 and indicated that the receptionist would alert staff if R11 left the front porch area. No direct supervision plan</p>		<p>11/23/15 RHS</p>
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<p>3225.7.0 3225.7.1</p>	<p>was established although nursing note documentation dated 4/21/15 and timed 3:44 PM indicated that R11 had left facility property and was a block away moving in the opposite direction of the facility with her rolling walker when a staff member who was leaving happened to see her there. On 6/13/15, a psychiatry progress note indicated that R11 was known to have confusion and delusions (false beliefs). On 6/16/15, facility staff once again assessed R11 as at high risk for elopement. On 9/13/15 at 6 PM, E15 (receptionist) was interviewed and identified R11 as a resident she currently was supposed to watch when she (R11) went outside on the porch. E15 stated that she resets the door alarm when R11 goes outside and will radio a message to the nurse that R11 is outside. When reviewed on 9/13/15, the service agreement for R11 failed to contain an elopement prevention plan describing how staff would ensure the safety of R11 when she was outside. There was a notation (undated) that R11 was not allowed to walk around the block unsupervised. The facility failed to follow established policy / procedure by developing an effective elopement prevention plan that included direct supervision of R11 when she went outside. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p> <p>Specialized Care for Memory Impairment Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations herein.</p>	<p>3225.7.0 Specialized Care for Memory Impairment</p> <p>3225.7.1 Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations</p>	<p>11/23/15 RHS</p>
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<p>3225.11.0 3225.11.5</p>	<p>Based on staff interviews, it was determined that the facility had a specialized care unit for residents with memory impairment but had outdated policies / procedures for this unit with new policies / procedures currently under development and not yet implemented. As a result, at the time of the survey there was a lack of clear policies and procedures currently in effect related to the form of care or treatment provided on the specialized care unit. Findings include: Observations on the initial tour of the facility on 7/26/15 at approximately 2:30 PM revealed a locked unit requiring entry of a key code for access. The surveyor was told by E3 (LPN) who was giving the tour that this was the facility's "memory care unit" and that approximately eleven (11) residents resided on this unit. When requested by the surveyor, there were no currently implemented policies / procedures for this unit provided for the surveyor's review and the surveyor was informed that the facility was in the process of developing and implementing an improved program (including policies / procedures) on this specialized care unit. At the time of the survey, the facility lacked current policies/procedures for their specialized care unit describing the form of care or treatment provided and addressing each of the areas listed in section 7.3 (7.3.1 through 7.3.10) of the State of Delaware Regulations for Assisted Living Facilities. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p> <p>Resident Assessment</p> <p>The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular</p>	<p>herein.</p> <p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? a .The policies/ procedures for the Memory Care unit were updated on 8/1/15. Current policies/ procedures are available on the Memory Care unit.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents have the potential to be affected. b. The policies/ procedures for the Memory Care unit were updated on 8/1/15. Current policies/ procedures are available on the Memory Care unit. (Attachment 4)</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? a. The policies /procedure for the Memory Care unit will be reviewed, updated annually and as needed. b. Memory Care Staff will be inserviced on the updated policies/procedures for the Memory Care unit. (Attachment 5)</p> <p>4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? a. The Executive Director/Memory Care Program Coordinator will monitor the Policy and Procedure manual for the Memory Care unit using a tracking tool for new policies, revisions and implementation monthly x 3. All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcome. (Attachment 6)</p> <p>3225.11.0 Resident Assessment 3225.11.5 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</p>	<p>11/23/15 RHS</p>
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	<p>updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition</p> <p>Based on record review, interviews and observations, it was determined that for one (1) of thirteen (13) residents reviewed (R9); the facility failed to ensure that the UAI was revised when there was a significant change in the resident's status. Findings include:</p> <p>According to an annual UAI dated 5/15/15, R9 required staff supervision with eating, assistance of one staff person with transfers, and occasional physical assistance with mobility (walking). Interview with E12 (CNA) on 8/7/15 at 1:15 PM, however, revealed that R9 had been declining for several weeks and now required staff to feed him; required two staff persons to assist him to transfer; and required at least two staff persons to help him walk. E12 further stated to the surveyor that R9 now had an open sore on his buttocks. At the request of the surveyor, a nurse (E4,SD) was contacted to come to R9's room to assess the open sore. On 8/7/15 at 2:05 PM, the surveyor observed that R9 was unable to move from his chair or walk without two staff members providing significant weight bearing support. E4 observed the open area on R4's left buttocks and stated that it was a Stage II pressure sore measuring 3.5 cm long by 2 cm wide by < 0.1 cm in depth. Nursing notes revealed that on 7/22/15 at 9:44 PM this area had been described as purple in color and unblanchable (discolored but intact skin) and on 7/27/15 at 2:40 PM progressed to an open sore measuring 3 cm by 0.5 cm. Both of these nursing notes indicated that the physician for R9 had been contacted, however, no follow-up was documented and</p>	<p>and when there is a significant change in the resident's condition.</p> <ol style="list-style-type: none"> 1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice? <ol style="list-style-type: none"> a. R 9 had a significant change UAI completed on 8/7/15. R9 had orders obtained for treatment of wound on 8/7/15. R9 wound resolved on 9/15/15. A PT evaluation was completed on 11/11/15. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ol style="list-style-type: none"> a. All residents will have a pressure ulcer risk assessment completed. Residents identified at risk will have a pressure ulcer plan implemented on the Service Agreement and CNA flowsheet. b. Pressure ulcer risk assessments will be completed on admission, quarterly and with a significant change in status. Skin prevention/ treatment plans implemented on residents identified at risk. c. The 24 hour reports are reviewed daily by the licensed nurse for changes in condition/ ADLs and interventions will be initiated and reported to the Director of Nursing/ Memory Care Program Coordinator.. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ol style="list-style-type: none"> a. The Pressure ulcer risk / treatment policy and procedure will be implemented and includes identification of residents at risk, prevention, obtaining physician orders and implementation of treatment plan. (Attachment 7) b. Nursing Staff will be inserviced on the revised Pressure ulcer risk / treatment policy and procedure to include immediate MD notification of skin issues ,prompt treatment orders, documentation and notification of the DON/ED/ Memory Care Program Coordinator. Nursing staff will be inserviced on monitoring for changes in condition/ ADLs and appropriate interventions and documentation of changes in status.(Attachment 8) c. The DON/ Memory Care coordinator will review the 24 hr reports, meet with the LPNs and CNAs to discuss resident changes in condition/ skin issues/ ADLs When a skin issue is identified, an incident report will be completed, a nurses note completed, the physician and 	<p>4/23/15 RHS</p>
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<p>3225.12.0 3225.12.3</p>	<p>no treatment orders had been received. On 7/30/15 at 10:50 PM, a nurse documented that R9 required assistance to eat dinner. This was a change since R9's most recent UAI dated 5/15/15 indicated that he usually only required supervision while he fed himself. No nursing assessment of R9 was documented in response to the report of the open wound on the buttocks or the decline in ability to feed himself. As of 8/7/15 there was still no treatment order for the pressure sore. R9's UAI was revised on 8/7/15 to reflect his declined ability to eat, walk, and transfer, and to indicate the presence of a Stage II pressure sore. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p> <p>Services</p> <p>The assisted living facility shall ensure that the resident's service agreement is being properly implemented.</p> <p>Based on record review, staff interview, and observations, it was determined that for one (1) of thirteen (13) residents reviewed (R2) the facility failed to ensure the resident's service agreement was properly implemented. R2 required the use of a walker when transferred by staff; however, the walker was not used as required by the service agreement in effect for R2. Findings include:</p> <p>Cross-refer 16 Del. Code Chapter 11, Subchapter III, § 1131 (10)a, example 1.</p> <p>The service agreement for R2 dated 12/3/14 instructed staff that R2 required the assistance of one person with transfers and used a walker during transfers. There was no evidence that a walker was used on 2/12/15 when R2 fell while being transferred from her recliner chair to a wheelchair by a</p>	<p>family notified, treatment orders obtained and the DON/ED/ Memory Care Coordinator notified. The DON/ Memory Care coordinator will follow up with the nurse to ensure physician orders have been obtained and implemented.</p> <p>d. Weekly Wound tracking will be continued to include wound measurements, status, and recommendations. (Attachment 9)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Director of Nursing/ Memory Care Program Coordinator will monitor the Pressure Ulcer risk/ treatment Policy and procedure using a tracking tool that includes date of assessment, physician notification, treatment orders, change reflected on UAI, and interventions on the service plan and CNA flowsheet weekly x 8 weeks, monthly x 3 months, then Quarterly x 3 for compliance (Attachment 10)</p> <p>The DON/ Memory Care Coordinator will monitor changes in condition using a tracking tool that includes date of change, type of change, plan on UAI, service plan and CNA flowsheet weekly x 8 weeks, monthly x 3 months, then Quarterly x 3 for compliance. (Attachment 11) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.</p> <p>3225.12.0 Services</p> <p>3225.12.3 The assisted living facility shall ensure that the Resident's service agreement is being properly implemented.</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. R2 was discharged from the community on 2/12/15.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>a. All residents will have transfer status reviewed and documented on the Service Agreement and CNA flowsheet.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>a. The policy and procedure for Service Agreement/ Care</p>	<p>11/23/15 RHS</p>
