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

DHSS - DLTCRP
3 Mill Road, Suite 308
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(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Heritage at Milford

DATE SURVEY COMPLETED: 12/16/15

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. An unannounced annual and complaint survey was conducted at this facility from December 3, 2015 through December 16, 2015. 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 50 (fifty). The survey sample totaled twelve (12) residents, plus an additional six (6) sub sampled residents. Abbreviations and definitions used in this state report are as follows: ED – Executive Director; DON – Director of Nursing; RN – Registered Nurse; LPN – Licensed Practical Nurse; NP-Nurse Practitioner; PCA – Patient Care Assistant; AWSAM (Assistance with Self-Administration of Medication) – PCA with special training to assist with medication administration; DME (Durable Medical Equipment) items that can be used repeatedly for a medical purpose; Fahrenheit (F) - unit of temperature measurement; FBS – Fasting blood sugar; MAR – Medication Administration Record; MMSE (Mini Mental State Examination) – oral test to determine degree of cognitive impairment [24-30 = no impairment; 18-23 = mild impairment; 0-17 = severe impairment]; PT – Physical Therapy; PRN – as needed;		

Provider's Signature [signature] Title Executive Director Date 3/9/16

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	RCD – Resident Care Director; SQ – subcutaneous (injection given under the skin into the fat); UAI (Uniform Assessment Instrument) – a standardized resident assessment tool used in Assisted Living facilities; Activities of Daily Living - usual activities such as bathing, dressing, grooming, and toileting; Cognitive – mental process, thinking; CT Scan – imaging test to take detailed pictures inside the body; Dementia - brain disease that causes difficulty with memory and decision making; Diabetes Mellitus – disease where blood sugar is too high; Fatigue – being tired; Furniture cruises – hold onto furniture to walk around the room; Homestead unit – locked unit for residents with memory impairment; Hospice – service that provides care to residents who are terminally ill; Insulin – injected medication to control blood sugar; Novolog Flexpen – type of insulin; Psychosocial – dealing with mind, behavior and social relations; Skin tear – wound when outer skin separates from tissue below, occurs more often with thin, fragile skin; Sliding Scale – dose of insulin based on blood sugar reading; Sub-Sample – additional residents reviewed for a specific care area; Suicidal – thoughts about killing oneself.		
3225 **3225.5.0** **3225.5.3**	**Regulations for Assisted Living Facilities** **General Requirements** **The assisted living facility shall adopt**	**Corrective actions for resident affected** Resident R1 no longer resides at the facility.	2/29/16

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	internal written policies and procedures pursuant to these regulations. No policies shall be adopted by the assisted living facility which are in conflict with these regulations. **This requirement is not met as evidenced by:** Based on review of facility policies and procedures and staff interviews, it was determined that the facility lacked policies and procedures related to hospice services and pain management. The lack of defined protocol for staff to follow affected 1 (one) of twelve (12) residents reviewed (R1) who required both hospice and pain management services from facility staff. Findings include: Record review revealed that on 1/9/15 R1 began to receive hospice services in the facility for declining medical condition, weakness, and pain. The clinical record lacked evidence that the facility effectively communicated and planned with hospice and the resident's family to meet R1's care needs. The clinical record also lacked evidence of a pain management plan for R1 so that facility staff were aware of effective pain control interventions (in addition to medication). No policy / procedure related to hospice services could be provided by E1 (ED) when requested by the surveyor and a draft "Hospice Policy" was developed during the survey. This draft (not yet implemented) addressed coordination of services between hospice and the facility along with steps to ensure effective communication. On 12/16/15, the surveyor requested the facility's pain management policy / procedure from E1. The surveyor was advised on 12/16/15 at 12:10 PM by E2 (DON) that the	**Identified of others with the potential to be affected** Facility resident on hospice have the potential to be affected. The facility currently does not have any residents requiring hospice services. **Measures to prevent reoccurrence** The facility initiated a pain management policy and a hospice policy. The hospice policy outlines the facility plan for an interdisciplinary approach to hospice care involving facility staff, hospice team members, and family members. The pain management policy outlines the facility approach of maintaining the highest possible level of comfort for residents and provides a system to identify, assess, treat, and evaluate pain. (Exhibit 1 &2) DON provided education related to hospice and pain management policies to facility staff. (Exhibit 3) **Monitoring of Corrective Action** DON or designee will complete audits of facility hospice residents to ensure that their pain management program adequately addresses their symptoms and that there is an interdisciplinary approach to manage their care. (Exhibit 12) Audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	

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	facility did not have a policy / procedure related to pain assessment and management. These findings were reviewed with E1 and E2 at the exit conference on 12/16/15 at 1:40 PM.		
3225.7.0	**Specialized Care for Memory Impairment**		
3225.7.3 3225.7.3.5	**The information disclosed shall explain the additional care that is provided in each of the following areas:** **Staffing Plan and Training Policies: staffing plan, orientation and regular in-service education for specialized care.** **This requirement is not met as evidenced by:** Based on review of the facility admission packet provided to persons seeking specialized care for memory impairment and provided to the surveyor for review upon request, the facility failed to clearly identify and describe the "Staffing Plan and Training Policies". Findings include: The admission packet document titled "Homestead (Memory Impairment Unit) Policy and Procedure Disclosure" contained in the facility's admission packet included one sentence to describe the "Staffing Plan and Training Policies". This sentence, which stated "Each member of the Homestead staff is specially trained in memory impairment and Alzheimer's care and takes pride in the exceptional level of care", failed to identify and explain the staffing plan for the specialized memory care unit. These findings were reviewed with E1 (ED) and E2 (DON) at the exit conference on	**Corrective action for resident affected** No negative outcomes to residents. **Identification of others with the potential to be effected** Homestead residents have the potential to be affected. **Measures to prevent reoccurrence** The facility has a Homestead Staffing Policy (Exhibit 15) that states, "the Homestead Program will provide qualified and appropriate staffing levels to meet the needs of the patient/resident population" who qualify for assisted living services based upon resident's assessments. The Homestead Standards of Care: Assisted Living Policy states the specialized staffing, "program director is assigned to the unit, direct care staff to resident ratio as needed, stable assignment of staff with primary assignments, dedicated recreation staff." (Exhibit 18) DON educated homestead director on how to assess resident level of care needs as it relates to staffing. (Exhibit 3) Staffing levels will be evaluated upon residents change in status, service plan updates, and upon admission and discharge. Staffing levels and duties will be discussed at each quality assurance meeting. **Monitoring of Corrective Action** The Business Office Manager will complete audits of the resident admission packet to	2/29/16

