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: BROOKDALE WHITE CHAPEL **DATE SURVEY COMPLETED: December 16, 2016**

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 December 1, 2016 and ending December 16, 2016. The facility census on the entrance day of the survey was 99 residents. The survey sample was composed of nine residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations/definitions used in this state report are as follows:** **ED – Executive Director** **DHW – Director of Health and Wellness** **ADHW – Assistant Director of Health and Wellness** **RN – Registered Nurse** **LPN – Licensed Practical Nurse** **FSD – Food Service Director** **UAI – Uniform Assessment Instrument – an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.** **Dementia – a severe state of cognitive**	The following is the Plan of Correction for Brookdale Whitechapel regarding the Statement of Deficiencies dated January 16th, 2017. This Plan of Correction is not to be construed as an admission of agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality of health care services and will continue to make changes and improvements to satisfy that objective. [signature] NHA Executive Director POC Acceptance 2/27/17 [initials]

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	impairment characterized by memory loss, difficulty with abstract thinking and disorientation or loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning. Osteoporosis – weakened bones with increased risk of breaking. Parkinson's Disease – a progressive disorder of the nervous system that affects movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination. Osteoarthritis – a disease characterized by deterioration of the connective tissue and underlying bone of an entire joint, most common of arthritis. Lumbar stenosis – a narrowing of the open spaces within the lower back.	
	Regulations for Assisted Living Facilities	
3225	Infection Control	
3225.9.0 3225.9.6	The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents as recommended by the Immunization Practice Advisory Committee of the Center for Disease Control, unless medically contraindicated. All	

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	residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record. **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that the refusal or administration of influenza vaccinations were documented for four residents (R1, R2, R4 and R9) out of 9 residents sampled. Findings include: 1. Clinical record review revealed that documentation of the administration or refusal of the influenza vaccination for R1 was absent for the year 2016. Additionally the facility failed to document any discussion with R1 regarding the health risks involved due to refusal of the influenza vaccine and to document reasons expressed by R1 for refusal of the influenza vaccine or to document reasons why the influenza vaccine was not recorded in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 2. Clinical record review revealed that R2 refused the influenza vaccination for the year 2016. Additionally the facility failed to document any discussion with R2	**3225.9.6** 1. The DHW (HWD) Community Nurse and/or designee will offer the vaccination for influenza to Residents R1, R2, R4 and R9 or and/or document reason(s) for refusal. **Feb 20th** 2. Other residents have the potential to be affected by the alleged deficient practice. Other-residents will be protected by taking the corrective action(s) outlined below in #3. **Feb 20th** 3. A 100% audit of current resident files will be conducted by the licensed nurse/designee to verify all current residents have either documentation of refusal (along with being informed of the risks and benefits of refusal) or will be offered the opportunity to obtain the flu vaccine during the 2016/2017 flu season. This audit was completed on **Feb 28th**

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	regarding the health risks involved due to refusal of the influenza vaccine and to document reasons expressed by R2 for refusal of the influenza vaccine or to document reasons why the influenza vaccine was not recorded in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 3. Clinical record review revealed that documentation of the administration or refusal of the influenza vaccination for R4 was absent for the year 2016. Additionally the facility failed to document any discussion with R4 regarding the health risks involved due to refusal of the influenza vaccine and to document reasons expressed by R4 for refusal of the influenza vaccine or to document reasons why the influenza vaccine was not recorded in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 4. Clinical record review revealed that R9 refused the influenza vaccination for the year 2015. Clinical record review also revealed that documentation of the administration or refusal of the influenza vaccine for R9 was not recorded for the year 2016. Additionally the facility failed to document any discussion with R9	DHW / Designee will verify proper documentation is entered in the resident's medical record. Results of the review will be shared with the Executive Director to assure compliance with the regulation. Corrective action will be taken for records found not in compliance which will include documentation of administration or refusal and re-training of appropriate staff on the importance of proper documentation. **Feb 20th** 4. After the review listed in #3 above has been completed, DHW/Designee will be responsible for completing audits of new move-ins as well as annual audits to verify ongoing compliance. Results of these audits will be provided to the Executive Director for review. The Executive Director will be responsible for directing additional corrective action which will include re-training and disciplining of staff that did not document properly based on audit findings. **Feb 28th - Ongoing**

