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: Luther Towers I & II

DATE SURVEY COMPLETED: June 13, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning June 8, 2011 and ending June 13, 2011. The resident census on the entrance day of the survey was 53. The survey sample totaled 5 residents. The survey process included observations, interviews, review of residents' clinical records, facility documents and facility policies and procedures.	
3225.0	**Assisted Living Regulations**	
3225.18.0	**Fire Safety and Other Emergency Plans**	
3225.18.1	**The assisted living facility shall comply with all applicable state and local fire and building codes. All applications for license or renewal of license shall include a letter certifying compliance by the Fire Marshall having jurisdiction. Notification by the Fire Marshall of noncompliance with the Rules and Regulation of the State Fire prevention Commission shall be grounds for enforcement remedies in 16 Del. C. CH. 11, Subchapter 1, Licensing By The State.** **This requirement is not met as evidenced by:** Based on staff interview it was determined that the facility failed to provide a letter certifying compliance with applicable state, local and building codes by the Fire Marshall having jurisdiction. Findings include: In an interview conducted with E1 (assisted living administrator) on 6/13/2011 it was confirmed that a letter	A copy of a letter from the Wilmington Fire Marshall's Office certifying compliance with the codes has been requested and will be forwarded to DLTCRP when it is received. **Completion Date: August 15, 2011**

Provider's Signature [illegible] NHA Title Administrator Date 7/12/11

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	certifying compliance with applicable state, local and building codes by the Fire Marshall having jurisdiction, was unavailable.	
3225.18.4	**The assisted living facility shall promote staff knowledge of fire and other emergency safety by:**	
3225.18.4.3	**Conducting fire drills in accordance with State of Delaware Fire Prevention Regulations.** **This requirement is not met as evidenced by:** Based on staff interview it was determined that the facility failed to conduct fire drills in accordance with State of Delaware Fire Prevention Regulations. Findings include: In an interview conducted with E1 (assisted living administrator) on 6/10/2011 this surveyor was informed that the facility lacked documentation of any fire drills performed for the year 2010 and first half of the year 2011. Instead this surveyor was handed a list of facility documented "Fire Alarm Occurrences" with date, time and location by E1 (assisted living administrator) that occurred during the year 2010 and first half of the year 2011. The facility failed to conduct fire drills in accordance with State of Delaware Fire Prevention Regulations. This finding was reviewed with E1 (assisted living Administrator) and E3 (staff nurse) on 6/13/2011.	When the Facility Administrator discussed the need for regular fire drills with the Wilmington Fire Marshall's Office, he was advised the WFD will conduct the drills, but there was no follow through with this. The facility will immediately begin conducting its own drills on a quarterly basis on each of the three shifts and will report the outcomes of these drills to the Quality Assurance Committee. The Committee will monitor this process to ensure the deficient practice does not recur. **Completion Date: July 30, 2011**
3225.18.4.5	**Maintaining records for two years of facility fire and other emergency drills/training sessions.**	

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	This requirement is not met as evidenced by: Based on staff interview it was determined that the facility failed to maintain two years of facility fire drills. Findings include: In an interview conducted with E1 (assisted living administrator) on 6/10/2010 this surveyor was informed that the facility lacked records of the performance and documentation of fire drills for all shifts during the year 2010 and first half of the year 2011. The facility failed to maintain documentation of facility fire drills conducted on all shifts from January 1, 2010 through May 31, 2011. This finding was reviewed with E1 (assisted living Administrator) and E3 (staff nurse) on 6/13/2011.	The Facility Administrator will maintain a formal record of each drill which is conducted. The record will be presented quarterly to the facility Quality Assurance Committee. The Committee will monitor this process to ensure the deficient practice does not recur. **Completion Date: July 30, 2011**
3225.13.0	**Service Agreements**	
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility developed a service agreement that failed to address all assessed needs with goals and interventions for one resident (Resident #1) out of three sampled. Findings include:	

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	Clinical record review revealed a care plan developed for Resident #1that failed to address behaviors of resistance to care including noncompliance of diet with measurable goals and specific interventions. This finding was reviewed with E1 (assisted living administrator) and E3 (staff nurse) on 6/13/2011.	1. This resident was hospitalized prior to the onset of the annual survey. She has since been permanently transferred to a LTC facility. However, in the case of Resident #1, it is recorded on the weekly care sheet that the resident is reminded several times daily that it would be appropriate to come out of the apartment and participate in a community activity or meal. See attached care sheet (Attachment "A") and monthly wellness check (Attachment "B"). 2. During the UAI process, it is frequently not Immediately evident that a resident will be resistant to a level of care. Once this becomes apparent, the resident will be monitored more closely by the staff, and additional efforts will be made in the particular area of resistance. 3. All residents are reminded daily to participate in meals in the common area, and to attend activities that are available. All residents are told at the time of admission of the expectation of participation in the common areas at mealtimes. 4. Care sheets will be reviewed randomly on a monthly basis to determine any resident who is resisting any level of care. The results of this review will be reported to the facility Quality Assurance Committee quarterly. **Completion Date: August 30, 2011**