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<p>3225.13.2</p> <p>3225.13.2.5</p>	<p>staff member (E9). There was no mention of the walker in staff statements related to the fall; in the incident report; or in staff interviews conducted during the survey. Interview with E9 (CNA) on 8/4/15 at 10:25 AM revealed that she was a newly employed CNA at the time and the facility was supposed to have tablets (small portable computers) for staff to use to see what a resident's needs were but the tablets were not working for the first few months of her employment. Interview with E4 (SD) on 8/4/15 at 1:10 PM revealed that when operating correctly, a CNA could click on a photo of a resident on the tablet and see all of their care needs listed. E4, however, confirmed that there had been numerous problems with the use and function of the tablets since they were first implemented less than a year ago and several remained broken as of the time of the survey. When asked if there was an established back-up plan for staff to use since the tablets were not always functioning or available, E4 replied that there was not. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p> <p>The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:</p> <p>Psychosocial/emotional services including those related to memory impairment and other cognitive deficits;</p> <p>Based on record review and staff interviews, it was determined that for two (2) of thirteen (13) residents reviewed (R8 and R13) the service agreement developed by the facility failed to address the psychosocial services required by R8 and R13 to effectively and safely manage their behaviors and</p>	<p>plan/ CNA flowsheet was reviewed and revised to include that interventions will be placed on the CNA flowsheet. (Attachment 12)</p> <p>b. Paper generated CNA flowsheets were implemented on 8/8/15 with transfer status addressed. The CNA will refer to the flowsheet for the residents transfer status and the residents who need assistance and/or assistive devices will be posted on the inside of the apartment door.</p> <p>c. Nursing Staff will be inserviced on the policy and procedure for Service Agreement/ Care plan/ CNA flowsheet (Attachment 13)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Executive Director and /or the Registered Nurses will monitor the compliance with the policy and procedure using the Transfer Status audit tool that includes transfer status including devices used, transfer status on UAI, service plan, CNA flow sheet and posted in residents apartment weekly x 8 weeks, monthly x 3 months, then quarterly x 3 for compliance. (Attachment 14) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.</p> <p>3225.13.2 The service agreement or contract shall address The physical, medical, and psychosocial services that the resident requires as follows:</p> <p>3225.13.2.5 Psychosocial/emotional services including those Related to memory impairment and other cognitive deficits;</p>	<p>4/23/15 RHS</p>
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	<p>psychosocial distress. Findings include:</p> <p>1. R8, a resident with dementia, was known to often seek time outdoors and had repeatedly left facility property while unsupervised by staff. Review of R8's service agreement during the survey revealed a lack of a documented plan for all staff to follow in meeting R8's need for time outdoors and in managing R8's agitation and restlessness. There was no behavior management plan documented in R8's service agreement for staff to be aware of and follow.</p> <p>According to a nursing note dated 9/8/15 and timed 2:10 PM, at about 8:30 AM that morning the receptionist had requested assistance with R8 who was outside of the facility. The receptionist had asked the nurse to contact R8's family requesting their immediate presence to help with R8 who had become combative with staff and declined to be brought back into the facility. The nurse wrote that she went over to the college building where R8 had gone (across the street from the facility) where she observed R8 "yelling at staff and attempting to slam the door to the office and lock out staff members" and also that R8 "became physically aggressive towards staff of (college)".</p> <p>Interview with E4 on 9/13/15 at 1 PM revealed that on the morning of 9/8/15 she received a radio message from the receptionist telling her that R8 needed assistance in the parking lot. E4 explained to the surveyor that she walked to R8 who was at the edge of the parking lot about to leave facility property to try to redirect her and R8 became combative and agitated hitting and kicking at her (E4). Some other individuals were in the parking lot (two hospice aides and a physical therapist) who tried to assist</p>	<ol style="list-style-type: none"> 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? <ol style="list-style-type: none"> a. R8 service agreement has been reviewed and updated to include a plan for meeting the residents need for time outdoors exercise, and managing agitation and restlessness. R8 was moved to the secured memory care unit on 9/9/15. A detailed plan of supervision, supervised activities and instructions for staff was developed in conjunction with the family. R8 sees her PCP for medication adjustment per her family request. b. R13 service agreement has been reviewed and updated to include a plan for suicidal thoughts and use of alcohol. R13 was evaluated by Med Options psychiatric services on 9/29/15. Psychiatric services had no new recommendations, continue current medications. A meeting was held with R13 on 11/10/15 with the Executive Director and Registered Nurses to address alcohol. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ol style="list-style-type: none"> a. All residents will be reviewed for Psychosocial Issues to include any Psychosocial / Emotional needs using the 24 hour reports. When a Psychosocial/ Emotional Issue is identified the physician will be immediately notified, orders received, a nurses note completed, and the responsible party, the Director of Nursing, Memory Care Coordinator, Executive Director will be notified. A plan will be implemented on the Service Agreement to include services that will be provided or arranged by the facility. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ol style="list-style-type: none"> a. Dementia Training was given on 10/13/15 and 10/14/15 for staff members by a certified dementia instructor. This Training will be ongoing. (Attachment 15) b. Staff will be inserviced on Behavior Management Strategies and Identifying and addressing Psychosocial needs of the residents. (Attachment 16) 	<p>11/23/15 RHS</p>
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	<p>according to E4. E4 further stated that a corporate employee (E16) happened to pull in the parking lot and also tried to assist. E4 stated that R8 became more agitated and crossed the street and entered a building on the campus of the college across from the facility and closed the door before E4 could also enter the building. E4 stated that for 5 - 6 minutes she tried unsuccessfully to enter the building but R8 was able to prevent her from doing so by blocking the door. E4 stated that she called the police after she was able to enter the building but was unable to calm R8 down. E4 acknowledged that the fact that 5 people were attempting to intervene when R8 first left facility property may have increased R8's agitation. E4 stated that she told R8 "no" and told her not to go across the street or into the building. E4 stated that she and others had tried redirection which was not effective. When asked what plan was in place for R8's agitation and combative behaviors, E4 replied the plan was to call the nurse, administer medicine, and attempt redirection. Interview with E17, an employee of the college who was present when R8 entered the college building, revealed that when R8 entered she was visibly agitated, cursing, and stating that she was upset that staff of the facility were "following" her.</p> <p>E4 was asked by the surveyor to ensure that an effective plan for responding to R8's agitation, combativeness, and need for time outdoors was established by the facility in conjunction with R8's family. In response to this request, the surveyor was provided with a detailed plan of supervision, supervised activities, and instructions for staff to avoid using terms such as "no" or "you can't do that" when R8 was agitated or restless.</p>	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Executive Director and/or the Registered Nurses will monitor the Behavior Management and Psychosocial needs of the residents using the audit tool that includes type of behavior/ psychosocial issue identified, physician notification, orders received, change reflected on UAI, interventions on the service plan and CNA flowsheet weekly x 8 weeks, monthly x 3 months, Then quarterly x 3 for compliance. (Attachment 17) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to Improve outcomes.</p>	<p>11/23/15 RHS</p>
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	<p>The plan, developed with input from R8's family, included diversion strategies and "work" activities where R8 would assist staff with simple activities to stay busy.</p> <p>2. R13 had diagnoses including paralysis of the legs, history of suicide attempt, depression, and anxiety. Record review revealed multiple indicators of the need for psychosocial support and services including: -a 5/21/15 2:34 PM nursing note documenting that R13 reported to E18 (former DON) having some suicidal thoughts although denying a current plan to attempt suicide; -a physician communication form initiated on 8/17/15 to alert the physician that R3 admitted to having one alcoholic beverage every night but staff were unable to monitor exactly how much alcohol she (R13) actually drank. The physician documented in reply that the staff needed to make sure R13 had only one drink per night or he could not authorized her to have any alcohol. The staff documented in reply "this is an assisted living facility" with the physician documenting in reply "no further instruction, (R13) is high risk for alcohol abuse".</p> <p>On 9/13/15 at 6:45 PM, the surveyor asked E19 (activities director and manager on duty that day) to determine if R13 still had alcohol in her room. E19 spoke to the staff and then told the surveyor that two nurses she asked were not aware that R13 had alcohol in her room, however, the CNAs reported that the resident did have alcohol (vodka) in her room.</p> <p>The service agreement for R13 lacked a behavior management plan or any evidence of follow-up on R13's report of suicidal thoughts and use of alcohol. The service agreement failed to identify what services would be provided or arranged by the facility</p>		<p>11/23/15 RHS</p>
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3225.13.6