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	12/16/15 at 1:40 PM.	ensure that each resident as appropriate and responsible party sign in acknowledgement of the facility admission forms. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	
3225.8.0 3225.8.1 3225.8.1.4	**Medication Management** **An assisted living facility shall establish and adhere to written medication policies and procedures which shall address: Administration of medication, self-administration of medication, assistance with self-administration of medication, and medication management by an adult family member/support person.** **This requirement is not met as evidenced by:** Based on record review, observation and interview it was determined that the facility failed to ensure: - complete documentation of the administration and/or effectiveness of PRN medications on the MAR for 3 (R2, R3 and R10) out of 12 sampled residents plus 3 additional (SS1, SS2 and SS3) sub-sampled residents; - accurate physician order and MAR for an ear medication [documented order did not match the dose written on the medication's label for one (SS4) sub-sampled resident]; and - medications were initialed on the MAR (meaning the medication had been given to the resident) by the nurse only after actual administration. Findings include: 1. 12/4/15 review of MARs, for the residents listed below, revealed the back page of the MAR contained areas for the nurse to write the date/time, medication name and reason for administration as well as resident	**Corrective action taken** No negative outcome to resident R2, R3, and R10 and SS1, SS2, and SS3. There was no negative outcome to SS4. A physician clarification was obtained. **Identification of other with the potential to be effected** Facility residents have the potential to be effected. Nurse Managers completed an audit of PRN medication administered in the last 30 days to ensure that effectiveness was documented on the MAR. (Exhibit 6) Nurse Managers completed an audit of current physician orders for facility residents and compared them to current medication labeled to ensure accuracy (exhibit 7). **Measure to prevent occurrence** DON completed education with licensed nurses and LLAM trained staff on the importance of accurate documentation as it relates to PRN effectiveness. This education also focused on standard of practice as it relates to medication administration specifically on not signing the MAR for medications until after the medication has been administered. A review was completed on the 6 rights of medication administration including the need to verify accuracy between the physician order and the medication label prior to administering the medication. Staff members were advised that the physician would need to be notified and a clarification order would need to be obtained if a discrepancy was noted. (Exhibit 3)	2/29/16

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	response for PRN medications. 12/8/15 review of facility policy entitled Medication Administration: General (last revised 7/1/15) included the following documentation standards: - administration of medication on the MAR; - patient's response to the medication; and - effectiveness of PRN medication. The following reflect incomplete documentation of PRN medications found in the clinical records: - R2 (PRN medication for anxiety) missing resident response for 7/21/15 (4:00PM); 10/1/15 (9:30 AM); 10/2/15 (9:40 AM) and 10/28/15 (7:30 PM) ; missing all documentation on the back of the MAR for 8/3/15 (9:35 AM), 9/11/15 (7:45 AM), 9/22/15 (9:30 AM), 9/24/15 (9:50 AM), 9/26/15 (9:45AM) and 9/27/15 (9:20 AM); and missing reason and resident response for 9/28/15 (9:40 AM). R2 (PRN medication for diarrhea) missing resident response for 11/29/15 (8:45 PM). - SS3 missing resident response for 11/11/15 (9:45 AM) medication for pain. - R3 missing resident response for 11/12/15 (4:15 PM) medication for pain. - R10 missing resident response for 11/21/15 (9:45 PM) and missing all documentation on the back of the MAR for 12/2/15 (1:00 AM) and 12/7/15 (12:00 AM) medication for anxiety. - SS2 missing all documentation on the back of the MAR for 12/4/15 (1:10 PM) medication for pain. - SS1 missing resident response for 12/6/15 (7:00 PM) medication for pain. 12/8/15 (12:50 PM) interview - E6 (LPN) stated that, on evenings and nights, the nurse	The DON also provided education to licensed nurses on order transcription and the 24 hour chart check policy. (Exhibit 3) Facility night nurse completes MAR surveillance audits checking for complete documentation of the administration and/or effectiveness for PRN medication and nightly audits for accurate order documentation including verification between the physician order and the medication labels. New orders are then reviewed again during facility clinical rounds. Reports are forwarded to the Resident Care Director. The Resident Care Director or designee will complete random med pass audits which will be forwarded to Quality Improvement Committee verifying medications are initialed on the MAR by the nurse only after administration. **Monitoring of Corrective Action** DON or designee will complete random audits of facility MAR's to ensure accurate documentation of PRN medication is on the MAR. Sample census size will be 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review. DON or designee will complete random audits of physician orders compared to medication labels to ensure accuracy. Sample census size will be 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review. DON or designee will complete random med	

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	administers the PRN medication when there is no AWSAM staff on the Homestead unit. The nurse should document the reason and the effectiveness on the back of the MAR. "If it is not there, it's our [nursing] fault." 12/8/15 (2:10PM) interview with E4 (Dementia Program Director) confirmed missing documentation on the December MARs for PRNs for SS1, SS2, and R10. E4 was informed about numerous missing entries for R2's medication for anxiety from July through October. The facility failed to follow their policy for documentation of PRN medications. 2. 12/4/15 (9:12 AM) medication administration observation on the Homestead unit - E9 (PCA) gave one (1) puff of an ear medication to SS4 which corresponded with the medication's label of one (1) puff. 12/8/15 (9:30 AM) review of SS4's clinical record - physician orders and MAR stated the resident should have two (2) puffs of the ear medication. 12/8/15 review of facility policy entitled Medication Administration: General (last revised 7/1/15) included: if discrepancies, including medication not available, notify physician/mid-level provider and/or pharmacy as indicated. 12/8/15 (10:25 AM) interview with E4 (Dementia Program Director) confirmed that SS4's MAR had the dose as 2 puffs and the label on the medication had the dose as 1 puff. E4 stated that she would need to clarify the correct dosage.	pass audits with licensed nurses and LLAM trained staff to ensure they are completing accurate PRN documentation on effectiveness, comparing medication label physician orders, and to ensure that medications are not being signed off as given until the medication has actually been administered. Sample census size will be one nurse and one LLAM trained staff. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	

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	12/8/15 (11:50 AM) interview with E4 told the surveyor that the family had taken SS4 to the doctor then had the prescription filled at a retail pharmacy. The faxed copy of the original prescription from the retail pharmacy showed the prescription was originally filled 6/9/15. Since this date the incorrect dose of this medication was written on both the physician order and MAR. The resident received the correct dose during the medication observation, but it is unclear if the incorrect dose as recorded on the MAR was ever administered since June. E4 stated the physician informed her that it was not harmful if the resident received two (2) puffs of the medication. E4 entered the correct order in the resident's record so the order and the MAR would match the label on the actual medication. The facility failed to clarify the discrepancy of different doses written on the physician order, MAR and medication label for this resident's ear medication since June 2015. Cross Refer 3225.9.8 3. 12/8/15 (3:00 – 3:10 PM) observation – E8 (LPN) was preparing medications for all the residents receiving evening medications through the wellness center. The nurse reviewed the MAR, removed the medication from the cabinet and placed them in a medicine cup that was positioned on a tray in front of a small card with the resident's name. The nurse then used her pen to write her initials on the MAR for each medication, indicating that she had administered that medication. 12/8/15 (3:23 PM) interview – When asked if		