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	regarding the health risks involved due to refusal of the influenza vaccine and to document reasons expressed by R4 for refusal of the influenza vaccine or to document reasons why the influenza vaccine was not recorded in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM.	
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless specifically, medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that refusals or the administration	**3225.9.7** 1. The DHW (HWD) Community Nurse and/or designee will offer the pneumococcal vaccine to Residents R1, R3, R4 and R9. The administration or refusal of the vaccine will be documented in their medical record. Resident R6 will be re-approached and/or reasons for declination documented. **Feb 20th** 2. Other residents have the potential to be affected by the alleged deficient practice. Other residents will be protected by taking the corrective action(s) outlined below in #3. **Feb 20th**

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	of pneumococcal vaccinations were documented for 5 residents (R1, R3, R4, R6 and R9) out of nine residents sampled. Findings include: 1. Clinical record review revealed that documentation of the administration or refusal of the pneumococcal vaccination for R1 was absent for the year 2016. Additionally the facility failed to document any discussion with R1 regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R1 for refusal of the pneumococcal vaccine or to document reasons why the pneumococcal vaccine was not recorded in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 2. Clinical record review revealed that R3 refused the pneumococcal vaccine in the year 2016. However the facility failed to document any discussion with R3 regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R3 for refusal of the pneumococcal vaccine in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 3. Clinical record review revealed that	3. A 100% audit of current resident files will be conducted by the licensed nurse/designee to verify all current residents have either documentation of being offered the Pneumococcal Vaccine (along with being informed of the risks and benefits of refusal) or will be offered the opportunity to obtain the vaccine for 2016/2017. Proper documentation will be placed in the resident's medical record. Results of the review will be shared with the Executive Director to assure compliance with the regulation. Corrective action will be taken for records found not in compliance which will include documentation of administration or refusal and re-training of staff on the importance of proper documentation. **Feb 28th**

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	documentation of the administration or refusal of the pneumococcal vaccination for R4 was absent for the year 2016. Additionally the facility failed to document any discussion with R4 regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R4 for refusal of the pneumococcal vaccine in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 4. Clinical record review revealed that R6 refused the pneumococcal vaccine in the year 2016. However the facility failed to document any discussion with R6 regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R6 for refusal of the pneumococcal vaccine in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 5. Clinical record review revealed that R9 refused the pneumococcal vaccine for the year 2015. Clinical record review also revealed that documentation of the administration or refusal of the pneumococcal vaccine was not recorded for R9 in 2016. Additionally the facility failed to document any discussion with R9	4. The DHW (HWD) Community Nurse/Designee will be responsible for completing audits of new move-ins as well as annual audits to verify ongoing compliance. Results of these audits will be provided to the Executive Director for review. The Executive Director will be responsible for directing additional corrective actions which will include re-training and disciplining of staff that did not document properly based on audit findings. **<u>Feb 28th - Ongoing</u>**

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	regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R9 for refusal of the pneumococcal vaccine or to document reasons why the pneumococcal vaccine was not recorded in the clinical record. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM.	**3225.11.5** 1. Resident R4 : deficient practice cannot be corrected as UAI was completed 30 days after admission date of 11/3/16, however, all subsequent UAIs are up to date and within timely guidelines for affected resident.
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 and when there is a significant change in the resident's condition.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to ensure that the UAI (Uniform Assessment Instrument) was updated 30 days after the admission of one resident (R4) out of nine residents sampled. Findings include: Review of the R4's clinical record revealed that the 30 day UAI assessment required within 30 days after admission on 11/3/2016 to the assisted living facility was not completed by the facility. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45	2. All residents have the potential to be affected by this deficient practice. The DHW (HWD) Community Nurse and other licensed nurses will be provided re-education related to this requirement by **Feb 20th** Completed 3. The DHW (HWD) Community Nurse and/or designee will review 100% of current resident's medical records to verify resident UAIs have been updated annually. Corrective action will include the re-training of staff on how to properly and annually update a UAI to assure that UAIs are updated annually. This re-training will be provided **Feb 20th completed** Results of the review will be shared with the Executive Director to verify compliance with the regulation. **Feb 20th**