to address R13's documented and serious psychosocial needs. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 AM

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.

Based on record review, staff interviews, and observations, it was determined that the facility lacked an effective system for ensuring that the service agreements for one (1) of thirteen (13) residents reviewed (R8) was changed when the needs of the residents changed. Findings include:

Cross-refer 3225.5.5, example 1. The service agreement for R8 established by the facility indicated that R8 could leave the facility independently (the box for 1:1 supervision was not checked off). The service agreement indicated that R8 was permitted to walk outside to sitting areas and the circular parking lot area in front of the facility. A note on the service agreement dated 6/19/15 indicated that R8 enjoyed walks in the facility's garden gazebo (located at the back of the facility opening to a sidewalk and a busy street). Review of the service agreement revealed a lack of an elopement prevention plan that addressed the supervision of R8 when she was outside of the facility (e.g. sitting on the porch) although she had dementia and a history of wandering away from the facility.

According to a nursing note dated 6/21/15 timed 2:50 PM, R8 was found off facility property by the family member of another

3225.13.6 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.

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?
 - a. R8 elopement prevention plan has been reviewed and revised to include staff supervision when outside. R8 was moved to the secured memory care unit on 9/9/15. The Service Agreement has been revised and updated.
2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
 - a. All residents Service Agreements have been reviewed, revised and updated to reflect the current needs of the resident.
3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?
 - a. The policy and procedure for Service Agreements has been reviewed and revised to include that the service agreement shall be reviewed when the needs of the resident have changed as necessary.
 - b. The Registered Nurses have been inserviced on the Service Agreement policy and procedure. (Attachment 18)
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?
 - a. The Executive Director will monitor the Service Agreements procedure using the change in condition audit tool that includes date and type of change, plan on UAI, Service Agreement and CNA flowsheet weekly x 8 weeks, monthly x 3 months, then quarterly x 3 for compliance. (Attachment 11) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.