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	it was standard of practice to sign off meds before they were given, E4 (Dementia Program Director) responded "I would think not, but will check." 12/8/15 review of the facility policy entitled Medication Administration: General (last revised 7/1/15) included the following practice standards [in order of how they were written in the policy]: maintain standard precautions; administer medication; document. Administering medication was listed before documentation in the facility policy. 12/9/15 (2:40 PM) observation/interview – E7 (LPN) was preparing medications for all the residents receiving evening medications through the wellness center. When asked if she was allowed to sign off the medications on the MAR when she poured them, and circle the ones that were not given afterward, E7 stated "I don't sign the meds until they are given. I could, but I don't. Always been taught to give the med [medication] then sign it off." The facility failed to: - accurately document PRN medications for 19 administrations for 6 residents. - ensure a medication dose written on the physician order and MAR matched the dose on the medication label. - sign off medications after administration. These findings were reviewed with E1 (ED) and E2 (DON) at exit conference on 12/16/15 at 1:40 PM.		
3225.8.1	**Provision for a quarterly pharmacy review conducted by a pharmacist which shall**		

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3225.8.1.5.3	**include:** **Review of each resident's medication regime with written reports noting any identified irregularities or areas of concern.** Based on record review, staff interviews and review of facility policies, it was determined that no sliding scale order was written by the physician and facility staff failed to clarify an incomplete order for insulin in a timely manner and the discrepancy was not identified during pharmacy review. 10/28/15 - physician order for Insulin stated: Novolog Flexpen 100 units/ml Insulin Pen, inject as per sliding scale subcutaneously 3 times daily. FBS and before lunch & dinner. Review of the printed physician orders for December 2015 transcribed the handwritten physician orders as: Novolog Flexpen 100unit/1ml insulin pen, inject SQ per sliding scale: check blood sugar 3 times a day for diabetes mellitus. These orders were reviewed on 11/30/15 and signed by a nurse. There were no sliding scale orders on the printed physician orders. Review of the MARs from November & December 2015 had the order for insulin per sliding scale documented, however, there was no sliding scale order documented on either of these MARs. Review of the facility's policy Medication Assistance/Administration: General (last revised 7/1/15) stated if any discrepancies, including medication not available, notify physician/mid-level provider and/or pharmacy, as indicated.	**Correct actions taken** No negative outcome to resident effected. A physician's clarification order has been obtained and the order has been discontinued 12/8/15. **Identification of others with the potential to be effected** Facility residents with a sliding scale order have the potential to be effected. Nurse Managers completed an audit of facility residents requiring sliding scale to ensure order accuracy and completion. (Exhibit 8) **Measures to prevent reoccurrence** DON educated licensed nursing staff on how to accurately transcribe a physician's order, 24 hour chart check policy and procedure, and the facilities medication administration policy (Exhibit 3). Facility night nurse will complete a MAR surveillance audits checking for complete and accurate documentation of new orders. New orders are then reviewed again during facility clinical rounds. Audit reports are forwarded to the Resident Care Director. Regional Clinical Operations Manager completed education to nurses on how to accurately complete end of month order reconciliation. This included the need to verify that all orders were complete and required information. Education is scheduled for 2/9/2016. **Monitoring of corrective actions** DON or designee will complete random audits of new physician orders to ensure that they have been accurately transcribed. Census sample size 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive	2/29/16

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	During the November and December 2015 pharmacy review, the missing sliding scale for the insulin order was not identified. 12/4/15 (11:20 AM) interview - E4 (Dementia Program Director), who was present when resident arrived at the facility with bags full of medicines), confirmed that there were no sliding scale orders written initially by the physician and no one from the facility called to clarify the orders written on 10/28/15. 12/4/15 (11:40 AM) interview - E2 (DON) and E3 (ADON) confirmed that the facility should have clarified the orders written on10/28/15 regarding the sliding scale for the insulin. E2 reported that the Physician's Order Form was printed by an outside Pharmacy Service monthly and the printed orders were to be reviewed for accuracy. If an inaccuracy was found, the pharmacy was to be notified to reprint the orders with the corrections. E2 reported that the facility will call the physician to clarify if a sliding scale was to be ordered. Record review showed that on 12/8/15, the facility received a physician order to discontinue previous sliding scale insulin orders. The facility failed to clarify a discrepancy in medication orders written by the physician.	evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review. DON or designee will complete random audits of end of month order reconciliation to ensure all orders were complete with all required information. Sample size will be 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	
3225.11.0 **3225.11.5**	**Resident Assessment** **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**		

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	significant change in the resident's condition. **This requirement is not met as evidenced by:** Based on record review and staff interviews, it was determined that for one (1) of twelve (12) residents reviewed (R1), the facility failed to use the UAI to update the resident assessment for R1 when there was a significant change in status. R1 experienced an overall decline in medical condition including a decline in function and increased pain. The UAI was not updated for R1 despite the fact that she was receiving hospice services her last three months in the facility and required staff assistance and services that she had not previously required. According to the facility's "Assessment / Customer Service Plan" policy / procedure, a complete re-assessment of a resident will occur whenever a resident's physical and / or mental condition changes and a new service agreement will be generated with each re-assessment. The policy further stated that all assessments would be reviewed at the Service Plan meeting and incorporated into the Service Plan. There was no evidence in the closed clinical record for R1 that this policy / procedure was followed. Findings include: R1 was admitted to the facility on 6/13/14. A 30-day assessment completed on 7/13/14 indicated that her pain related to chronic conditions was adequately controlled with Tylenol. In addition, this assessment indicated that R1 had no nutritional risk (stable weight); no problem with dizziness; no balance problems; no limited activity due to fear of falling; no memory problem and no	**Corrective actions for resident affected** Resident R1 no longer resides at the facility. **Identified of others with the potential to be affected** Facility resident with changes in status have the potential to be affected. Nurse Managers complete an audit of facility residents going back 30 days to ensure a UAI was completed upon change of status. Exhibit (9) **Measures to prevent reoccurrence** DON educated nurse managers on completing the UAI when a change of status occurs. Assessments will be reviewed at the service plan meeting and will be incorporated in to the Service Plan. (Exhibit 3) DON educated clinical team to review nursing notes, physician orders, and resident assessments to identify residents with change of status. Residents with a change in status will have a UAI completed. (Exhibit 3) Nurse managers will complete reviews for resident significant changes in status during clinical rounds by completing staff interviews, Resident observations, and reviews of resident specific information. A resident significant change in status will based upon meeting the thresholds in the facility resident evaluation policy which is an identified problem or variance from baseline. (Exhibit 17) **Monitoring Corrective Action** DON or designee will complete random audits of nurse's notes and physician orders to ensure a UAI was completed upon a resident change in status. Census sample size 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	2/29/16

