STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	C 03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON SENIOR LIVING OF GEORGETOWN, LLC	110 W. NORTH STREET GEORGETOWN, DE 19947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 7, 2019 through March 12, 2019. The deficiency contained in this report is based on observations, interviews, review of residents' clinical records and review of other facility documentation. The facility census first day of the survey was 130. The survey sample totaled 4 (four) residents. Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Director and Medical Doctor; CNA - Certified Nurse's Assistant; NP - Nurse Practitioner; PA - Physician Assistant; AM - times before noon on the 12-hour clock system; d/c (dc) - discontinue and stop a physician's order; Dementia - loss of mental functions such as memory, judgement, personality and orientation that is severe enough to interfere with a person's daily functioning; EHR - electronic (computerized) health record; Epilepsy - a neurological disorder marked by abnormal electrical discharges in the brain and manifested by sudden brief episodes of altered or diminished consciousness, involuntary movements, or convulsions. Epilepsy means the same thing as "seizure disorders"; Etc. - used at the end of a list to indicate that further, similar items are included like "and so on";	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/29/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 MAR / TAR - Medication Administration Record / Treatment Administration Record; MDS - Minimum Data Set is a standardized assessment tool used in long term care facilities; ug/mL - milligram, metric unit of measurement of weight; mg-milligram; HS - hour of sleep, bed time; Neuro checks - neurological checks/assessment comprised of a series of simple questions and physical tests to determine if the nervous system is impaired; Neurologist - type of physician who diagnoses and treats disorders of the nervous system (diseases of the brain, spinal cord, nerves, and muscles); Neurology - study of disorders of the nervous system; PM - After noon on the 12-hour clock system; Post - after; Postictal - altered state of consciousness after an epileptic seizure. It usually lasts between 5 and 30 minutes, but sometimes longer in the case of larger or more severe seizures and is characterized by drowsiness, confusion, nausea, hypertension, headache or migraine and other disorienting symptoms; Recap - state again as a summary; Reconciliation - process of comparing a patient's medication orders to all of the medications that the patient has been taking. Reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions; Seizure - Uncontrolled electrical activity in the brain, which may produce a physical convulsion, minor physical signs, thought disturbances, or a combination of symptoms. The type of symptoms and seizures depend on where the abnormal electrical activity takes place in the brain, what its	F 000		

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F 000	Continued From page 2 cause is, and such factors as the patient's age and general state of health; Seizure disorder - a neurological disorder marked by abnormal electrical discharges in the brain and manifested by sudden brief episodes of altered or diminished consciousness, involuntary movements, or convulsions. therapeutic level / range - the effective level of medication in a patient 's bloodstream to treat specific disorders; ug/mL - microgram per milliliter is a metric measure of mass; Valproic Acid - medication used to treat seizure disorders; Valproic Acid level - blood test to measure if Valproic Acid medication was within the therapeutic range.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, review of medical literature and review of other facility documents, it was determined that the facility failed to ensure that one (R1) out of four sampled residents was free from significant medication errors. The facility incorrectly transcribed a physician's order which resulted in R1's seizure medication being completely stopped. R1 sustained harm when he/she suffered a two-minute seizure after not receiving an ordered seizure medication for eight doses. This significant medication error was not discovered by the facility until after the seizure occurred. Findings include:	F 760	Disclaimer: Development and/or execution of this Planof Correction does not constitute admission of or agreement with the facts and conclusions set forth on the 2567 survey report. Our plan of correction is prepared and executed to continually improve thequality of care and comply with all applicable State and Federal regulatory requirements. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	4/26/19

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F 760	Continued From page 3 Drug information documented the purpose of Valproic Acid was to treat seizure disorders. Do not stop using Valproic Acid without your doctor's advice. Stopping suddenly may cause a serious, life-threatening type of seizure. Do not stop using Valproic Acid suddenly, even if you feel fine. Follow your doctor's instructions about tapering your dose. (https://www.drugs.com/mtm/valproic-acid.html) Review of the facility's document entitled "Chart Check Policy and Procedure" (dated 1/25/19), stated: Realizing the seriousness of medication compliance, the facility has developed an objective system for completing chart checks daily to ensure a second review of medication changes is completed. This process allows administration to ensure order entry accuracy. The procedure for chart checks was to review each resident's medication changes daily by: 1. Print order listing report and review for accuracy: ensure each resident's medication/treatment is a complete order, review 24 hour report for confirmation of medication changes, confirm order in EHR (electronic health record) and obtain clarification orders as needed. 2. Print resident specific order recap report. Once order is confirmed in EHR, place in resident chart. 3. Nurse to initial Chart Check Form and inform shift supervisor immediately of any variances in chart check. The following was reviewed in R1's clinical record: 10/7/16 - Progress notes documented R1 was admitted to the facility with a primary admitting diagnosis of seizures. Secondary diagnosis included generalized epilepsy and dementia with	F 760	practice; R1 orders were clarified, and the MAR was updated to reflect accurate and correct physician order. R1 was assessed at time of occurrence and MD saw resident and assessed resident. Resident□s neurologist was notified. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The facility immediately completed an audit of all resident□s Medication Administration Record that E4 transcribed from physician orders during E4 orientation process and these orders were verified and rechecked for accuracy. The facility will complete 30-day order reconciliation for all medications and anticonvulsants (new, discontinued and completed) Last 30 days consult reports will be reviewed and orders verified. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur; Root cause analysis revealed revision to the facility□s Order Entry Process was necessary. To ensure accurate order transcription, the entire physician□s order will need to be viewed prior to	