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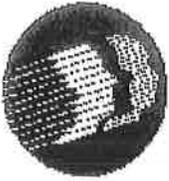
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	<p>resident who parked his car and convinced R8 to return to the facility with him. There was no change made to the service agreement following this incident to provide supervision to R8 when she was outside. According to a 7/28/15 nursing note timed 9:07 AM; R8 was also found walking in the parking lot of an apartment complex across the street from the facility.</p> <p>Interview with E5 (receptionist) by a State agency investigator on 7/30/15 at 1:20 PM revealed that on 7/28/15 she (E5) was the receptionist at the front desk when R8 exited the building wearing an alarm bracelet which activated the door alarm. E5 stated that the door alarm was re-set and she checked on R8 a few minutes later and observed her sitting on the front porch of the facility. According to Incident Report documentation, R8 was found approximately 10 minutes later off the facility property (across the street in a parking lot). On 8/12/15 at 1:40 PM, E4 confirmed to the surveyor that it was the facility practice to allow R8 to stay outside with the receptionist looking out for her. E4 stated that R8's family did not want her on the facility's locked unit. Observations of the receptionist desk daily throughout the survey revealed that the "L" shaped desk faces the main lobby and the elevator and that visualization of the porch is very limited. E4 agreed with this description of the visualization of the front porch area.</p> <p>The facility lacked an effective system for recognizing that the service agreement for R8 failed to meet her safety need for supervised time outside. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p>		<p>11/23/15 RTH</p>
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<p>3225.16.0 3225.16.2</p>	<p>Staffing</p> <p>A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.</p> <p>Cross refer 16 Del., C., Chapter 11, Subchapter III; §1131.</p> <p>Based on record review, observations, and interviews, it was determined that the facility failed to have a staff of persons sufficient in number and adequately trained to meet the requirements of the residents. The facility had a specialized memory care unit where approximately eleven (11) cognitively impaired (lacking normal ability to think and make decisions) residents lived. This unit was routinely staffed by two CNAs on the day and evening shift and one CNA on the 11 PM to 7 AM shift. No nurse was assigned to this unit and the nursing station was located on another floor of the facility. The care needs of the residents could not be met by the routine staffing provided by the facility causing some families to seek volunteer senior companion services to meet residents' care needs. Findings include:</p> <p>The facility has a specialized care memory unit where eleven (11) residents were residing at the time of the survey. According to staffing information provided to the surveyor by E3 (LPN) during the initial tour of the survey on 7/26/15 at approximately 2:30 PM, two CNAs were assigned to this unit on the day and evening shifts and one CNA on the night shift. Staffing documentation provided to the surveyor by E1 upon request during the survey revealed that on a typical 7 AM to 3 PM shift, there were five CNAs on-</p>	<p>3225.16.0 Staffing</p> <p>3225.16.2 A staff of persons sufficient in number and Adequately trained, certified or licensed to meet the Requirements of the residents shall be employed and Shall comply with applicable state laws and regulations.</p> <p>Cross refer 16 Del., C., Chapter 11, Subchapter III; § 1131.</p> <ol style="list-style-type: none"> 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? <ol style="list-style-type: none"> a. A nurse has been hired to serve as the Memory Care Coordinator. b. We have increased Nursing Assistant staffing on the Assisted Living side. c. The Memory Care residents families have been scheduled for Care Plan meetings to discuss any concerns with care needs beginning 11/11/15. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ol style="list-style-type: none"> a. A Resident Level of care service tool will be used in conjunction with resident assessment on admission, discharge and significant change. (Attachment 19) 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ol style="list-style-type: none"> a. A Resident Level of care service tool will be used in conjunction with resident assessment on admission, discharge and significant change to help determine the staffing needs. (Level 1 care- 60 minutes per day, Level 2 care- 90 minutes per day, Level 3- 120 minutes per day). b. The Registered Nurses will be inserviced on the Resident Level of care tool and the procedure. (Attachment 20) 	<p>11/23/15 RHS</p>
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	<p>duty to care for the 85 residents of the facility. With two of those five CNAs assigned to care for the eleven residents on the locked unit, three CNAs would then be providing assistance to the remaining 74 residents of the facility.</p> <p>A review of the staffing compared to the care needs of the facility's residents not residing on the special memory care unit was conducted by the surveyor on 9/13/15 at approximately 2:45 PM using information provided by the three CNAs on duty (E12, E13, and E14). It was determined that each CNA was assigned to provide services to between 23 and 27 residents on the 7 AM to 3 PM shift on 9/13/15. Each CNA's assignment of 23 – 27 residents included 8 – 11 residents each who required total or partial staff assistance to perform activities of daily living. In an 8 hour shift (not taking into account any meal break), this would mean that the CNAs would have an average of 20 minutes of time to provide services to each resident on their assignment.</p> <p>During the survey, a non-employee volunteer (E6) from an outside agency was observed sitting with two female residents (R4 and SS1). On 8/7/15 at 12:40 PM, E6, explained to the surveyor that she was a volunteer senior companion from a community agency who provided supervision and assistance to R4 and SS1 at the request of their families who arranged for volunteer services on their own to meet the care needs of the two residents. E6 informed the surveyor that the family of R1 had contacted her agency to inquire about having her also supervise and assist R1, in addition to R4 and SS1. On 8/3/15 at 12:50 PM E8 (spouse of R4) confirmed to the surveyor that he arranged for a volunteer senior companion</p>	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place?</p> <p>a. The Executive Director will monitor the use of the Resident Level of care service tool using the Daily staffing assignment sheets monthly x 3 months, then quarterly x 3 for compliance. All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.</p>	<p>11/23/15 RHS</p>
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<p>3225.16.19</p>	<p>to provide care to R4 in the facility for 6 - 8 hours per day five days a week to ensure that her care needs were met because his wife, R4, required staff assistance with toileting, bathing, hygiene, and meals. Interview with E7 (outside agency volunteer coordinator) on 8/10/15 at 11:50 AM revealed that the volunteers from her agency are intended to provide respite for family members and are not intended to provide staffing support to any facility. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p> <p>The assisted living facility shall provide orientation training to all new staff.</p> <p>Based on staff interviews and review of orientation documentation it was determined that the facility lacked an effective system for ensuring that orientation (including skills verification) was documented for two out of two CNAs (E9 and E10) for whom this information was requested. In addition, the orientation provided by the facility to new CNAS did not include orientation to the actual assignment they would have once off orientation. Findings include:</p> <p>The facility was unable to provide an orientation skills verification check list for two out of two CNAs (E9 and E10) whose orientation skills checklist was requested by the surveyor. Review of the facility's orientation provided to E9 and E10 revealed that orientation was not coordinated with the actual assignments E9 and E10 would have when orientation was completed. On 8/4/15 at 1:10 PM, E4 (SD) explained to the surveyor that there was a one day general orientation and then new CNAs received five shifts of orientation working alongside a CNA. E4 explained that they generally allow the newly hired CNAs to</p>	<p>3225.16.19 The assisted living facility shall provide Orientation training to all new staff.</p> <ol style="list-style-type: none"> 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? <ol style="list-style-type: none"> a. E 9 and E 10 are no longer employed at State Street Assisted Living. b. An Orientation with Skills CNA/ RA check off list has been revised and implemented on 9/1/15. (Attachment 21) c. Paper generated CNA flowsheets were implemented on 8/8/15 which identify the care needs of each resident assigned to the CNAs care. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ol style="list-style-type: none"> a. An audit of all current CNA/RA skills checklist has been completed and corrected. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ol style="list-style-type: none"> a. The Department Heads will be inserviced on the policy/ procedure for Orientation. (Attachment 22) b. The Human Resource Manager will monitor that the procedure is being followed and employees will not be given an assignment until completed. 	<p>11/23/15 RHS</p>
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<p>3225.16.23</p>	<p>choose what days they can complete orientation on and then match them to work with the most effective CNA working those days. E4 stated that the actual assignment the newly hired CNAs would have when off orientation was not a factor in deciding which assignment they were given for orientation.</p> <p>E4 explained that one CNA could be assigned up to 25 or more residents to provide care to and acknowledged that when the tablets (small, portable computers) were not functioning, there was no established back-up plan known to all staff for readily identifying the care needs of each resident assigned to their care. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 AM</p> <p>Written policies and procedures shall be required and adhered to for any assisted living facility utilizing volunteers.</p> <p>Based on policy and procedure review and interviews, it was determined that the facility lacked written policies / procedures related to volunteers. Findings include:</p> <p>A volunteer senior companion (E6) was observed on the specialized memory care unit throughout the survey providing care to R4 and SS1. When policies / procedures related to volunteers were requested from the facility, the surveyor was provided with a newly drafted one dated 8/7/15, however, the use of volunteers from outside agencies was not addressed. There was a lack of written policies / procedures related to the use of volunteers from outside agencies although a volunteer was regularly coming to the facility (5 days a week) to provide care to R4 and SS1. Interview with E7 (outside agency volunteer coordinator) on 8/10/15 at 11:50 AM revealed that the volunteers from her agency are intended to provide respite for</p>	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Human Resource Manager will monitor that the Procedure is being followed using the audit tool that includes the date of hire, orientation and skills check off list completed and in employee file of all direct caregivers weekly x 4, monthly x 3 and then quarterly x 3. (Attachment 23) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcome.</p> <p>3225.16.23 Written policies and procedures shall be required and adhered to for any assisted living facility utilizing volunteers.</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. The policy and procedure on Private Duty Assistant/ Volunteer was reviewed and revised. (Attachment 24)</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>a. All Private Duty Assistant/ Volunteers currently employed by residents families have been contacted about the revised policy and procedure.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>a. The policy and procedure on Private Duty Assistant/ Volunteer was reviewed and revised to include PrivateDuty Assistant/ Volunteer may not perform any services for any other resident other than their assigned residents.</p>	<p>11/23/15 RHS</p>
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family members and are not intended to provide staffing support to any facility. E7 explained that her agency has a "Memorandum of Understanding" (a formalized agreement that defines roles and expectations between two groups) with some locations where the volunteers go but not with this facility. Observations and interviews by the surveyor throughout the survey confirmed that E6 was functioning as a caregiver in the facility by routinely providing care and services to residents of the locked unit. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.