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	refusal of care / staff assistance. However, record review revealed that there was evidence of significant changes in R1's function and status documented in the nursing notes with no reassessment after 7/13/14: - 9/27/14 5:02 AM- R1 verbalized fear of falling and required assistance of two staff to ambulate to the bathroom; - 10/28/14 5:31 PM- R1's gait unsteady at times, use of wheelchair needed at times; - 12/28/14 9:08 PM- R1 reported pain at a 10 out of 10 severity level with swelling of both legs identified by the nurse; slow / unsteady gait; grimacing at times when ambulating; - 1/4/15 12:48 PM- R1 refusing meals; - 1/8/15 4:49 PM- R1's meal refusal and weight loss documented; - 1/9/15 1:16 PM- R1 refusing routine toileting assistance; - 1/9/15 3:46 PM- Hospice care initiated. Despite the pattern of declining function and significant change in status, the facility failed to re-assess R1 to ensure that her care needs were identified and addressed by the facility. In an interview with the surveyor on 12/8/15 at 10:15 AM, E3 (ADON) stated that E11 (former DON) would have been the one responsible for completing a new assessment of R1. E3 also stated that R1 was not discussed at the facility's routine morning meetings where changes in resident status and needs were typically discussed by the nursing staff. On 12/9/15 at 10:30 AM, E12 (hospice nurse) stated to the surveyor that while receiving hospice services between January and March of 2015, R1 experienced anxiety at times, decreased memory, and increased swelling of the legs causing difficulty for R1 in getting		

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	to the bathroom. On 12/9/15 at 12:30 PM, E13 (Hospice Social Worker), stated to the surveyor that she had discussed with E6 (LPN) and E11 that R1 needed more help, especially when ambulating, because R1 feared falling. As of 3/22/15 when R1 left the facility following a fall (transported to hospital by ambulance), there was no updated assessment of R1's function and care needs since 7/13/14 despite the significant change in R1's status. These findings were reviewed with E1 (ED) and E2 (DON) at the exit conference on 12/16/15 at 1:40 PM.		
3225.13.0	**Service Agreements**		
3225.13.2	**The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:**		
3225.13.2.5	**Psychosocial/emotional services including those related to memory impairment and other cognitive deficits:** **This requirement is not met as evidenced by:** Based on record review, observations, and staff interviews, it was determined that for two (2) of twelve (12) residents reviewed (R3 and R10), the facility failed to address in the service agreement the psychosocial / emotional service to be provided to these residents who each demonstrated psychosocial distress with need for staff intervention and monitoring. R3 verbalized suicidal thoughts and required in-patient psychiatric care. R10 demonstrated unwanted behaviors targeting another	**Corrective Action to resident effected.** No negative outcome to residents R3 and R10. Resident R10 no longer lives in the facility. Resident R3's service plan has been updated to reflect R3's documented psychosocial and emotional needs. **Identification of others with the potential to be affected** Complete an audit facility residents to ensure that services plans have been updated to reflect their documented psychosocial and emotional	2/29/16

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	resident. The facility failed to identify and describe in the service agreement what services facility staff would provide to these two residents to meet their documented and known psychosocial and emotional needs. According to the facility's "Service Plan: Resident" policy / procedure, the service plan is based upon all available resident specific information and is reviewed and updated based on ongoing evaluation of resident needs. The policy further stated that when there is a change in the resident's status the service plan is reviewed and updated to include new approaches / interventions. Findings include: 1. Record review revealed that R3 had known and documented psychosocial / emotional needs including suicidal verbalization with an in-patient psychiatric hospital stay in January, 2015. R3 was observed during the initial tour of the facility on 12/3/15 at approximately 10:40 AM to actively seek social interaction with the surveyors and solicit positive feedback. E1 who was touring with the surveyors stated that R3 was known to seek attention from the staff. Record review revealed that on 1/22/15 (nursing note timed 5:28 PM), R3 had been sent to the hospital emergency room for suicidal talk and several coins had been found in R3's esophagus (tube extending from throat to stomach). A nursing note dated 2/12/15 times 2:57 PM indicated that R3 was readmitted to the facility after an in-patient psychiatric facility stay. A nursing note dated 5/4/15 at 5:39 PM revealed that R3 made suicidal comments again and was evaluated in the hospital emergency room and returned to the facility on the same day. Although a mental health	needs. (Exhibit 10) **Measures to prevent reoccurrence** Regional Clinical Operations Manager provided education to licensed nurses on updating and creating service plans to accurately reflect resident's psychosocial and emotional needs to include appropriate approaches and interventions. Facility nurse managers during clinical rounds will ensure service plans are updated accurately by licensed nurses with appropriate approaches and interventions based upon resident and family interviews, resident observations, resident specific information, and any change in status monitoring for any identified problems or variances from baseline to meet resident's needs and promote independence, dignity, and choices. **Monitoring corrective actions** DON or designee will complete random audits of physician orders, consult notes, nurses notes, and completed UAI's to ensure service plans are updated with staff interventions and monitoring upon a residents psychosocial or emotional need change and change in status. Census sample size 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	

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	consultation for R3 was ordered by the physician on 5/6/15, this order was discontinued (cancelled) on 5/7/15 for unclear reasons. E3 (LPN) stated to the surveyor at 1:52 PM on 12/3/15 that prior to being moved to the locked unit of the facility, R3 had been very active socially and talked to "everyone". On 12/4/15 at approximately 1 PM E4 (Dementia Program Director) agreed with the surveyor's observation of R3's attention seeking behavior and need for social interaction but E4, who had recently started working at the facility, was unfamiliar with R3's psychiatric history. The service agreement for R3 lacked specific services to be provided by facility staff to ensure that R3's emotional and psychosocial needs were met. For example, a psychiatric consultation report dated 2/27/15 included an instruction for staff to "please approach (R3) with pleasant affect and monotone voice" but this was not added to the service agreement to ensure that all staff were aware. The service agreement developed by the facility referred to psychiatric consultation and monitoring medications without specific services identified for staff to provide to R3. 2. R10's clinical records revealed: 11/6/15 – admission to the Homestead unit with multiple diagnoses including dementia. Review of 11/7/15 – 12/5/15 nurses' notes found 30 documented episodes of anxiety including pacing in the hallway, being visibly upset / shaking, entering other resident rooms. R10 received medication for anxiety twenty nine (29) times after redirection did not work.		