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  3225.12.0 3225.12.1 3225.12.1.3	AM. **Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **This requirement is not met as evidenced by:** Based on observations and interviews during the tour of the kitchen on 12/8/2016, it was determined that the facility failed to comply with sections: 2-402.11 (A), 3-305.11 (A) (2), and 6-301.12 of the State of Delaware Food Code. **2.402 Management and Personnel Hygienic Practices on Hair Restraints** **(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles;** **(B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single**	4. The DHW (HWD) Community Nurse/Designee will be responsible for completing audits of new move-ins as well as conducting quarterly audits to verify ongoing compliance with UAI updates. Results of these audits will be provided to the Executive Director for review. Based on the audit findings, the Executive Director will be responsible for directing additional corrective action which will include re-training and progressive discipline of staff that did not properly annually update the UAI. **Feb 28th - ongoing** **3225.12.1.3** 1. All employees will receive re-education provided by the Dietary Services Manager on use of hair restraints (including beard). Observations will be conducted in an on-going manner and additional corrective action, up to and including termination, may occur, if deficient practices continue. **Feb 20th completed** 2. Residents have the potential to be affected by the alleged deficient practice, therefore all Food Service Associates were re-educated by the Dietary Services Manager/Designee on **Feb 20th & All Staff Meeting Completed** 3. The FSD and/or designee will observe food service employees weekly x 1 month to verify compliance. Observations will occur for 30 days or until 100% compliance with hand washing techniques have been achieved, then ongoing as deemed appropriate by audit findings. Re-training will be provided as necessary and scheduled yearly. The results of the random observations will be reviewed by the Executive Director. **Feb 28th – ongoing Audits**

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	use articles. **This requirement is not met as evidenced by:** 1. Observations at 1:30 PM on 12/8/16 of the food prep area of the main kitchen revealed that all 4 kitchen workers in the food preparation area did not wear hair restraints. The E1 (FSD) was present during the tour and confirmed the finding.	4. The Executive Director and/or designee will conduct random observations for 30 days after 100% compliance as stated above has been achieved. The observations will continue until the Executive Director is assured 100% compliance has been achieved. **Feb 28th** – Ongoing **Sanitation Checklists 2-3 months**
305 3-305.11	**Preventing Contamination from the Premises** **Food Storage** **(A) Except as specified in ¶¶ (B) and (C) of this section, food shall be protected from contamination by storing the food:** **(2) Where it is not exposed to splash, dust, or other contamination.** **This requirement is not met as evidenced by:** 1. Observations at 1:40 PM on 12/8/16 of corn bread in a 9 and 1/2 inch diameter baking sheet stored on the cooling rack in the dry storage room was uncovered. At 1:40 PM an interview with E3 confirmed the finding. **6-3 Physical Facilities Hand sink Numbers and Construction** **6-301.12 Hand Drying Provision** **Each handwashing sink or group**	**3.305.11** 1. The FSD immediately had the baking sheet with cornbread served for lunch covered and dated. Completed Time of Survey. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The FSD will provide training for food service employees on the proper techniques for food storage. The FSD and/or designee will observe food service employees for proper food storage and equipment cleaning and/or maintenance of supplies. Observations will occur for 30 days or until 100% compliance with proper food storage has been achieved. Re-training will be provided if necessary. The results of the observations will be reviewed by the Executive Director. **Feb 28th** 4. The Executive Director and/or designee will conduct random observations for 30 days after 100% compliance as stated above has been achieved. The audits will continue until the Executive Director is assured 100% compliance has been achieved. **Sanitation Checklists 2-3 months**

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	adjacent handwashing sinks shall be provided with: **(A). Disposable towels;** **(B). A continuous towel system that supplies the user with a clean towel;** **(C). A heated-air hand drying device;** **(D). A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.** **This requirement is not met as evidenced by:** Observations at 1:45 PM on 12/8/16 of the dementia dining room revealed that the hand washing station lacked provision for hand drying. Finding was confirmed by E3.	**3.305.12** 1. The Maintenance Manager installed a hand drying station in the Memory Care Dining Room immediately upon notification. Completed Time of Survey. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The FSD will provide training for food service employees on the proper techniques equipment/supply maintenance. The FSD and/or designee will observe food service employees for equipment cleaning and/or maintenance of supplies. The hand towel machine will be restocked as needed. Observations will occur for 30 days or until 100% compliance with equipment/supply maintenance has been achieved. Re-training will be provided if necessary. The results of the observations will be reviewed by the Executive Director. **Feb 28th** 4. The Executive Director and/or designee will conduct random observations for 30 days after 100% compliance as stated above has been achieved. The audits will continue until the Executive Director is assured 100% compliance has been achieved. **Sanitation Checklists 2-3 months**
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, review of facility documents and staff interviews it was determined that the facility failed to ensure that service agreements were appropriately developed, reviewed,	3225.13.5 1. Resident R1, R3, R6, and R8 service agreements will be reviewed to address the specificity of interventions unique to that person's physical and psychosocial needs and in relation to the progression of need due to their diagnoses. Goals will be established to provide for a safe environment with a focus on falls. **Resident R8 has already been discharged from facility. Feb 20th**