3225.17.0 Environment and Physical Plant

3225.17.5.3 Bedrooms and all bathrooms used by residents in assisted living facilities, except in specialized care units for memory impairment, shall be equipped with an intercom or other mechanical means of communication for resident emergencies. For specialized care units for memory impairment, staff must be equipped to communicate resident emergencies immediately.

Based on record review, staff interviews, and review of incident report documentation, it was determined that the mechanical means (walkie talkies) provided to staff to use in resident bedrooms to communicate, including communication of resident emergencies, was ineffective resulting in delayed emergency response for one (1) of thirteen (13) residents reviewed (R2). It was determined that a call for emergency assistance made by a staff member using the walkie talkies would be over ridden by the verbal, repeated automated announcements over the walkie talkie system that occurred anytime a resident in the building pushed their pendant

- b. A Private Duty Assistant/ Volunteer Check off list has been developed and implemented include assigned residents, community rules and specific duties.
 - c. A letter was sent to the families to notify of the policy change on Private Duty/ Volunteer.
 - d. The procedure was added to the Admisslon Packet
 - e. The Staff will be Inserviced on the revised Policy and procedure for Private Duty Assistant/ Volunteer. (Attachment 25)
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?
- a. The Executive Director will monitor the procedure on Private Duty Assistant/ Volunteer by communicating with the DON and reviewing the binder for completion of the check off list weekly x 4 weeks, monthly x 3 months, Then quarterly x 3 for compliance. All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.

3225.17.0 Environment and Physical Plant

3225.17.5.3 Bedrooms and all bathrooms used by Residents in assisted living facilities, except in specialized care units for memory impairment, shall be equipped with an intercom or other mechanical means of communication for resident emergencies. For specialized care units for memory impairment, staff must be equipped to communicate resident emergencies immediately.

- 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?
 - a. R2 was discharged from the community on 2/12/15
- 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
 - a. All residents have the potential to be affected.

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<p>3225.18.0 3225.18.1</p>	<p>button (a type of call bell) for staff assistance. The facility lacked a system that allowed for an emergency call for assistance to be made and heard without delay. Findings include:</p> <p>Cross-refer 16 Del. Code Chapter 11, Subchapter III, § 1131 (10)a, example 1. On 2/12/15, E9 (CNA) was unable to obtain timely assistance for R2 in an emergency situation (R2 had fallen and hit her head and was bleeding from the head). The walkie talkie system in use by the facility at the time failed to allow for an emergency call for help to break-in or override routine call bells going off over the walkie talkie system. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p> <p>Emergency Preparedness</p> <p>Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.</p> <p>Based on record review and staff interviews, it was determined that two (2) of thirteen (13) residents reviewed (R7 and R13) smoked in their rooms at times in violation of facility policy and placing the facility out of compliance with applicable state and local fire and building codes. Both residents were issued written warnings by the facility that smoking in their rooms was a violation of State law and facility policy and that according to the facility's smoking policy, "smoking is not permitted inside the building" and was allowed outside only. Findings include:</p> <p>1. During the initial tour of the facility on 7/26/15 at approximately 2:23 PM, an obvious odor of cigarette smoke was</p>	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>a. The Radio System was updated to include an emergency feature. If the pendants are being announced back to back, Hold the talk button in between the pendant announcements and this will free up the system so that staff can call out to a nurse to come to the emergency with location and emergency code on 9/16/15.</p> <p>b. A procedure for the Emergency Radio Call was completed on 9/16/15. (Attachment 26)</p> <p>c. The Staff have been inserviced on the Radio System emergency call procedure. (Attachment 27)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Director of Nursing/ Human Resources will monitor the Emergency Radio Call procedure by using the procedure form and requesting a return demonstration of the procedure weekly x 8 weeks, monthly x 3 months, Then quarterly x 3 for compliance. All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.</p> <p>3225.18.0 Emergency Preparedness 3225.18.1 Nursing facilities shall comply with the rules And regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.</p> <p>1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</p> <p>a. R 7 was counseled and received a 30 day discharge notice on 7/29/15. A second 30 day notice was issued on 11/12/15. R 7 is receiving supervision while in his apartment.</p> <p>b. R 13 was counseled and received a 30 day discharge notice on 11/15/15. R 13 is receiving supervision while she is awake, up in her apartment. She has no access to her cigarettes/ lighter while she is in bed.</p>	<p>11/23/15 RTJ</p>
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**DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: State Street Assisted Living