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F 760	Continued From page 4 behaviors. 10/7/16 - 2/25/19: Review of physician orders revealed that R1 was receiving Valproic Acid continually from admission to the facility through 2/25/19 when all orders for Valproic Acid were incorrectly discontinued by E4 (RN on orientation). 1/17/17 - Care plan created (last revised 3/8/19): The resident has a seizure disorder and has had a recent seizure with a goal that the resident will be free from injury from seizure activity. The interventions included: -Follow up with neurology as scheduled. Date Initiated: 1/17/17. -Give Valproic Acid as ordered by doctor. Monitor/document side effects and effectiveness. Date Initiated: 1/17/17. -Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 1/17/17. 3/21/18 (Annual) and 12/11/18 (Quarterly) - MDS with active diagnoses of seizure disorder or epilepsy. 1/30/19 - Lab result: Valproic Acid level was 95.3 ug/mL (therapeutic level is 50.0 - 100.0) (the last level prior to the 3/5/19 seizure). 2/25/19 - Neurologist's Report of Consultation after office visit: "Decrease Valproic Acid to (one thousand) 1000 mg. at bedtime. D/C (discontinue) AM 500 mg dose." 2/25/19 at 1:09 PM: Telephone order to discontinue AM 500 mg dose of Valproic Acid from E12 (Nurse Practitioner) was given to E4 (RN on orientation).	F 760	discontinuing and/or clarification of that physician□s order. It was also identified during root cause analysis that this incident occurred during a new hire orientation period. Revisions have been made to our facility□s Orientation Policy and Checklist to ensure appropriate supervision during the entire order entry process. An addition to the orientation checklist was Precepting RN will be responsible to review all new orders placed by orienting nurses. The following Harrison Senior Living policies were revised on 03/08/2019 Medication Order (attachment 1) 24-hour chart check (attachment 2) Emergency Procedure -Seizure (attachment 3) Change in Resident Condition (attachment 4) Orientation Policy & Checklist (attachment 5) The facility nurse educator will re-educate licensed nurses on the revised policies The facility instituted a medication order competency for licensed nurses. These competencies will be completed at orientation and annual thereafter. (attachment 6) The facility has inquired with Synergy Pharmacy Consultant to look at current system related to order entry and review for any recommendations if identified. Synergy Pharmacy will complete a review of all active orders and d/c orders and compare to Point Click Care to the	

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F 760	Continued From page 5 2/25/19 at 1:09 PM: Physician's order incorrectly entered into the EHR by E4 (RN on orientation) to discontinue both the AM and bedtime doses of Valproic Acid. 2/25/19 at 1:14 PM - Progress note by E4 (RN on orientation): "Resident seen at Neurology office today with family present. Recommendations made to d/c Valproic Acid dose in the morning and keep the Valproic Acid 1000 mg at bedtime ...Called E12 (Nurse Practitioner) for the discontinued morning order of Valproic Acid." 2/25/19 - Review of 11 PM - 7 AM shift's "24 hour chart check sign off sheet" indicated R1's chart check was completed by E5 (LPN) with no errors found. 2/25/19 - 3/5/19: Review of MAR revealed that R1 received no Valproic Acid from 2/26/19 through 3/4/19 (7 days and 8 missed doses). 3/5/19 at 6:02 AM - Progress note by E6 (RN supervisor): "At 5:00 AM this RN was called to resident's room by E10 (LPN) for seizure activity and responded to resident's room immediately, on entering room noted resident lying in bed with his/her eyes closed, no seizure activity at that time, postictal deep respirations noted. Per E10 and E11 (CNA) resident had approximately 2 minutes of whole body tremors ..." 3/5/19 at 6:16 AM Progress note by E6 (RN supervisor): "On review of medications, this RN noted hours sleep dose of Valproic Acid was discontinued on 2/25/19." 3/5/19 at 7:19 AM - Progress note by E6 (RN supervisor): "At 7:05 AM E7 (Medical Director)	F 760	Synergy Pharmacy Profile. 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 into place. The DON or designee will complete audits of medication orders to verify the Medication Administration Record is transcribed to accurately reflect the original physician order. These audits will be comprised of 15% of resident medication orders. The audit will be completed weekly for four consecutive weeks monitoring for 100% compliance then monthly for three consecutive months for continued 100% substantial compliance. Audit findings will be presented at the monthly QA meeting for further review. (attachment 7)	