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	evaluated and revised to address fall risk and actual falls with measurable goals and specific interventions for four residents (R1, R3, R6 and R8) out of nine residents sampled. Findings include: 1. Review of the clinical record revealed that R1 had diagnoses that included dementia and osteoporosis. Review of the annual UAI (Uniform Assessment Instrument) dated 8/3/2016 revealed that R1 was independent for mobility with an assistive device (walker). The above referenced UAI dated 8/3/2016 also revealed that R1 was oriented to person and place but experienced short-term memory and long-term memory problems. Additionally the UAI dated 8/3/2016 revealed that R1 was also at increased risk for falling due to the risk factors of osteoporosis and confusion. However review of the annual service agreement dated 8/4/2016 revealed that the facility failed to address R1's assessed fall risk or potential for falls with measurable goals and specific interventions. Further review of the clinical record revealed that R1 sustained four falls between July 21, 2016 and November 14, 2016. Three of the four falls required transport of R1 to an acute care facility for evaluation and treatment. The facility also failed to review and to revise the annual service agreement dated 8/4/2016 and to develop, implement and monitor the effectiveness of measurable goals and specific interventions that addressed	2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The DHW (HWD) Community Nurse and/or designee will review 100% of current resident service agreements to verify appropriate goals and interventions are in place to provide a safe environment for residents. This will include an analysis of residents above fall threshold. Corrective action will include Fall Meetings to be initiated and maintained inclusive of "Collaborative Care Meetings" separate and unique from current quality assurance directives. Results may include alteration of fall interventions, increased specificity for goals and measured progress as well as utilization for rehabilitative intervention, hospice and discharge when appropriate. Results of the review will be shared with the Executive Director to assure compliance with the regulation. **Feb 28th** - ongoing

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	actual falls sustained by R1. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM. 2. Clinical record review revealed R3 had diagnoses of dementia and osteoporosis. According to the annual UAI assessment dated 3/6/2016, R3 was oriented to place and person. Additionally the UAI dated 3/6/2016 revealed that R3 experienced short-term memory problems. Although the above referenced UAI revealed R3 was independently mobile with the assistance of a walker and able to transfer herself without assistance, R3 was also assessed as an increased risk for falls due to osteoporosis. The facility failed to address R3's assessed fall risk or potential for falls with measurable goals and specific interventions. Further review of the clinical record revealed an annual service agreement dated 3/6/2016 that failed to address four unwitnessed falls sustained by R3 between 10/11/2016 and 12/2/2016. The facility failed to review and to revise the annual service agreement dated 3/6/2016 with measurable goals and specific interventions after actual falls sustained by R3. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM.	4. The DHW (HWD) Community Nurse and/or designee will maintain fall focus meetings until 95% of census maintain within fall threshold guidelines and have appropriate interventions in place. ED will further conduct random audits of 10% of the service plans monthly until 100% compliance has been achieved. **Feb 28th** - Ongoing

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	3. Clinical record review revealed R6 had diagnoses that included Parkinson's Disease and osteoarthritis. According to the annual UAI assessment dated 4/7/2016 R6 was oriented to person and place and exhibited a short-term memory problem. Review of the above referenced UAI also revealed that R6 required usage of a wheelchair, required observation/standby/transfer assist during toileting and needed standby assistance during transfers. Additionally the UAI dated 4/7/2016 also revealed that R6 was at risk for increased falls due to a "gait problem, impaired balance, Parkinson's Disease and falls occurring in the last 31 to 180 days". Further review of the clinical record revealed that R6 sustained approximately eight unwitnessed falls between 7/1/2016 and 10/15/2016. Two of the eight documented falls required the transport of R6 to an acute care facility for evaluation and treatment. Although review of the annual service agreement dated 4/7/2016 revealed that the facility identified R6's fall risk, it failed to develop measurable goals and specific interventions to address the potential for falls. The facility also failed to review and to revise the annual service agreement dated 4/7/2016 and to develop, implement and evaluate measurable goals and specific interventions that addressed eight actual falls sustained by R6. These findings were reviewed with E1 (Executive Director) and E2 (Assistant	