DATE SURVEY COMPLETED: September 22, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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<p>3225.19.0 3225.19.7 3225.19.7.5</p>	<p>detected by the surveyor outside the room of R7. E3 who was giving the surveyor the tour of the building stated that R7 was the resident who had passed the surveyor and E3 a few minutes earlier as he walked down the hall. E3 opened the door to R7's room at the request of the surveyor and a very strong odor of cigarette smoke was noted by both the surveyor and E3. Record review revealed that the written warning issued to R7 by the facility on 7/26/15 was the second written warning to R7 for smoking in the facility.</p> <p>2. The clinical record for R13 contained a nursing note dated 4/3/15 and timed 8:19 AM documenting that when E18 (former DON) went to talk to R13 about reports that she (R13) was smoking in her room the previous day (4/2/15), E18 smelled cigarette smoke outside of R13's room. A written warning for smoking in the facility was issued to R13 dated 4/2/15 with a second warning dated 5/19/15 also issued. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 AM.</p> <p>Records and Reports</p> <p>Reportable incidents include:</p> <p>Resident elopement.</p> <p>Based on record review and staff interview, it was determined that for one (1) of thirteen (13) residents reviewed (R8) the facility failed to report to the State survey agency that R8 left facility property and happened to be found by the family member of another resident who returned R8 to the facility. This elopement was not reported to the State survey agency nor was an investigation conducted. Findings include:</p> <p>According to a nursing note dated 6/21/15 and timed 2:50 PM, R8 (a resident with known dementia) was found standing on the</p>	<p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>a. All residents that smoke have been reviewed for any smoking in the building and action taken to correct any issues as needed.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>a. The Director of Nursing has met with other known smokers to review State Streets House rules for smoking .</p> <p>b. The House rules for smoking will be reviewed in the Monthly Resident Council Meeting</p> <p>c. The Staff will be inserviced on the House rules for smoking . (Attachment 28)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Executive Director will monitor the adherence to the House rules for smoking by auditing any reports of resident smoking inside the building weekly x 8 weeks, monthly x 3 months, Then quarterly x 3 for compliance. All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.</p> <p>3225.19.0 Records and Reports</p> <p>3225.19.7 Reportable incidents include:</p> <p>3225.19.7.5 Resident elopement</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. R 8 was returned to the community by another resident family member without distress or injury. Any further incidents will be reported to the State Survey Agency. When R8 is outside she will be supervised by staff.</p>	<p>4/23/15 RTH</p>
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<p>16 Del. C., Chapter 11, Subchapter III; § 1131</p>	<p>corner of two busy streets near the back of the facility by the family member of another resident who reported to facility staff that he parked his car and made his way to R8 as she was attempting to cross the street and then returned her to the facility. A review of State agency reported incidents was conducted during the survey and revealed no report of this elopement by the facility. In a conference call with the surveyor on 8/14/15 at approximately 9 AM, E1 confirmed that this elopement was not reported by the facility because at the time R8 had a service agreement allowing her to be outside. E1 stated that in hindsight the elopement should have been reported with a change in services implemented. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p> <p>Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients 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>(10) "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>Cross refer to 3225.19.7.2 Neglect as defined in Del. C. § 1131.</p> <p>Based on record review, interviews, and review of other documentation as indicated, it was determined that for four (4) of thirteen (13) residents reviewed (R2, R8, R9, and R11) the facility failed to ensure that the</p>	<ol style="list-style-type: none"> 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ol style="list-style-type: none"> a. The Incident Reports will be reviewed daily by the Registered Nurse/ Executive Director for Reportable Incidents and Issues identified will be corrected immediately. And if appropriate will be reported to the State agency. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ol style="list-style-type: none"> a. The Nurses will be re-educated on the requirements of State Reportable Incidents and communication with the Registered Nurse. (Attachment 29) b. The Incident Reports will be reviewed daily by the Registered Nurse/ Executive Director for Reportable Incidents and initiate appropriate interventions and shall be in full compliance for reporting. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? <ol style="list-style-type: none"> a. The Executive Director and Registered Nurse will review all incidents for appropriate reporting daily and if appropriate shall be reported. All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes. 	<p>11/23/15 RHS</p>
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	<p>residents' care and safety needs were met. R2 received a head injury when she was transferred by a staff member without the use of a walker as required by her service agreement. R8 eloped from facility property multiple times and had no elopement prevention plan (supervision) in place for the times she was permitted to go outside of the facility. R9 developed a stage II pressure sore of the buttocks which was initially identified as a discolored area of intact skin. No order for treatment of the area was obtained until after the area had progressed to a stage II pressure sore (shallow, open area) and the surveyor intervened. R11 was at high risk for elopement but the facility failed to include in R11's service agreement a plan for supervision when R11 was outside. Consequently, R11 was able to leave facility property without staff being aware. The facility lacked effective systems for communicating care needs and changes in condition among staff members to ensure that required changes to resident care occurred. Facility policies and procedures related to elopement and wound care were not followed. Findings include:</p> <p>1. Cross refer 3225.12.3 and 3225.17.5.3. R2 had a UAI dated 12/3/14 which indicated that she required physical assistance from a staff member for transfers and used a walker for assistance when transferring. According to an incident report dated 2/12/15, after 5 PM that evening R2 lost her balance and fell hitting her head while being transferred from her recliner chair to a wheelchair in her apartment in the facility sustaining a bleeding head wound and bruise of the head along with a puncture wound of the face. The facility obtained two (2) written statements by E9 describing the incident. In the first statement dated 2/12/15,</p>	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? a. R2 was discharged from the community on 2/12/15.</p> <p>2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. All residents will have transfer status reviewed and documented on the Service Agreement and CNA flowsheet.</p>	<p>11/23/15 RTH</p>
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	<p>E9 wrote that at about 5:15 PM, she placed her right arm under R2's left armpit while her (E9's) left hand was on the wheelchair. E9 wrote that when R2 became shaky as she (R2) stood up, E9 tried to move her left hand from the wheelchair to R2 but R2 fell to the floor before she was able to. The second written statement obtained from E9 by the facility was dated 2/14/15 and in this statement, E9 wrote that she had gone to R2's room between 5:15 PM and 5:20 PM and assisted her to transfer by placing her right arm under R2's underarm with her (E9's) left hand on the wheelchair. E9 wrote that she helped R2 stand but R2 became shaky so she tried to help R2 stand straight but R2 fell to the ground hitting her head. E9 wrote that she kept calling for help on the walkie talkies but she could not be heard because the walkie talkies repeatedly broadcast the routine calls for assistance coming from other residents who were pushing their call buttons. (E9) wrote that she didn't think her call for help was heard. E9 wrote that she opened the door yelling "I need help" and she saw R8 (a resident with dementia who wanders around the facility) so she sent R8 to get the nurse.</p> <p>In an interview with the surveyor on 8/4/15 at 10:25 AM, E9 stated that during the transfer of R2 she had one hand on R2 to guide her and as R2 came up out of the recliner her (R2's) upper body was bent forward and her arms were in mid-air (nothing to hold or reach for such as a walker) and R2 lost her balance falling to the floor and hitting her head on the floor. E9 recalled that she immediately saw a lot of blood coming from R2's head. E9 explained that as a new CNA this was the first fall she had seen and she immediately began calling "Code Purple" (fall) over the walkie talkie. E9 stated that she</p>	<p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>a. The <u>policy and procedure for Service Agreement/ Care plan/ CNA flowsheet</u> was reviewed and revised to include that interventions will be placed on the CNA flowsheet. (Attachment 12)</p> <p>b. Paper generated CNA flowsheets were implemented on 8/8/15 with transfer status addressed. The CNA will refer to the flowsheet for the residents transfer status and the residents who need assistance and/or assistive devices will be posted on the inside of the apartment door.</p> <p>c. Nursing Staff will be inserviced on the policy and procedure for Service Agreement/ Care plan/ CNA flowsheet (Attachment 13)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</p> <p>a. The Executive Director and /or the Registered Nurses will monitor the compliance with the policy and procedure using the Transfer Status audit tool that includes transfer status including devices used, transfer status on UAI, service plan, CNA flow sheet and posted in residents apartment weekly x 8 weeks, monthly x 3 months, then quarterly x 3 for compliance. (Attachment 14) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.</p>	<p>11/23/15 RHS</p>
