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) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Harrison Senior Living Of Georgetown, LLC **DATE SURVEY COMPLETED: June 4, 2021**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. **POST IDR STATE REPORT** An unannounced Complaint Survey was conducted at this facility from June 2, 2021 through June 4, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and one (101). The survey sample totaled eight (8).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.** No deficiencies were identified at the time of the survey.		

Provider's Signature _____ Title_____ Date _____

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 06/04/2021

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 POST IDR REPORT An unannounced Complaint Survey was conducted at this facility from June 2, 2021 through June 4, 2021, The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and one (101). The survey sample totaled eight (8). Abbreviations and Definitions used in this report are as follows: DON - Director of Nursing; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; Acute - occurs suddenly or new, sudden; Agitated - an emotional state of restlessness; Dementia - a severe state of cognitive 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; Drug toxicity - occurs when a person has accumulated too much of a drug in the bloodstream, leading to adverse effects on the body; Encephalopathy - disease affecting brain functioning due to an agent or condition such as a viral infection or toxins in the blood; Hypotensive - abnormally low blood pressure; Normal Saline Bolus - a rapid delivery of a mixed	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/23/2021

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 pat ents. (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 ava lable 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 solution of salt and water given through a vein; Severely cognitively impaired - never/rarely makes decisions; Unresponsive - not reacting in any way when spoken to, shaken, etcetera;	F 000		
F 760 SS=J	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, and review of other facility documentation, it was determined that the facility failed to ensure that one (R1) out of eight residents reviewed for medication errors were free from significant medication errors. R1 received another resident's medication causing harm, which required R1 to be transferred to the hospital where R1 became unresponsive and hypotensive in the emergency department requiring hospitalization for treatment and monitoring. This was identified as a past non-compliance Immediate Jeopardy situation. Findings include: Review of a facility policy titled "Medication Administration - General Guidelines" (effective date 9/1/15) included: 5) Medications are administered without unnecessary interruptions. 6) The person who prepares the dose for administration is the person who administers the dose. 7) Residents are identified before medication is administered.	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 2 Review of CMS guidance stated, " ...accepted standards of practice that require the following be confirmed prior to each administration of medication (often referred to as the 'five rights' of medication administration practice)" include: The right patient, the right time, the right dose, the right route, and the right drug." (https://www.cms.gov/Regulations-and Guidance/Guidance/Transmittals/Downloads/R116SOMA.pdf) 4/12/21 - R1 was admitted to the facility with a diagnosis of dementia. 4/16//21 - R1's admission Minimum Data Set Assessment (MDS - periodic assessment of resident needs) documented R1 was severely cognitively impaired. 5/27/21 10:02 PM - Review of information submitted to the State Agency included: "During evening medication pass, medication was administered in error to 84-year-old female resident. NP (Nurse Practitioner) informed and order received to send resident to the ER (Emergency Room) for further evaluation and treatment." 5/27/21 10:28 PM - A nursing progress note documented: "Resident was given another resident's medication in error by this nurse. Resident received; Plavix 75 mg (medication that prevents blood clots), Chlorpromazine 100 mg (antipsychotic medication), Mirtazapine 15 mg (antidepressant medication), Atorvastatin 40 mg (cholesterol lowering medication) Haloperidol 10 mg (antipsychotic medication), Lorazepam 1 mg tab (antianxiety medication), (and) Tylenol 650 mg (pain and fever medication). Resident	F 760		

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F 760	Continued From page 3 swallowed medication at time of administration. E5 (NP) made aware. Resident to be transferred to (said hospital) ER for evaluation and monitoring. 911 EMS made aware need for transport to ER." Although the facility documented the medication error in the progress notes, the documentation lacked evidence of the mental status of R1 (such as alert, drowsy, or unresponsive) upon transfer out of the facility. 5/27/21 10:45 PM - Review of E3 s (RN) statement revealed that he administered another male resident's (R2) medication to R1. 5/28/21 2:39 AM - A nursing progress note documented: "Spoke with (named nurse at named hospital), resident admitted to the ICU with dx (diagnosis of) Encephalopathy (disease affecting brain functioning due to an agent or condition such as a viral infection or toxins in the blood)." 5/28/21 - Review of E4's (RN) statement revealed that E3 (RN) came to the medicine cart to help give the medications that were set aside for R2. E4 thought that E3 (RN) was going to administer the medications to R2 (a male resident next to R1), but instead administered them in error to R1. 5/28/21 12:10 PM- A doctor's consult progress note (at the hospital) documented: "Since presentation to the hospital, patient received IV (intravenous) fluids, 1500 ml (milliliters) of normal saline and currently is getting IV (intravenous) infusion. This morning she went into SVT (Supraventricular Tachycardia - an abnormally fast heart rate) with a rate of 140 to 150 beats per minute (normal heart rate is 60 - 100) and she has remained unresponsive. She is on (a)	F 760		

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F 760	Continued From page 4 Norepinephrine drip (medication to help maintain a constant blood pressure)." 5/30/21 2:20 PM - A hospital discharge summary documented: "Presented at the ED (Emergency Department) at the behest (sic) of staff at her living facility ...where they report that she was found to be unresponsive soon after receiving the wrong medication ... In the ED she is unresponsive and hypotensive. She was given 1500 cc of normal saline bolus and blood pressure improved." The assessment and plan included a diagnosis of Acute Encephalopathy presumably secondary to drug toxicity and that her airway was being protected. 6/3/21 12:15 - 12:25 PM - During an interview, E3 (RN) confirmed that he did not prepare the medications that were on E4 (RN's) medication cart and he was just trying to help. E3 stated that there was "a lot going on" and there were multiple residents in the common area who were agitated. E3 thought in error that R2's medications were for R1. E3 reported that when he administered the medications to R1 (the wrong resident), E4 yelled out that the medications were not for R1, but it was too late. R1 had already swallowed them. 6/3/21 1:45 PM - During an interview, E4 (RN) stated that the medications were on her cart by her computer while she was attempting to chart on R2, who she had just given Ativan gel because R2 would not take his medications by mouth due to being too agitated. E4 reported that she put the meds on her cart next to her and was going to attempt to administer them to R2 after he calmed down from the Ativan gel. E3 (RN) took the medication cup off of E4's medication cart and said that he would help administer them. E4	F 760		

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F 760	Continued From page 5 thought that E3 was administering them to R2, but he administered them to R1. E4 stated it was just a few seconds until she looked up, but it was too late. E4 had already administered the medications to the wrong resident. Past non-compliance Immediate Jeopardy was revealed to E1 (NHA) and E2 (DON) on 6/4/21 at approximately 3:30 PM. Immediately after the medication error, the facility created a corrective action plan that include: re-education of licensed nursing staff on the five rights of medication administration, nurse to nurse support with medication administration during an emergency, and how to respond to a medication error with a completion date of 6/2/21 and a plan was in place to educate staff not currently working before they return to work. The facility instituted medication competency with facility Nurse Supervisors with a completion date of 6/3/21. Review of facility documentation, staff interviews and medication observations revealed that the corrective action was fully implemented and completed by 6/3/21, at which time, the Immediate Jeopardy was removed. The facility failed to ensure that R1 was free of a significant medication error, which resulted in a serious adverse outcome to the resident and required a transfer and admission to the ICU (Intensive Care Unit) at the hospital with a diagnosis of acute encephalopathy due to accidental drug toxicity. 6/4/21 approximately 3:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 760		