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	Director of Health and Wellness/RN) on 12/16/2016 at approximately 10:45 AM. 4. Clinical record review revealed R8 had diagnoses that included dementia, osteoporosis and lumbar stenosis. Review of the UAI dated 9/9/2016 revealed R8 needed observation/standby/transfer assist during toileting, the physical assistance of one person for transfers and occasional physical assistance for mobility. The UAI dated 9/9/2016 also revealed that R8 was oriented to place and person but experienced short-term memory problems. Additionally the above referenced UAI revealed that R8 was at increased risk for falling due to the risk factors "osteoporosis, gait problem, impaired balance and confusion". However review of the service agreement dated 9/15/2016 revealed the facility failed to address R8's assessed fall risk with measurable goals and specific interventions. Further review of the clinical record revealed that R8 sustained five unwitnessed falls between 7/8/2016 and 12/12/2016. Three of the five falls revealed R8 attempting to transfer without staff assistance. Two of the three falls occurred in the bathroom while R8 was attempting to transfer herself from the toilet to the wheelchair or from the wheelchair to toilet. The remaining three falls occurred as R8 was attempting to transfer without staff assistance from her bed to wheelchair in her room.	

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	Additionally review of the service agreement for a significant change dated 9/15/2016 revealed the facility failed to develop, implement and monitor the effectiveness of measurable goals and specific interventions that addressed five actual falls sustained by R8. These findings were reviewed with E1 (Executive Director) and E2 (ADHW/RN) on 12/16/2016 at approximately 10:45 AM.	3225.19.6 1. Deficient practice cannot be corrected as beyond the reporting requirement. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3.
3225.19.0 3225.19.6	**Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **This requirement is not met as evidenced by:** Based on review of the clinical record, facility documents and staff interview it was determined that the facility failed to report four reportable incidents affecting two residents (R1 and R6) out of nine residents sampled to the Division within 8 hours. Findings include: 1a. Clinical record review revealed that R1 was transferred to an acute care facility on 7/21/2016 after sustaining a fall with complaints of head and neck discomfort. Review of the facility incident report	3. The DHW (HWD) Community Nurse and/or designee has completed in-servicing and re-education of all staff responsible for reporting requirement. **Feb 20th** 4. The Executive Director and/or designee will conduct random observations for 30 days after 100% compliance as stated above has been achieved. Comparison will be made between falls and other quality assurance incidents and those requiring reporting within 8 hours. Any significant events from morning report will be assessed for requirement. **Feb 28th** - ongoing

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	revealed that R1 was observed ambulating with her walker when she lost her balance and fell backwards. The facility failed to report the incident to the Division after R1 was transferred to an acute care facility for evaluation and treatment of head and neck injuries. These findings were reviewed with E1 (Executive Director) and E3 (ADHW/RN) and confirmed during the exit conference on 12/16/2016 at approximately 10:45 AM. 1b. Clinical record review revealed that R1 was transferred to an acute care facility on 10/17/2016 after sustaining a fall with complaints of pain affecting her head and neck. Review of the facility incident report revealed that R1 was observed ambulating with her walker when she lost her balance and fell backwards hitting her head on the floor. The facility failed to report the incident to the Division after R1 was transferred to an acute care facility for evaluation and treatment of head and neck injuries. These findings were reviewed with E1 (Executive Director) and E3 (ADHW/RN) and confirmed during the exit conference on 12/16/2016 at approximately 10:45 AM. 2a. Clinical record review revealed that R6 was transferred to an acute care facility with increasing confusion following a fall on 7/1/2016. Further review of the	

DELAWARE HEALTH AND SOCIAL SERVICES

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STATE SURVEY REPORT

NAME OF FACILITY: BROOKDALE WHITE CHAPEL **DATE SURVEY COMPLETED: December 16, 2016**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	clinical record and the facility incident report revealed that R6 was sent to an acute care facility for evaluation and treatment for increasing confusion by order of her physician at 4:30 PM after a fall out of bed at 1:45 AM. The facility failed to report the incident to the Division after R1 was transferred to an acute care facility for evaluation and treatment of increasing confusion following a fall. These findings were reviewed with E1 (Executive Director) and E3 (ADHW/RN) and confirmed during the exit conference on 12/16/2016 at approximately 10:45 AM. 2b. Clinical record review revealed that R6 was transferred to an acute care facility for complaints of right leg pain and tingling in toes of right foot following a fall. Review of the facility incident report revealed that R6 fell out of her wheelchair while attempting to reach and hang an item on the bathroom door. The facility failed to report the incident to the Division after R6 was transferred to an acute care facility for evaluation and treatment of right leg and foot injuries sustained during the fall. These findings were reviewed with E1 (Executive Director) and E3 (ADHW/RN) and confirmed during the exit conference on 12/16/2016 at approximately 10:45AM	

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