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	<p>didn't want to leave the resident alone so she kept trying to call for help on the walkie talkie for the next 5 or 6 minutes despite the routine call bell messages that were coming over the walkie talkie at the time. E9 recalled that R2 seemed to be in pain and was moving side to side on the floor. E9 stated that after getting no response she opened the door calling for help and saw R8 in the hall. E9 stated that she told R8 to go get help. E9 recalled that R8 did go tell the nurse and a nurse responded to the room several minutes later with 911 then being called.</p> <p>According to the report by the ambulance crew who responded to the 911 call, they were dispatched at 5:38 PM and arrived at R2's side at 5:45 PM and observed bleeding and swelling of R2's face. This would have been approximately 20 minutes after R2 had fallen. R2 was transported to the hospital via ambulance for evaluation and treatment of her head and facial injuries.</p> <p>During the interview on 8/4/15 at 10:25 PM, E9 stated that she had never been trained on how to care for R2 because R2 resided on the 2nd floor of the facility and E9's training had been with 3rd floor residents. E9 stated that she had not been shown by anyone how to get R2 up out of her recliner and that the tablets which had resident care information for CNAs to access were not working at the time. E9 stated that while she had transferred R2 on previous occasions, this was the first time R2's legs became shaky.</p> <p>The facility failed to meet the physical and safety needs of R2. The facility failed to ensure that R2 was transferred with the use of her walker as required by her service agreement. The facility failed to have an effective emergency call system in place resulting in a delay of approximately 10 - 15</p>		<p>11/23/15 RTH</p>
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	<p>minutes for getting emergency assistance to R2 following a fall with bleeding from the head and face.</p> <p>2. Cross refer 3225.5.5, example 1 and 3225.13.6.</p> <p>According to a UAI dated 4/21/15 R8 had dementia and a short term memory problem with a history of wandering outside. The facility failed to meet the safety needs of R8 by not recognizing her need for direct supervision when outside of the facility. The facility is located near busy city roads and intersections; however, it was the practice of the facility to allow R8 to spend time outside of the facility without direct staff supervision. This practice placed R8 at risk when she crossed nearby streets or attempted to cross. The facility failed to provide effective supervision to R8 when she was outside and consequently she was able to leave facility property without the knowledge or assistance of facility staff (as described in nursing notes on 6/21/15 timed 2:50 PM and 7/28/15 timed 9:07 AM).</p> <p>3. Cross-refer 3225.11.5.</p> <p>R9 developed an open stage II pressure sore after facility staff failed to ensure that a treatment order was received for a discolored but intact pressure area of the buttocks. R9 failed to receive treatment and monitoring of this pressure area as required by the facility's Wound Care policy / procedure. In addition, the facility failed to meet the physical care needs of R9 by failing to reassess his condition and care needs when he experienced a significant, overall decline in function during July and August of 2015. A stage II pressure sore was identified by a facility nurse who was called to assess the area at the request of the surveyor who was told of the open sore by E12 (CNA). Nursing</p>	<ol style="list-style-type: none"> 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? <ol style="list-style-type: none"> a. R8 elopement prevention plan has been reviewed and revised to include staff supervision when outside. R8 was moved to the secured memory care unit on 9/9/15. b. R11 elopement prevention plan has been reviewed and revised to include staff supervision when outside. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ol style="list-style-type: none"> a. All residents will have an elopement risk reassessment completed. Those identified at risk will have the elopement prevention plan reviewed and revised as needed to include staff supervision when outside. b. Elopement risk assessments will be completed on admission, quarterly and with a significant change in status. Elopement prevention plans will be implemented on residents identified at risk to include staff supervision when outside. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ol style="list-style-type: none"> a. The Elopement policy and procedure was reviewed and revised to include any resident at risk will have staff supervision when outside. (Attachment 1) b. The Wanderguard Door System was updated to include automatic self locking of the front door and parlor door when a resident with a wanderguard approaches. The Door System will be checked q shift for proper functioning. Residents at risk will have supervised staff time outside. c. Staff will be inserviced on the revised Elopement policy and procedure. (Attachment 2) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place? <ol style="list-style-type: none"> a. The Executive Director and/or the Director of Nursing will monitor the Elopement Policy and procedure weekly x 8 weeks, monthly x 3 months, then quarterly x 3 for compliance. (Attachment 3) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes. 	<p>11/23/15 RHS</p>
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	<p>note documentation confirmed that the pressure area had first been reported to a nurse on 7/22/15 who documented at 9:44 PM that a message was left for a physician. No follow-up (e.g. treatment order) to this message had been received as of 8/7/15 until the surveyor intervened.</p> <p>4. Cross-refer 3225.5.5, example 2.</p> <p>R11 was a resident with dementia known to be at risk for eloping from the facility. Despite the known risk, the facility failed to establish and implement a plan for direct supervision of R11 when she was outside of the facility. Consequently, on 4/21/15 R11 left facility property and happened to be found a block away by a staff member who was leaving the facility. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.</p>	<ol style="list-style-type: none"> 1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice? <ol style="list-style-type: none"> a. R 9 had a significant change UAI completed on 8/7/15. R9 had orders obtained for treatment of wound on 8/7/15. R9 wound resolved on 9/15/15. A PT evaluation was completed on 11/11/15. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? <ol style="list-style-type: none"> a. All residents will have a pressure ulcer risk assessment completed. Residents identified at risk will have a pressure ulcer plan implemented on the Service Agreement and CNA flowsheet. b. Pressure ulcer risk assessments will be completed on admission, quarterly and with a significant change in status. Skin prevention/ treatment plans implemented on residents identified at risk. c. The 24 hour reports are reviewed daily by the licensed nurse for changes in condition/ ADLs and interventions will be initiated and reported to the Director of Nursing/ Memory Care Program Coordinator.. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? <ol style="list-style-type: none"> a. The Pressure ulcer risk / treatment policy and procedure will be implemented and includes identification of residents at risk, prevention, obtaining physician orders and implementation of treatment plan. (Attachment 7) b. Nursing Staff will be inserviced on the revised Pressure ulcer risk / treatment policy and procedure to include immediate MD notification of skin issues ,prompt treatment orders, documentation and notification of the DON/ED/ Memory Care Program Coordinator. Nursing staff will be inserviced on monitoring for changes in condition/ ADLs and appropriate interventions and documentation of changes in status.(Attachment 8) 	<p>11/23/15 RTH</p>
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4. Cross-refer 3225.5.5, example 2.

