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

IAME OF FACILITY: Dover Place

DATE SURVEY COMPLETED: July 20, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility beginning July 13, 2017 and ending July 20, 2017. The facility census on the entrance day of the survey was 70 residents. The survey sample totaled seven residents and two sub-sampled residents for focused review. 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 CSM – Care Services Manager MCD – Memory Care Director LPN - Licensed Practical Nurse BOM – Business Office Manager RN - Registered Nurse C – Chef DA – Dietary Aide AA – Activity Aide HS – Housekeeping 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.		

Provider's Signature Virginia Beth Kelly Title Executive Director Date 9/22/17

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3225 5.0 5.12	**Assisted Living Facilities** **General Requirements** **An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** Based on review of facility records and staff interview, it was determined that the facility failed to provide dementia specific training each year to two [E6, E7] of seven sampled healthcare providers. Findings include: On 7/18/17 at approximately 3:00 PM, the surveyor requested from E1 (ED), the facility's evidence of the mandatory, yearly dementia specific training for E6 (SLP) and E7 (PT). On 7/19/17 at approximately 2:00 PM, the surveyor was informed by E2 (CSM) that the facility did not have evidence of the training for the two contracted therapy staff, E6 and E7.	5.12 A. E6 received the mandatory yearly dementia specific training on 8/9/2017. E7 received the mandatory yearly dementia specific training on 8/7/2017. Evidence of the training has been placed in the contracted employee files. B. Current residents have the potential to be affected by the alleged deficient practice. Audits of all employee files (to include 3rd party providers) were completed. 1 other 3rd party provider's training did not meet the regulation. At this time, ALL 3rd party providers have completed 4 hours of dementia training. Routine yearly in-services will be provided to all employees (including 3rd party employees). C. Contracted employee files will be reviewed upon beginning contracted services and prior to resident contact, by the Executive Director and/or designee, to ensure the mandatory yearly dementia specific training is completed. D. The Executive Director is responsible for sustained compliance. The Care Services Manager and/or designee will audit records for contracted healthcare providers monthly to ensure compliance. The audits will be reviewed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of 100% compliance. Continued monitoring will be ongoing. (Attachment A)	9/30/2017

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	Findings were reviewed with E1, E2, and E3 (MCD), at approximately 1:30 PM on 7/20/17.	8.0/8.8/8.8.2	
8.0	**Medication Management**	A. SSR1 exhibited no negative effects. E8 was re-educated on following physician's orders for medication administration on 9/21/2017 by CSM. SSR2 exhibited no negative effects. E4 was re-educated on the five rights of medication administration and facility policy for medication administration on 9/21/2017 by CSM.	10/15/2017
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:**		
8.8.2	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;**	B. Current residents have the potential to be affected by the alleged deficient practice.	
	Based on observations, clinical record reviews, staff interviews, and review of the facility's policy as indicated, it was determined that the facility failed to follow the facility's policy and the standard of practice for medication administration for two (SSR1 and SSR2) out of two residents. The facility failed to administer a medication, in accordance with the physician's order for SSR1. In addition, the facility failed to observe SSR2 taking the medications. Findings include:	C. Current nurses will be in-serviced by 10/1/2017 by the Care Services Manager, on the proper procedures for following physician's orders for medication administration, the five rights of medication administration and the current facility policy for medication administration.	
	Review of the facility's policy titled Medication Management, with an effective date of 7/1/2014 documented: - Medications are administered in accordance with the physician order. - Staff will observe the resident taking the medication and the medication will not be left with a resident to take at a later time.	D. The Care Services Manager is responsible for sustained compliance. The CSM and/or designee will monitor medication administration techniques randomly, 5 x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks, to ensure compliance. Results will be discussed at monthly QI meetings. The QI Committee will determine if continued monitoring is necessary based on three consecutive months of 100% compliance.	

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	1. During medication administration observation, on 7/14/17 at approximately 4:45 PM, E8 (LPN) administered a medication to treat high blood pressure to SSR1. At approximately 5:00 PM on 7/14/17, SSR1 verbalized that she had taken her blood pressure reading after the above medication was administered. SSR1 provided a BP reading of 139/69. Review of the July 2017 physician order indicated to hold this medication for systolic blood pressure less than 100. An interview immediately after the observation with E8 revealed that SSR1 takes her own BP and SSR1 usually provides this before the above medication is scheduled to be given and confirmed that the physician's order was not followed. Findings were reviewed with E1 (ED), E2 (CSM), and E3 (MCD), at approximately 1:30 PM on 7/20/17. 2. During medication administration observation, on 7/17/17 at approximately 8:15 AM, E4 (LPN) poured five pills into a medication cup, mixed the medication with applesauce and provided this to SSR2. For approximately 15 minutes, from 8:15 AM to 8:30 AM, SSR2 was observed by the surveyor taking her medications, while E4 was performing other tasks, including walking into an adjacent room and failed to observe SSR2 taking all the medications. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17.		

