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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Millcroft Assisted Living

DATE SURVEY COMPLETED: August 7, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced annual survey was conducted at this facility beginning July 31, 2017 and ending August 7, 2017. The facility census on the entrance day of the survey was 24 residents. The survey sample totaled three residents and one sub-sampled resident for medication observation. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations used in this state report are as follows:** ED - Executive Director; RSD – Resident Services Director; SDE – Staff Development Educator; LLAMS – Limited Lay Administration of Medication Staff; 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; RD-Regional Director.	3225.9.4.1 A. SSR1 was not adversely affected by this practice. E4 (LLAM) was coached and counseled regarding the facilities policy about hand washing prior to gloving. B. All residents who require assistance with administration of eye drops are at risk with this practice. All LLAM certified aides will be reeducated by RSD (Resident Service Director) on the hand washing policy and eye drop administration. RSD or designee will monitor eye drop assistance monthly to ensure accuracy and consistency until 100% compliant, then quarterly eye observations. If LLAM certified tech is not following proper procedure "on the spot" training will occur at the time of the deficient practice. C. LLAM certified Aides will complete in-service by Resident Service Director or designee to review training on the facility's assistance with self-administration eye drop policy with demonstration by the Resident Service Director. D. The Resident Service Director will witness a random audit of assisted self-administration eye drop passes monthly until 100% compliant and record in audit book for ED review, then quarterly checks per policy.	original completion date 11/1/17
3225.0	**Regulations for Assisted Living Facilities**		
3225.9.0	**Infection Control**		
3225.9.4.1	**The assisted living facility shall have policies and procedures for infection control as it pertains to staff, residents, and visitors.** Findings include: Based on observations, clinical record review,		

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	staff interview, and review of the facility's policy as indicated, it was determined that the facility failed to follow the facility's infection control policy and procedure for one (SSR1) out of one resident observed during medication observation. Findings include: Review of the facility's policy and procedure, dated 11/14/2015, titled handwashing indicated handwashing is the most important component for preventing the spread of infection. Hand washing was to be performed after removal of gloves. 8/4/17 at approximately 10:00 AM - During medication administration observation, E4 (LLAM) washed her hands and donned a pair of gloves and proceeded to administer one drop of artificial tear into SSR1's right eye. Subsequently, E4 removed the gloves and donned a new pair of gloves without hand washing and proceeded to administer one drop of artificial tear into SSR1's left eye, removed the gloves, and performed hand washing. An interview immediately after the observation with E4 confirmed that E4 failed to perform hand washing after she removed the gloves after administration of the first eye drop to SSR1's right eye. Findings were reviewed with E1 (ED), E2 (RSD), and E3 (RD), at approximately 3:45 PM on 8/7/17.	3225.9.5.2 For E2 A. No employee was adversely affected by this practice. E2 will receive a two-step ppd by 10/31/2017 and results will be documented within 2 days B. All employees have the potential to be affected by this practice. An audit will be conducted of all active employee files to ensure all employees receive a two-step ppd. C. All new hires will not be scheduled for new hire orientation initial 2nd step ppd has been completed. The Human Resource "new hire checklist" has been updated regarding the system change. D. ED or designee will audit new hire files every month times 3 months and/or until 100% compliant. For E6 A. E6 will receive a two-step ppd by 10/31/2017 and results will be read and documented. B. All employees have the potential to be affected by this practice. An audit will be conducted of all active employee files to ensure all employees receive a two-step ppd. C. All new hires will not be scheduled for new hire orientation initial 2nd step ppd has been completed. The Human Resource "new hire checklist" has been updated regarding the system change.	original completion date 11/6/17
3225.9.5.2	**Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of**		

