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: The Lorelton

DATE SURVEY COMPLETED: July 19, 2012

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 July 6, 2012 and ending July 19, 2012. The resident census on the entrance day of the survey was 69. The survey sample was composed of 8 residents and included 7 selected residents and a subset of an additional resident. The survey process included observations, interviews, review of residents' records, facility documents and facility policies and procedures.	
3225	**Regulations for Assisted Living Facilities**	
3225.8.0	**Medication Management**	
3225.8.8	**Concurrently with all UAI-based assessments, the assisted living facility shall arrange for an on-site medication review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication, to ensure that:**	
3225.8.8.1	**Medications are properly labeled, stored and maintained** **This requirement is not met as evidenced by:** Based on observation of medication administration, clinical record review, review of facility policies and procedures and staff interview it was determined that the facility failed to ensure medications were properly labeled for one resident (Resident #SS1) out of eight sampled. Findings include:	

Provider's Signature A. Sue Rugg, NHA Title EXECUTIVE DIRECTOR Date 8/8/2012

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	1a. An observation conducted of assistance with self-administration of medication on 7/19/2012 revealed an over-the-counter bottle of medication for Resident #SS1 had two labels. The second container label was handwritten by the facility and included the name, dosage, route and time of administration of the medication. Further observation of the medication bottle revealed the original label was illegible and completely covered by the second label. The facility policy "Storage of Medications" states "...E. All medications shall be kept in their original containers and shall be properly labeled and identified...". These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 7/19/2012. 1b. During observation of assistance with self-administration of medications conducted on 7/19/2012 it was revealed that the original label of a medication filled for Resident #SS1 was altered by the facility with the insertion of the handwritten comment "1/2 tab". The original medication label read "Sertraline 100mg take 1 tablet by mouth daily." Further observations also revealed inconsistency between the label of the above referenced medication and the MAR dated July 2012. According to the medication label Sertraline was prescribed for administration on a daily basis. However review of the MAR dated July 2012 read "Sertraline 50mg, take one tablet by mouth twice a day". Review of the facility's "Physician's Order" form dated July 1, 2012 through July 31, 2012	**3225.8.1** **Corrective Action(s):** Resident #SS1 has all orders and labels changed to reflect the appropriate medications as prescribed by the physician. Date completed 7/31/12. **Identification of other Affected Residents:** All residents that have their medications given the The Lorelton staff have the potential to be affected. An audit will be conducted by the Director of Nursing/RN to assure all medication is labeled properly and the labels match the physician order. Date completed 8/8/12. **Measures of systemic changes to prevent future deficient practice:** All nurses have been in-serviced on the proper way to change a medication dosage, how to label over the counter medications, how to properly write orders on MAR and the physician order sheet that actually reflect the label of the medication. Date completed 7/26/12.

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	revealed that the medication order was prescribed as "Sertraline 50mg one tablet by mouth twice a day". Review of the facility policy "Medication Labeling" states ...B. General Information...2. The prescription label must not be altered, modified, or marked on in any way...3. Should it be necessary to change information on the prescription label, the Facility must contact the pharmacist directly to advise of the need for a label change...". These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 7/19/2012. 1c. Observation of assistance with self-administration of medications conducted on the morning of 7/19/2012 revealed a MAR dated July 2012 that included the order "Hydralazine 50mg take two tablets by mouth twice daily". Additionally it was observed that the medication label included alterations in the dosage and frequency of the administration superimposed upon the dosage and frequency of administration of the original label in bold black print. The medication label read "Hydalazine Tab 50mg, take 2 tablet by mouth 2 times daily". Review of Resident #SS1's clinical record revealed the "Physician Order" form dated July 2012 included an order that stated "Hydralazine 50mg take two tablets by mouth twice daily". Review of the facility policy "Medication Labeling" states ...B. General Information...2. The prescription label must not be altered, modified, or marked on in any way...3. Should it be necessary to change information on the prescription	**Monitoring of Corrective Action(s):** The Director of Nursing or RN designee will conduct a quarterly audit of all residents who receive medication administration to assure proper labeling of over the counter medications; as well as proper medication orders, proper documentation of all medications, and to ascertain that no changes have been made to any labels that are on the bottles. Any deficient practice will be addressed with the nurse involved and the Executive Director will be notified. Reports will be communicated at the quarterly QA meetings. Date completed 8/8/12 and ongoing.