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	11/9/15 (3:24 PM) nurses' note – documented R10 approached a female resident with inappropriate sexual advances thinking she was his wife of over 70 years. 11/13/15 (9:58 AM), 11/17/15 (7:43 PM), 11/18/15 (7:02 PM) nurses' notes - R10 continued to try to kiss, touch and/or follow a specific female resident. 11/23/15 (5:22 PM) nurses' note - R10's wife was being admitted to the nursing facility across the street. 11/25/15 evaluation note by psychiatric NP for anxiety and behaviors toward female resident offered recommendations for medication changes. 11/28/15 (5:52 PM) nurses' note – slight anxiety, pacing back and forth and flirting/hitting on other female residents thinking they are his wife, which caused R10 anxiety when those residents get upset and tell him they are not his wife. 12/3/15 review of service agreement found the following areas of focus were initiated on 11/9/15: - Barriers to meaningful engagement: interventions listed 'loneliness' which was a symptom and not an intervention. - Worried/anxious: no interventions were written to address R10's anxiety over missing his wife and thinking a female resident was his wife. - Sexually inappropriate: interventions included to react with patience and gentleness; try not to show own embarrassment or disapproval; redirect from female resident; use distraction.		

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	- Adjustment to the facility, staff, program: no interventions were written to address this issue. 12/4/15 (2:00 PM) interview – when asked if R10 had any special needs, E9 (PCA on days) stated there were no special needs. On evenings R10 does get anxious but I'm not here then. 12/4/15 (3:04 PM) interview - E10 (PCA on evenings) stated R10 usually gets anxious after dinner and will pace and walk all around, looking at the names on the resident rooms. [maybe to look for wife's name]. When asked about the frequency of monitoring he requires on her shift, E10 stated "we [the staff] constantly need to keep track of where he is". He thinks that SS4 is his wife. SS4 does "look kind of like his wife". 12/8/15 (9:30 AM) review of R10's service agreement found it remained the same as the 12/3/15 review. 12/8/15 (10:20 AM) interview – When asked about strategies in the service agreement, E4 (Dementia Program Director) stated she had contacted other dementia experts for other suggestions besides redirection but has not hear. She also stated she was concerned that the psychiatric NP had not showed up to follow up on the medication management plan. When the surveyor asked if the resident could read since he had been seen carrying a newspaper, E4 said he could read but was very forgetful and couldn't remember from one minute to the next. There was no evidence that the facility tried using written signs to remind the resident that his wife was not there. E4 added that on his way here, the family met and had lunch with R10's wife		

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	which may have aggravated his behaviors. 12/8/15 (1:00 PM) - R10 was observed sitting next to SS4 in the living room of the Homestead unit. SS4 said it was "ok for him to sit there". The facility failed to include interventions in the service agreement for two residents to address their specific psychosocial and emotional needs. These findings were reviewed with E1 (ED) and E2 (DON) at exit conference on 12/16/15 at 1:40 PM.		
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 record review, staff interviews, and review of other documentation as indicated, it was determined that for one (1) of twelve (12) residents reviewed (R1), the facility failed to develop and follow a service agreement consistent with the resident's unique physical and psychosocial needs with recognition of R1's capabilities and preferences. R1 was receiving hospice services and had an overall decline in condition (strength and function). The service agreement in effect for R1 in March, 2015 failed to identify specific services to be provided to address her fall risk, weakness, pain control, and use of mobility aides (e.g. when to use the walker vs the wheelchair). R1 fell in the lobby of the facility near the dining room on 3/22/15 hitting	**Corrective Action to resident effected.** Resident R1 no longer lives in the facility. **Identification of others with the potential to be affected** Complete an audit of facility residents to ensure that services plans have been updated to reflect their documented psychosocial and physical needs. (Exhibit 11) **Measures to prevent reoccurrence** Regional Clinical Operations Manager completed education to licensed nurses on updating the service plan to accurately reflect resident's psychosocial and physical needs to include appropriate approaches and interventions. Facility nurse managers during clinical rounds will ensure service plans are updated accurately by licensed nurses with appropriate approaches and interventions based upon resident and family interviews, resident observations, resident specific information, and any change in status monitoring for any identified problems or variances from baseline to meet resident's needs and promote independence, dignity, and choices.	2/29/16

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	her head on the floor and was transported to the hospital for evaluation. Findings include: Cross-refer 3225.11.5; 3225.13.6 (example 3); and 3225.14.1. R1 had multiple fall risk factors identified in her clinical record. The last assessment completed for R1 by facility staff was dated 7/13/14 and indicated that R1 had a gait problem. Hospice notes starting on 1/9/15 indicated that R1 was not eating consistently, had pain of the legs, swelling of the legs, and difficulty ambulating at times. On 1/13/15, the physician ordered a wheelchair with footrests for R1 who also had a walker that she had used since her admission to the facility (June, 2014). The service agreement failed to identify how staff would determine when the walker vs the wheelchair should be used by R1. A nursing note dated 3/20/15 timed 8:04 PM indicated that a signed physician order had been received for oxygen 2 liters per minute by nasal cannula (prongs in nose) for shortness of breath or resident request and that R1 had stated she felt better with the oxygen on. The use of oxygen was not addressed in the service agreement for R1 and it was unclear whether the necessary portable equipment was available for R1 to use the oxygen when she was out of her room. According to a facility incident report dated 3/22/15, at 9:30 AM that morning, R1 had been assisted by staff (a nurse and two PCAs according to the incident report) from the dining room to a bench in the lobby using her walker. The incident report described R1 as looking tired when seated on the bench and staff instructed her to ask for assistance if she wanted to go back to her room. Shortly after this, R1 stood and fell hitting her head on the	**Monitoring corrective actions** DON or designee will complete random audits of physician orders, consult notes, nurse's notes, and completed UAI's to ensure a service plans are updated upon a resident's psychosocial or physical need and change in status. Census sample size 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	

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	floor. R1 was sent to the hospital for evaluation via ambulance after 911 was called. The incident report documented that the wheelchair had been offered to R1 several times by staff but she had declined and used her walker instead. The incident report further documented that R1's unsteady gait contributed to the fall and that she had received an antianxiety medication (Ativan) three hours prior to the fall. Interview with E14 (PCA) on 12/8/15 at 11:50 AM revealed that R1 had complained of leg pain on the morning of 3/22/15 and seemed to be in more pain than usual. When asked why she thought this, E14 replied that R1 was yelling out in pain so she (E14) told the nurse and the nurse talked to R1. E14 recalled that after R1 ate in the dining room, she and E15 (PCA) walked R1 into the lobby and R1 sat on a bench there. E14 recalled seeing R1 "nodding" and going to sleep and she left to go to the nearby nursing station to tell the nurse. Interview with E15 revealed that R1 was seated in the lobby because she wanted to rest. E15 stated that she only worked at the facility every other week-end but she recalled that about half the time she saw R1, R1 was using a wheelchair, not the walker. E15 explained that R1 had good days and bad days depending on her pain and fatigue level. The facility failed to develop and follow a service agreement for R1 that was consistent with her unique needs including specific staff interventions to minimize R1's fall risk and promote her comfort and safety. These findings were reviewed with E1 and E2 at the exit conference on 12/16/15 at 1:40		