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	Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category. Findings include Based on review of facility documentation and staff interview, it was determined that the facility failed to maintain an effective infection prevention and control program by failing to ensure TB testing was completed pre-employment for three (E2, E6, and E7) out of eight recently hired sampled employees. Review of the following employee Immunization and Tuberculosis Testing Consent and Record revealed: **1.** E2 (RSD) had a hire date of 8/8/16. One step TST result was documented as negative on 8/5/17. Record review lacked evidence of the second step TST. 2 .E6 had a hire date of 2/26/16. One step TST result was documented as negative on 2/18/16. Record review lacked evidence of a second step TST. An interview with E5 (SDE), on 8/4/17 at approximately 11:05 AM revealed that the facility had considered a previous negative result of a one-step TST on 6/9/15, as the first of the two step PPD requirement and confirmed that the second TST was not administered. 3. E7 had a hire date of 4/3/17. One step TST result was documented as negative on 3/22/2017 and the two step TST was administered on 4/3/17, the day of hire and the negative result was read on 4/5/2017, approximately two days after the date of hire. An interview with E5 on 8/4/17 at	D. ED or designee will audit new hire files every month times 3 months and/or until 100% compliant. For E7 A. E7 is still an employee with no adverse effect. PPD records are in the HR file and complete. B. All employees have the potential to be affected by this practice. An audit will be conducted of all active employee files to ensure all employees receive a two-step ppd. C. All new hires will not be scheduled for new hire orientation initial 2nd step ppd has been completed. The Human Resource "new hire checklist" has been updated regarding the system change. D. ED or designee will audit new hire files every month times 3 months and/or until 100% compliant. 3225.11.4 A. R1 was adversely affected by this practice. The annual UAI will be completed and signed by the resident/representative by 11/2/17. B. All residents have the potential to be affected by this practice. An audit will be conducted by the ED or designee to ensure all UAI's are completed and signed prior to admission times 3 months or until 100% compliant. Any UAI found out of compliance, training will occur immediately to address the issue.	original completion date 11/1/17

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	approximately 11:10 AM confirmed the results of the second TST was read on 4/5/17, two days after E7 was employed. Findings were reviewed with E1 (ED), E2 [RSD], and E3 (ED), at approximately 3:45 PM on 8/7/17.	C. All new prospective residents will be reviewed with the ED or designee to ensure all UAIs are completed and signed by the day of admission. D. ED or designee will audit 10% of UAIs every month times 3 months until 100% compliant.	
3225.11.0 3225.11.4	**Resident Assessment** **The resident assessment shall be completed in conjunction with the resident.** Based on record review and interview, it was determined that the facility failed to complete the Uniform Assessment Instrument (UAI) in conjunction with the resident for one resident (R1) out of three residents sampled. Findings include: Review of R1's record revealed: 11/2/16 – UAI completed and signed by E2 (RSD). Further review revealed that R2 had signed and dated the UAI on 11/6/17, four days after admission. During an interview with E2 on 8/4/17 at approximately 2:30 PM, E2 related that E2 had completed the UAI on R2's date of admission and had R2 sign the UAI on 11/6/17 after the UAI was completed. Findings were reviewed with E1 (ED), E2 [RSD], and E3 (RD), at approximately 3:45 PM on 8/7/17.	3225.13.6 For R2 A. R2 was not adversely affected by this practice. The Service Agreement has been updated and signed by the resident/representative. B. All residents have the potential to be affected by this practice. Any resident identified with not updated information regarding a change in condition will be completed, signed and dated with resident and/or representative. C. All residents with a condition or status change will be reviewed with the ED or designee. The ED or designee will ensure any change in a resident's level of service is updated in the Service Agreement times 3 months or until 100% compliant. D. ED or designee will audit 10% of Service Agreements every month x3 months or until 100 % compliant.	original completion date 11/6/17
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.** Findings include: Based on record review, observations, and staff interviews, it was determined that the facility lacked an effective system for		