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	label, the Facility must contact the pharmacist directly to advise of the need for a label change...". These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 7/19/2012	
3225.12.0	**Services**	
3225.12.1	**The assisted living facility shall ensure that:**	
3225.12.1.3	**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 7/6/2012, it was determined that the facility failed to comply with sections: 3-201.11 (C) and 6-501.11 of the State of Delaware Food Code.** **3-2 Sources, Specifications, and Original Containers and Records** **3-201 Sources** **3-201.11 Compliance with Food Law** **(C) Packaged Food shall be labeled as specified in Law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under §§ 3-202.17 and 3-202.18. Pf** **This requirement is not met as evidenced by:**	3225.12.1.3 – 3-2011.11 **Corrective Action(s):** All contents in walk-in freezer checked for labeling and dating as of 7/19/12. New label maker for frozen items purchased 8/3/12. **Identification of other Affected Residents:** All contents of walk-in freezer and refrigerates could be affected by this practice. **Measures or systemic changes to prevent future deficient practice:** Cooks in-serviced on proper food code regarding labeling and dating. Date completed 8/9/12. Labels/dates on all foods in refrigeration to be checked daily by Food Service Director/cooks. **Monitoring of corrective action:** The Food Services Director/head cook will monitor labeling/dating of freezer contents weekly. Any deficient practice will be addressed with dietary staff. Reports will be communicated at the quarterly QA meetings. Date completed 8/10/12 and ongoing.

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	1. Observations of the contents in the walk-in freezer at 8:15 AM revealed an unlabeled and undated product. The cook identified the product as being eggplant. **6-5 Maintenance and Operation** **6-501.11 Repairing.** **Physical facilities shall be maintained in good repair.** **This requirement is not met as evidenced by:** 1. Observations at 8:05 AM revealed that the floor tiles by the ice machine were in disrepair. DON confirmed the findings. 2. Observations at 8:13 AM revealed that the outside surface of the walk-in freezer was in disrepair. DON confirmed the findings. 3. Observations at 8:15 AM revealed that the juice bar counter top was damaged. The counter was not cleanable.	**3225.12.1.3- Food Code 6-501.11** **Corrective Action(s):** Floor tiles repaired 7/9/12. Outside surface of walk-in freezer repaired 7/9/12. Juice bar counter top to be replaced. Date to be completed 9/30/12. **Identification of other Affected Residents:** All areas of the physical building could be affected. **Measures or systemic changes to prevent future deficient practice:** New Maintenance Director hired mid-June. Maintenance Director/designee to assess physical facility for disrepair. Ongoing preventative maintenance started 8/1/12. Repairs addressed when identified. **Monitoring of Corrective Actions:** Maintenance Director/designee to assess physical facility for necessary repairs on monthly basis. Any deficient practice will be addressed with the Executive Director. Reports will be communicated at the quarterly QA meetings. Date completed 8/1/12 and ongoing.
3225.17.0 **3225.17.2** **3225.17.2.1**	**Environmental and Physical Plant** **Assisted living facilities shall:** **Be in good repair.** **This requirement is not met as evidenced by:** 1. Observations of the dining room at 8:25 AM revealed that the wallpaper was peeling. DON confirmed the finding. 2. Observation of the dining room at 8:27 AM revealed that the ceiling was damaged. DON confirmed that the	**3225.17.2.1** **Corrective Action(s):** Dining room wall paper repairs completed 8/10/12. Dining room ceiling to be repaired by 8/31/12. Roof leak previously repaired. **Identification of other Affected Residents:** All areas of the facility could be affected by this issue.