R11 was a resident with dementia known to be at risk for eloping from the facility. Despite the known risk, the facility failed to establish and implement a plan for direct supervision of R11 when she was outside of the facility. Consequently, on 4/21/15 R11 left facility property and happened to be found a block away by a staff member who was leaving the facility. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.

- c. The DON/ Memory Care coordinator will review the 24 hr reports, meet with the LPNs and CNAs to discuss resident changes in condition/ skin issues/ ADLs. When a skin issue is identified, an incident report will be completed, a nurses note completed, the physician and family notified, treatment orders obtained and the DON/ED/ Memory Care Coordinator notified. The DON/ Memory Care coordinator will follow up with the nurse to ensure physician orders have been obtained and implemented.
- d. Weekly Wound tracking will be continued to include wound measurements, status, and recommendations. (Attachment 9)
- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?
 - a. The Director of Nursing/ Memory Care Program Coordinator will monitor the Pressure Ulcer risk/ treatment Policy and procedure using a tracking tool that includes date of assessment, physician notification, treatment orders, change reflected on UAI, and Interventions on the service plan and CNA flowsheet weekly x 8 weeks, monthly x 3 months, then Quarterly x 3 for compliance (Attachment 10)
The DON/ Memory Care Coordinator will monitor changes in condition using a tracking tool that includes date of change, type of change, plan on UAI, service plan and CNA flowsheet weekly x 8 weeks, monthly x 3 months, then Quarterly x 3 for compliance. (Attachment 11) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.

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4. Cross-refer 3225.5.5, example 2.

R11 was a resident with dementia known to be at risk for eloping from the facility. Despite the known risk, the facility failed to establish and implement a plan for direct supervision of R11 when she was outside of the facility. Consequently, on 4/21/15 R11 left facility property and happened to be found a block away by a staff member who was leaving the facility. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?
 - a. R2 was discharged from the community on 2/12/15
2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
 - a. All residents have the potential to be affected.
3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?
 - a. The Radio System was updated to include an emergency feature. If the pendants are being announced back to back, Hold the talk button in between the pendant announcements and this will free up the system so that staff can call out to a nurse to come to the emergency with location and emergency code on 9/16/15.
 - b. A procedure for the Emergency Radio Call was completed on 9/16/15. (Attachment 26)
 - c. The Staff have been inserviced on the Radio System emergency call procedure. (Attachment 27)
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?
 - a. The Director of Nursing/ Human Resources will monitor the Emergency Radio Call procedure by using the procedure form and requesting a return demonstration of the procedure weekly x 8 weeks, monthly x 3 months, Then quarterly x 3 for compliance. All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcomes.

11/23/15
RTH

Provider's Signature _____ Title _____ Date _____



**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

NAME OF FACILITY: State Street Assisted Living

DATE SURVEY COMPLETED: September 22, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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note documentation confirmed that the pressure area had first been reported to a nurse on 7/22/15 who documented at 9:44 PM that a message was left for a physician. No follow-up (e.g. treatment order) to this message had been received as of 8/7/15 until the surveyor intervened.

4. Cross-refer 3225.5.5, example 2.

R11 was a resident with dementia known to be at risk for eloping from the facility. Despite the known risk, the facility failed to establish and implement a plan for direct supervision of R11 when she was outside of the facility. Consequently, on 4/21/15 R11 left facility property and happened to be found a block away by a staff member who was leaving the facility. These findings were confirmed with E1 and E2 at the exit conference on 9/22/15 at 9:30 A.M.

1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?
 - a. E 9 and E 10 are no longer employed at State Street Assisted Living.
 - b. An Orientation with Skills CNA/ RA check off list has been revised and implemented on 9/1/15. (Attachment 21)
 - c. Paper generated CNA flowsheets were implemented on 8/8/15 which identify the care needs of each resident assigned to the CNAs care.
2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
 - a. An audit of all current CNA/RA skills checklist has been completed and corrected.
3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?
 - a. The Department Heads will be inserviced on the policy/ procedure for Orientation. (Attachment 22)
 - b. The Human Resource Manager will monitor that the procedure is being followed and employees will not be given an assignment until completed.
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?
 - a. The Human Resource Manager will monitor that the Procedure is being followed using the audit tool that includes the date of hire, orientation and skills check off list completed and in employee file of all direct caregivers weekly x 4, monthly x 3 and then quarterly x 3. (Attachment 23) All findings will be reviewed at the Quality Assurance meeting to determine the need for further recommendations or to improve outcome.

11/23/15
RttJ

Provider's Signature _____ Title _____ Date _____