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	ensuring that the service agreements for two R2 and R3) of three residents reviewed were changed when needs of the residents changed. Findings include: Review of the facility's policy and procedure, dated 11/14/05 and titled, "Resident Service Plans", documented that the service plan would be periodically evaluated and would document the services required by the residents. The document indicated that the service plans shall be implemented/updated as indicated by change in resident level of service need. **1.** Review of R2's record revealed: 11/2/16 – R2 was admitted to the facility. 7/18/17 – Physician's order for wound care, of R2's left lower extremity wound which included for the licensed nurse to perform the wound care every 72 hours. 7/19/17 – 8/7/17 Treatment Administration Record revealed that the licensed nurses were performing this wound care as ordered, however, the most recent service agreement dated 12/16/16, lacked evidence of an initiation of this service agreement for this wound care. 8/7/17 at approximately 2:20 PM, an interview with E2 (RSD) confirmed the lack of initiation of a service agreement for the wound care. Findings were reviewed with E1 (ED), E2, and E3 (RD), at approximately 3:45 PM on 8/7/17. **2.** Review of R3's record revealed: 10/9/2012 – R3 was admitted to the facility. 12/10/16 – Service Plan for fall risk documented that R3 was assessed as moderate or high risk of fall and R3 had an actual fall on 11/23/16. Interventions included that the caregivers would make sure that R3's walker and call devices are within	For R3 A. R3 was not adversely affected by this practice. The Service Agreement has been updated and signed by the resident/representative. B. All residents have the potential to be affected by this practice. Any resident identified with not updated information regarding a change in condition will be completed, signed and dated with resident and/or representative. C. All residents with a condition or status change will be reviewed with the ED or designee. The ED or designee will ensure any change in a resident's level of service is updated in the Service Agreement times 3 months or until 100% compliant. D. ED or designee will audit 10% of Service Agreements every month x3 months or until 100 % compliant.	original completion date 1/1/17

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	reach and good working condition. 5/30/17 – Incident Report Form documented that R3 had experienced an unwitnessed fall in the dining room at 8:45 AM in which he had hit his head. The report documented that the fall occurred while R3 was transferring from the chair to his walker. Although R3 had experienced a subsequent fall, record review lack evidence that the facility reviewed and revised the Service Plan. 8/4/17 at approximately 2:30 PM - During an interview with E2 (RSD), E2 confirmed that the facility was not able to provide evidence, that R3's Service Plan was reviewed and revised after the fall on 5/30/17. Findings were reviewed with E1, E2, and E3, at approximately 3:45 PM on 8/7/17. **Title 16** **Health and Safety** **Regulatory Provisions Concerning Public Health** **Chapter 11. NURSING FACILITIES AND SIMILAR FACILITIES** **Subchapter I. Licensing By The State** **§ 1108 Posting of inspection summary and other information and public meetings.** **(a) Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees and visitors the following:** **(2) A sign prescribed by the Department that specifies complaint procedures and provides the "1-800" hotline number to receive complaints 24 hours a day, 7 days a week.** Based on observations and staff interviews, it	16 Del. Code., Chapter11,Subchaper 1 A. No resident was affected by this practice. Posters specifying complaint procedures and the hotline number are posted. B. All residents have the potential to be affected by this practice. C. Resident Service Director to in-service staff to ensure signs is posted during daily rounds. D. Resident Service Director will audit weekly for 1 month to ensure compliance.	original completion date 12/1/17

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	was determined that the facility failed to post a sign that specifies complaint procedures and the hotline number. Findings include: An observation was made on 7/31/17 at 12:20 PM and no postings could be located on either floor of the building, in any common room or corridor. During an interview on 7/31/17 at 2:35 PM with E2 (RSD) confirmed that such signs should be posted, but could not tell the surveyor where they were currently posted. On 8/1/2017 at approximately 10:00 AM, E2 confirmed that she was unable to locate the poster and following this interview, a surveyor provided a poster to E2 and subsequent observation on 8/7/17 at approximately 2:50 PM, revealed the poster in the lobby of the facility.		

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Provider's Signature Julie Hoff Title Executive Director Date 12/6/17