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F 760	Continued From page 6 aware of seizure activity and medication error. No new orders at this time." 3/5/19 at 7:38 AM - Progress note by E6 (RN supervisor): "E7 (Medical Director) gave new orders to restart Valproic Acid 1000 mg every night at bedtime per neurologist consult 2/25/19 and obtain Valproic Acid level in 2 weeks." 3/5/19 - Physician's order to restart Valproic Acid 1000 mg every night at bedtime for seizures and epilepsy. 3/5/19 at 11:44 AM - Progress note by E4 (RN on orientation): "E7 (Medical Director) visit. New orders...Continue Valproic Acid 1000 mg every night at bedtime." 3/5/19 at 1:46 PM - Progress note by E4 (RN on orientation): "Per family request, called Neurologist's office to notify of medication error. Left message for return call with physician assistant." 3/5/19 - Progress note by E7 (Medical Director): "Seizure disorder with breakthrough since dose reduction and missed doses. Valproic Acid restarted at 1000 mg every night at bedtime. Levels in 1 week and revisit the need for titration ..." 3/7/19 at 1:00 PM - During an interview with E1 (NHA) and E2 (DON), E2 explained that E4 (RN on orientation) was on the 6th day of orientation when this medication error occurred and was being oriented by E9 (RN). Neither E4 nor E9 realized that the Valproic Acid order was incorrectly transcribed into the Electronic Health Record (EHR) resulting in both the AM and bedtime doses being discontinued when the	F 760		

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F 760	Continued From page 7 actual physician's order was to only discontinue the AM dose. E1 explained that when the medication error was identified on 3/5/19 both E4 and E9 were educated that: After input into the EHR, read and print out orders to use as a comparison against written order, and compare the EHR order against consults, physician/nurse practitioner progress notes, etc. to ensure orders match. E2 stated that E5 (LPN) did complete the 24 hour chart check according to facility's procedure and did not identify the error, so the procedure has been revised and staff have been educated to compare the EHR orders against consults, physician/nurse practitioner progress notes, etc. to ensure orders match during the 24 hour chart check. E2 stated that all the orders that E4 transcribed during orientation have been audited and no other error was found. The facility is in the process of completing a 30-day order reconciliation of medications for all residents in the facility and educating all nurses on the procedure for transcribing orders and conducting 24 hour chart checks. 3/11/19 - Lab result: Valproic Acid level was low at 10.0 ug/mL (therapeutic level is 50.0 - 100.0). 3/11/19 at 8:14 PM - Progress note by E8 (RN supervisor): "E7 (Medical Director) made aware of Valproic Acid level of 10.0. Also made aware of Neurologist to review on 3/12/19. New order received for Valproic Acid 500mg tonight only." 3/11/19 - 5-day follow up report submitted to State Agency by E3 (ADON): " ...Neurologist made aware. No further seizure activity has been observed. Neuro checks are being completed. The resident's care plan has been updated to reflect any new orders and interventions."	F 760		

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F 760	Continued From page 8 3/12/19 - Lab result: Valproic Acid level was still low at 10.0 ug/mL (therapeutic level is 50.0 - 100.0). 3/12/19 at 9:00 AM - An interview with E2 (DON) confirmed that R1's last seizure prior to 3/5/19 was on 9/30/18 and that the last Valproic Acid level prior to 3/5/19 was on 1/30/19 and was 95.3 ug/mL (therapeutic level is 50.0 - 100.0). E2 also confirmed that between 2/25/19 and 3/5/19 none of the facility's nurses caring for R1 questioned why the Valporic Acid was suddenly completely stopped (which is against recommendations for Valporic Acid). E2 stated that the facility completed a 30-day (from 2/1/19 to 3/6/19) order reconciliation of medications for all residents in the facility (resident census was 130) and found six medication errors that have been corrected. R1 sustained harm when he/she suffered a two-minute seizure after not receiving an ordered seizure medication for eight doses. The significant medication error was not discovered by the facility until after the seizure occurred. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 3/12/19 during the exit conference beginning at 10:30 AM.	F 760		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Harrison Senior Living Of Georgetown, Llc **DATE SURVEY COMPLETED: March 12, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced complaint survey was conducted at this facility from March 7, 2019 through March 12, 2019. The deficiency contained in this report is based on observations, interviews, review of residents' clinical records and review of other facility documentation. The facility census first day of the survey was 130. The survey sample totaled 4 (four) residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by the following:** Cross Refer to the CMS 2567-L survey completed March 12, 2019: F760.	Cross reference to CMS 2567 Plan of Correction submitted via ePOC: F760	04/26/2019

Provider's Signature Kristi C. Bergeman Title RN/LNHA Date 03/29/2019