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	PM.		
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.** **This requirement is not met as evidenced by:** Based on record review, staff interviews and review of facility documents, it was determined that for four (R12, R10, R1 and R3) out of 12 residents reviewed the facility failed to revise the service agreement based on the changing needs of the residents. Findings include: 1. Review of facility incident reports provided to the surveyor upon request revealed that R12 had fallen on the following dates: - 5/7/15 (2:00 PM) no injury - 5/31/15 (12:00 PM) right arm skin tear - 6/3/15 (6:00 PM) right arm skin tear - 8/13/15 (9:30 AM) right knee scratch - 5/31/15 (12:00 PM) right arm skin tear - 8/20/15 (1:15 PM) redness to both knees - 9/26/15 (6:00 PM) no injury - 10/1/15 (4:35 PM) right arm skin tear - 10/8/15 (6:30 PM) hit head, head CT scan with no injury - 12/7/15 (4:20 PM) no injury Review of R12's service agreement (last reviewed 5/19/15) documented R12 walked with a walker but needed to be reminded to use the walker. This service agreement also identified that the resident's memory was	**Corrective Action to resident effected.** Resident R1 no longer lives in the facility. R3, R10, and R12's service plans have been updated. **Identification of others with the potential to be affected** Complete an audit of facility residents to ensure that services agreement have been updated to reflect their changing needs. (Exhibit 10 and 11) **Measures to prevent reoccurrence** DON completed education to nurse managers on executing the service agreement within 10 days of completing a UAI. Service plan agreements will be tracked during facility clinical meetings to ensure timely completion of the service agreement execution. (Exhibit 3) Service plans are updated by licensed nurses with appropriate approaches and interventions based upon resident and family interviews, resident observations, resident specific information, and any change in status monitoring for any identified problems or variances from baseline to meet resident's needs and promote independence, dignity, and choices. **Monitoring corrective actions** DON or designee will complete random audits of service agreements to ensure they are executed within 10 days of the UAI. Ensure a service plans are updated upon a resident's psychosocial or physical need and change in status. Census sample size 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to	2/29/16

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	impaired which interfered with everyday communication and understanding instructions. Resident's fall history revealed fifteen (15) falls between July 2014 and April 2015. 9/16/14 PT note - resident was unable to meet PT goals due to limitation or motion brought about by low back pain; resident presented with instability and decreased safety using tripod rollator; still with poor posture during gait and transfers which increased risk for falls. 6/10/15 PT note - resident seen for screening due to falls; resident had pain in low back; instability with walking and decreased safety awareness; resident denied any falls although PCA says she had fallen due to chronic instability; no need for PT services at this time due to chronic functional instability due to dementia. 8/25/15 PT note - spoke with niece & PCA; resident had falls because she forgets walker or gives it away; neither feel that rehab would benefit resident; reinforced with resident who agreed but said she forgets; spoke with resident who reports she did not fall, she slipped from bed when attempting to stand. PT orders from 8/13/15 were cancelled due to resident and family request. 10/12/15 PT note - discussed with PCAs: resident furniture cruises and had overall decreased balance and stability; resident was inconsistent with use of walker. 11/4/15 PT evaluation - resident was very anxious and moderately agitated but followed instructions; ambulated with supervision twice	ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	

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	in unit; resident reported back pain but unable to rate pain; ambulated as desired in unit but when she got anxious and tired she tended not to use her walker; this was when the falls occurred; PT services not necessary; falls occurring due to cognitive and behavioral factors; learning behaviors identified: anxious, agitated behavior. Facility's policy on Falls: Prevention (12/1/06, with no current revision date) stated that the RCD or designee will review "Falls Prevention Strategies" with residents at risk, their caregivers and their representatives as appropriate. There was no evidence in the resident's record that these strategies were discussed with the resident, the caregivers or resident representative. Facility policy on Falls: Care During and After (12/1/06 with no current revision date) stated all residents who experience a fall will receive appropriate care and investigation of the cause. Review of the investigation and the interventions will be conducted by Community staff and service plan updated to reflect new interventions. Review of the resident's service agreement (reviewed/revised date 5/19/15) indicated that it was not reviewed or revised until 12/4/15. 12/4/15 - findings were confirmed with E4 (ADON) during record review and interview. 2. Cross Refer 3225.13.2.5, Example 2 11/20/15 (2:40 PM) nurses' note documented the family brought in a picture of R10's wife. Staff will continue to redirect as needed when resident approaches a female resident who he thinks is his wife. R10's service agreement was not updated to		

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	include other interventions for the focus of being sexually inappropriate when behaviors continued and redirection did not work. There was no evidence how the facility used R10's picture of his wife or if they tried telephone conversation with R10 and his wife. 3. Cross-refer 3225.13.5. The facility failed to review and revise the service agreement for R1 when R1 had a significant change in condition, function, and care needs. The service agreement in effect at the end of R1's stay in the facility failed to address known care needs such as pain management, nutrition / weight loss, and mobility difficulties. Due to a lack of re-assessment of R1 and revision of the service agreement to address her changed care needs, the service agreement was inaccurate and outdated for at least the last three months of R1's stay in the facility. The service agreement did not include any reference to hospice services which R1 received for the last two months she was in the facility. 4. Cross-refer 3225.13.2.5, example 1. The facility failed to review and revise the service agreement for R3 to address R3's psychosocial and emotional needs. R3 had been hospitalized in an in-patient psychiatric facility in early 2015 after verbalizing suicidal ideas and swallowing coins. R3 again verbalized suicidal thoughts and was evaluated in the emergency room in May, 2015. It was unclear from the clinical record and service agreement in effect at the time of the survey what, if any, services the facility was providing to R3 related to her psychiatric needs. The facility failed to review the service		