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	damage was due to a leaking roof.	**Measures or systemic changes to prevent future deficient practice:** Maintenance Director/designee to assess physical facility for necessary repairs. Repairs addressed when identified.
3225.17.2	**Assisted living facilities shall:**	**Monitoring of Corrective Actions:** Maintenance Director/designee to assess physical facility for necessary repairs on monthly basis. Any deficient practice will be addressed with the Executive Director. Reports will be communicated at the quarterly QA meetings. Date completed 8/1/12 and ongoing.
3225.17.2.3	**Have a hazard-free environment; and**	**3225.17.2.3**
	This requirement is not met as evidenced by:	**Corrective Action(s):** All closets and trash rooms checked for hazardous chemicals, and chemicals (if found) removed 9/8/11.
	Based on clinical record review, review of facility incident report and staff interview it was determined that the facility failed to provide a hazard free environment when one resident (Resident #4) gained access hazardous chemicals out of eight sampled. Findings include:	**Identification of other Affected Residents:** All residents have the potential to be affected by this issue.
	Clinical record review revealed a nurse's note dated 9/7/2011 and timed (12:45 PM) that stated Resident #4 was observed with swollen lips. When questioned by E3 (caregiver) Resident #4 stated that she "accidently drank a heavy duty drain cleaner" thinking "it was a soda". In an interview conducted with E2 (RN/DON) on 7/19/2012 it was stated that Resident #4 was able to access the chemical from an unlocked and unattended housekeeping closet. Additionally E2 (RN/DON) stated that chemicals are not stored in housekeeping closets.	**Measures or systemic changes to prevent future deficient practice:** All staff reminded/ in-serviced regarding hazardous materials 9/8/11. Daily monitoring of closets/trash rooms by housekeepers/maintenance staff.
	Further review of the nurse's note revealed that Resident #4 was transported to an acute care facility for evaluation and released to the facility on the same date. The facility failed to provide a hazard-free environment for Resident #4.	**Monitoring of Corrective Actions:** Maintenance Director/designee to monitor closets/trash rooms for hazardous chemicals daily. Any deficient practice will be reported to the Executive Director. Reports will be communicated at the quarterly QA meetings. Date completed 9/8/11 and ongoing.
	These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 7/19/2012.	
3225.18.0	**Fire Safety and Other Emergency Plans**	

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3225.18.4 **3225.18.4.3**	**The assisted living facility shall promote staff knowledge of fire and other emergency safety by:** **Conducting facility fire drills in accordance with State of Delaware Fire Prevention Regulations;** **This requirement is not met as evidenced by:** Based on review of facility documents it was determined that the facility failed to conduct fire drills in accordance with the State of Delaware Fire Prevention Regulations. Findings include: Review of facility fire drill records revealed that the facility lacked documentation of the performance of fire drills for all shifts each quarter from July 2010 through June 2012. The first quarter of the year 2011 revealed the absence of a recorded fire drill for the 7-3 shift. Additionally the third quarter of the year 2011 revealed the absence of a documented fire drill for the 11-7 shift. Review of the year 2012 revealed the absence of a recorded fire drill for the 3-11 shift. The facility failed to conduct fire drills in accordance with the State of Delaware Fire Prevention Regulations. These findings were reviewed with E1 (executive director) and E2 (RN/DON) on 7/19/2012	**3225.18.0** **Corrective Action(s):** Fire drill documentation addressed with new Maintenance Director 7/19/12. **Identification of other Affected Residents:** All residents/staff/visitors could be affected by this issue. **Measures or systemic changes to prevent future deficient practice:** New Maintenance Director made aware of lacking documentation. Executive Director to be made aware of quarterly fire drills for each shift. Date completed 7/30/12. **Monitoring of Corrective Actions:** Maintenance Director/designee will conduct fire drills in accordance with the State of DE Fire Prevention Regulations. Executive Director will monitor documentation of drills quarterly. Reports will be communicated at the quarterly QA meetings. Date completed 7/31/12 and ongoing.