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	agreement for four residents after their needs changed. These findings were reviewed with E1 (ED) and E2 (DON) at exit conference on 12/16/15 at 1:40 PM.		
3225.16.0 3225.16.2	**Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** **This requirement is not met as evidenced by:** Based on observation and interview it was determined that the facility failed to provide sufficient number of staff on the Homestead unit. The facility failed to establish a plan for adjusting staffing patterns to actual changes in the care needs of the facility's resident population. Findings include: Cross Refer 3225.13.2.5, Example 2 1. 12/3/15 (around 10 AM) observation during initial tour with E1 (ED) – There were 19 (nineteen) residents on the Homestead unit that has a layout like a large square with a courtyard in the middle. Resident rooms were located along three hallways (back of the unit and both sides). When standing in the area where two hallways meet, the surveyor was able to see up both hallways. When not in the area where two hallways meet, the surveyor was only able to see activities only in that hallway.	**Corrective action for resident affected** No negative outcomes to residents. Facility nursing administration levels on 6/7/2015, 9/1/2015, and 11/5/2015 were appropriate as the total facility census varied between 49 and 52. The referenced 36 job responsibilities of the homestead director were assumed by the DON and ADON as the Nurse Administration to resident ration was 1:26 because of low total census. **Identification of others with the potential to be effected** Homestead residents have the potential to be effected. An audit was completed of the current resident ADL needs (Exhibit 4). An audit was also completed of the homestead unit's staffing pattern to ensure that it adequately reflects the resident needs and staff availability to ensure the highest practical outcome of the homestead residents. The audits reflect the current staffing ratio meet the current population's ADL needs. (Exhibit 5) **Measures to prevent reoccurrence** DON educated homestead director on how to assess resident level of care needs as it relates to staffing. (Exhibit 3) Nurse Managers will staff the facility based upon residents ADL levels determined from the UAI. Staff levels	2/29/16

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	12/4/15 – review of the staffing schedule determined the Homestead unit was staffed with one Dementia Program Director (RN manager) primarily during the day. On day and evening shifts there were 2 PCAs on duty. On night shift there was 1 PCA on the unit. One LPN manning the wellness center was available 24/7 for assistance and medication administration. 12/4/15 (3:04 PM) interview - E10 (PCA on evenings) stated that staff needed to constantly keep track of where R10 was since the resident believed a female resident on the unit was his wife. This female resident was not R10's wife. 12/8/15 (10:20 AM) interview – when asked about the frequency of monitoring on nights when one PCA was on duty, E4 (Dementia Program Director) stated that she worked nights one time and there were some residents on scheduled toileting times. Surveyor commented that with the layout of the floor it would be extremely difficult to hear or see residents at the other end of the unit. E4 agreed since there was a time she "was fortunate to be coming out of a room so I heard a resident call for help". 12/8/15 (2:20 PM) interview – E1 talked with the surveyor about R10 and his monitoring needs on evening and nights. Surveyor informed E1 that there had been times when R10 received PRN medication between midnight and 1am. "Oh, so that's on the night shift." Surveyor commented that if the night PCA is helping a resident at the back end of the unit the PCA would not be able to see what's occurring up here [pointing toward R10's room]. E1 stated that there may come a time when R10 may have to be moved,	are adjusted (increased or decreased) to provide necessary care to resident based upon resident acuity. (Exhibit 4) The facility has a Homestead Staffing Policy that states, "the Homestead Program will provide qualified and appropriate staffing levels to meet the needs of the patient/resident population" who qualify for assisted living services based upon residents assessments. (Exhibit 15) The Obligations of the Responsible Party in the admission packet requires and asks that if the resident requires services that exceed those provided as basic service, that the responsible party would be financially responsible for those services. (Exhibit 16) Basic services are outlined in the Residency Agreement. Staffing levels will be evaluated upon residents change in status, service plan updates, and upon admission and discharge. Staffing levels and duties will be discussed at each quality assurance meeting. **Monitoring of Corrective Action** DON or designee will complete audits of homestead unit's staffing pattern to ensure that it adequately reflects the resident needs and staff availability to ensure the highest practical outcome of the homestead residents. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	

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	when his needs are more than what the facility can offer. 12/9/15 (11:40 AM) interview - E4 stated that six of the 19 residents on the Homestead unit wore disposable undergarments due to incontinence. E4 explained these 6 residents required staff to check them every two hours to see if they needed changing or assistance for toileting. E4 confirmed that on the 11:00 PM – 7:00 AM shift (night shift) there was one PCA assigned to the locked unit to provide required care to all 19 residents. 12/10/15 - Review of facility-reported incidents from the previous year found three Homestead residents were discovered between 6:00 – 6:30 AM to have fallen. It was unclear how long each of these residents were on the floor prior to being found by the one PCA on duty. - 6/7/15: SS6 broke a wrist - 9/1/15: SS1 had a cut on a hand - 11/5/15: SS5 had no injury when found on the floor in apartment. 12/15/15 telephone interview with a resident's responsible party (RP1) who wished to remain anonymous – when asked "Is there enough staff available to make sure that residents get the care, assistance and supervision they need without having to wait a long time?" RP1 stated "They need more help. They [residents] need more care.... to oversee what they're doing." 12/16/15 (around 12:45 PM) – E17 (corporate clinical staff) stated the Dementia Program Director position (manager of Homestead unit) was vacant from December, 2014 to September, 2015. The job description for this position included thirty six (36) responsibilities		

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	including: - Complete resident assessment and plans with ongoing updates, as needed. - Coordinate, implement and monitor all service plans. - Assure implementation of all policies and procedures - Perform ongoing quality improvement evaluations including quality indicators for the environment, documentation, team functioning and all aspects of quality care. - Develop daily and monthly activity calendar for the unit. - Provides orientation as well as ongoing training on dementia care to staff. - Provides family education through support groups, family council and other methods of information like newsletters, brochures, etc. These findings were reviewed with E1 and E2 (DON) at the exit conference on 12/16/15 at 1:40 PM. 12/15/15 - During the exit conference E3 (ADON) stated that she and E11 (former DON) divided the responsibilities of the vacant Dementia Program Director position and that E11 often staffed the evening shift in the wellness center due to a vacant nursing position. It is unclear how the multiple responsibilities of the Dementia Program Director were adequately performed when the position was vacant for nine months and tasks were delegated to staff with other full-time responsibilities. There was no evidence that the corporation for the facility provided temporary assistance during this time frame. 2. Interview with E1, E2, and E3 (ADON) on 12/15/15 at 11:40 AM revealed that there was no established plan in place for adjusting		

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	staffing to actual changes in the care needs of the facility's resident population. E1 explained that in individual cases (e.g. a resident returning from the hospital who required temporary extra help), the facility provided additional staff to work one-to-one with the resident in need. There was no evidence provided, however, that overall acuity (level of help needed) of the resident population was regularly reviewed by the facility and then used to determine what staffing level was "sufficient" to meet the care and safety needs of all residents. The facility failed to provide sufficient number of staff on the Homestead unit and failed to establish a plan for adjusting staffing patterns to actual changes in the care needs of the facility's resident population. These findings were reviewed with E1 and E2 at exit conference on 12/16/15 at 1:40 PM.		
3225.16.14 3225.16.14.2 3225.16.14.2.10	**Assisted living facility resident assistants shall, at a minimum:** **Participate in a facility-specific orientation program that covers the following topics:** **Hospice services.** Based on staff interview, it was determined that the facility staff orientation failed to adequately address hospice service in the facility. Findings include: Cross-refer 3225.5.3. The facility lacked a policy / procedure for hospice services. On 12/15/15 at 12:10 PM, E2 (DON) stated that the orientation for staff included just a brief	**Corrective Action taken** The facility does not currently have any hospice residents. **Identification of other** Facility resident on hospice have the potential to be affected. The facility currently does not have any residents requiring hospice services. **Measures to prevent occurrence** The facility initiated a hospice policy. The policy outlines the facility plan for an interdisciplinary approach to hospice care involving facility staff, hospice team members, and family members. (Exhibit 2 &3) Administrator provided education to DON	2/29/16

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Heritage at Milford

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	mention that hospice services may be provided in the facility. E2 acknowledged the need for orientation and in-service to ensure all staff understood the role of hospice and how to coordinate between the resident, family, hospice, and the facility. These findings were reviewed with E1 (ED) and E2 at exit conference on 12/16/15 at 1:40 PM.	related to adequate addressing hospice services policies and procedures during facility orientation and annually. (Exhibit 3) **Monitoring of Corrective Action** Administrator or designee will complete audits of facility orientations and employee files to ensure that new hires receive hospice policy education. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	
3225.17.0 3225.17.5	**Environment and Physical Plant** **For all new construction and conversions of assisted living facilities with more than 10 beds, there shall be at least m100 square feet of floor space, excluding alcoves, closets, and bathroom, for each resident in a private bedroom and at least 80 square feet of floor space for each resident sharing a bedroom.**	**Corrective Action** No negative outcomes to residents.	2/29/16
3225.17.5.3	**Bedrooms and all bathrooms used by residents in assisted living facilities, except in specialized care units for memory impairment, shall be equipped with an intercom or other mechanical means of communication for resident emergencies. For specialized care units for memory impairment, staff must be equipped to communicate resident emergencies immediately.** **This requirement is not met as evidenced by:** Based on observation and interview it was determined that call cords in resident bathrooms were not accessible for activation if the resident would fall and be on the floor. Findings include:	**Identification of others with the potential to be effected** An audit was complete of the facility bathrooms to ensure that call cords are accessible for activation from the floor. (Exhibit 13) **Measures to prevent reoccurrence** Administrator educated Maintenance Director that call cords in bathrooms must be at a length that they would be accessible for activation from the floor. (Exhibit 3) Facility call bell cords identified are replaced they could be activated from the floor. (Exhibit 3) **Monitoring of corrective actions** Administrator or designee will complete random audits of resident bathrooms to ensure that call bell cords are accessible to be activated from the floor. Census sample size is 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations.	

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	12/3/15 observation during initial tour starting around 10:00 AM – bathroom call light cords in rooms 11, 18 and room 133 were each approximately 8-9 inches in length ending around 3 feet from the floor. 12/8/15 - observation to measure bathroom call light cords with a tape measure found: Room 18 (10:29 AM) 8.5 " Room 17 (10:30 AM) 7.5" Room 30 (10:34 AM) 10.25 " Room 123 (12:32 PM) 7" 12/8/15 (10:25 AM) interview – E4 (Dementia Program Director) denied that any falls occurred in a resident bathroom on the Homestead unit since her hire in September. When asked how a resident would call for help if a fall occurred in the bathroom, surveyor accompanied E4 to the bathroom in room 17. E4 confirmed the resident would not be able to pull the cord if on the floor. This call light cord was 7.5" in length. 12/8/15 (2:15 PM) interview - E1 (ED) stated he was aware of the bathroom call light cords and had been calling around to other assisted living facilities to see what they have. "Either way, I think that's a good idea to have them longer so they can be reached." These findings were reviewed with E1 (ED) and E2 (DON) at exit conference on 12/16/15 at 1:40 PM.	Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	
3225.17.8	**Hot water at resident bathing and hand-washing facilities shall not exceed 120 degrees Fahrenheit.** **This requirement is not met as evidenced**	**Corrective Action** No negative outcomes to residents. The water	2/29/16

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	by: Based on observation and interview it was determined that the facility failed to ensure the hot water in 5 (Room 11, 17, 18, 24, 30) out of 5 resident rooms surveyed on the Homestead unit did not exceed 120 degrees. Findings include: 12/3/15 (11:58 AM – 12:08 PM) - Observations of temperatures (F) of hot water in resident sinks using a Cooper – Atkins digital thermometer found: Room 11 – 121.2 Room 17 – 122.7 Room 18 – 121.8 Room 24 – 124.3 12/3/15 (1:37 PM) interview - E5 (Director of Maintenance) stated that resident sink temperatures are checked weekly in rooms at each end of the water pipe run, two rooms on each unit and that temperatures are "usually under 120 degrees". When informed of the temperatures obtained by the surveyor, E5 indicated he would adjust the hot water regulator immediately. 12/4/15 (8:28 AM – 8:35 AM) - temperatures (F) of hot water in resident sinks taken with the same thermometer found: Room 11 – 117.1 Room 18 – 117.5 Room 24 – 124.3 Room 30 – 121 12/4/15 (8:35 AM) interview – E5 stated the regulator temperature will be turned down a few more degrees. 12/4/15 (2:18 PM – 2:23 PM) – temperatures of hot water in resident sinks taken with the	temperature was adjusted at the mixing valve and set the resident room temperatures below 120F. **Identification of others with the potential to be effected** An audit was completed of resident rooms to ensure that water temperatures were below 120F. (Exhibit 14) **Measures to correct reoccurrence** Administrator educated Maintenance Director on facility regulations as it relates to resident safety for having water temperatures in resident sinks below 120F. (Exhibit 3) Maintenance Director or designee will complete weekly audits of water temperatures throughout the facility to ensure that water temperatures in resident sinks are below 120F. (Exhibit 14) **Monitoring of Corrective Actions** Administrator of designee will complete random audits of resident rooms to ensure that resident sinks are below 120F. Sample size will be 10. The audits will occur three times a week until the facility consistently reaches one hundred percent success at three consecutive evaluations. Then once a week until the facility consistently reaches one hundred percent compliance over three consecutive evaluations. Then the facility will measure one more time a month later to ensure compliance. Audits will be forwarded to the facility quality assurance committee for review.	

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	same thermometer found: Room 18 - 117.3 Room 24 - 116 Room 30 - 118.2 12/4/15 (3:05 PM) interview – E5 was informed the latest temperatures were under 120 degrees. 12/8/15 (10:29 AM – 10:34 AM) – temperatures of hot water in resident sinks taken with same thermometer: Room 18 - 114.4 Room 17 - 116.2 Room 30 - 119.6 These findings were reviewed with E1 (ED) and E2 (DON) at exit conference on 12/16/15 at 1:40 PM.		

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