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9.0	**Infection Control**	9.0/9.5/9.5.1	
9.5	**Requirements for tuberculosis and immunizations:**	A. R1 received a tuberculin test on 7/19/2017, with negative results read on 7/21/2017. Received 2nd Step on 7/26/17 with negative results read on 7/28/2017.	10/1/2017
9.5.1	**The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** Based on review of the clinical record and staff interview it was determined that the facility failed to ensure that one resident (R1) out of seven sampled had documented results of tuberculin testing upon admission. Findings include: R1 was admitted to the facility on 4/22/17. Review of the clinical record revealed no documentation of tuberculin testing and results of tuberculin testing for R1. An interview with E2 (CSM) on 7/20/17 at approximately 10:30 AM confirmed that the facility failed to complete the tuberculin testing upon admission and E2 related that R1's tuberculin testing has been initiated during the survey. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17.	B. Current residents have the potential to be affected by the alleged deficient practice. An audit of resident records was completed and 1 additional resident's PPD test was not complete. After receiving Dr. order, resident is in the process of receiving 2 step PPD (2nd step will be completed on 9/28/2017). C. The Care Services Manager was re-in serviced regarding the requirement for Tuberculosis testing for residents upon admission, on 9/7/2017 by ED. D. The Care Services Manager is responsible for sustained compliance. The CSM and/or designee will audit resident records within 3 days of admission to determine status of tuberculin testing, weekly for 1 month, monthly for 6 months. Audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of 100% compliance.	
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 Health and Human Services. Should the**	9.5.2 A. E9's two step tuberculin test was initiated on 7/13/2017. The second step was provided on 7/20/2017, with a negative result read on 7/23/2017. E10's two step tuberculin test was initiated on 7/13/2017. The second step was provided on 7/20/2017, with a negative result read on 7/23/2017. E11's two step tuberculin test was initiated on 7/13/2017. The second step was provided on 7/20/2017, with a negative result read on 7/22/2017.	10/1/2017

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	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. Based on review of facility documentation and staff interviews, it was determined that the facility failed to ensure that three staff members (E9, E10, and E11) out of seven sampled staff members had received the baseline two step tuberculin test prior to employment. Review of the following employee Immunization and Tuberculosis Testing Consent and Record revealed: 1. E10 (HS) with hire date of 4/42/17. No testing prior to employment. An interview with E13 (BOM), on 7/13/17 at approximately 4:00 PM confirmed the findings and E13 verbalized that the facility initiated TB testing for E10 on 7/13/17. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17. 2. E9 (DA) with hire date of 5/23/17. One step result documented as negative on 5/14/17. Record review lacked evidence of the second step being completed. An interview with E13 on 7/13/17, at approximately 4:00 PM confirmed the findings and E13 verbalized that the facility initiated TB testing for E9 on 7/13/17. Findings were reviewed with E1, E2, and E3,	B. Current residents/employees have the potential to be affected by the alleged deficient practice. An audit of all employee files was completed and 4 employees were found to have incomplete PPD tests. At this time, all employees are in compliance with PPD regulation. C. The Care Services Manager was re-in-serviced regarding the requirement for a base line two step tuberculin skin test prior to employment for new employees, on 9/7/2017 by ED. D. The Care Services Manager is responsible for sustained compliance. The CSM and/or designee will audit employee pre-employment records prior to beginning orientation. No employee will be permitted to work in their position until 2 step PPD completed. Audits will be conducted weekly for three months and monthly thereafter. Audit results will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of 100% compliance.	

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	at approximately 1:30 PM on 7/20/17. 3. E11 (C) with hire date of 5/31/17. First step result was documented as negative on 5/25/17. Record review lacked evidence of the second step being completed. An interview with E13 on 7/13/17, at approximately 4:00 PM confirmed the findings and E13 verbalized that the facility initiated TB testing for E11 on 7/13/17. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17.		
9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the refusal or administration of an influenza vaccination was documented for one resident (R7) out of seven residents sampled. Findings include: Review of the facility's Infection Control Policy for immunization documented that residents are encouraged to receive immunizations for influenza during the recommended vaccination periods. The	9.6 A. R7's physician was contacted regarding the 2016 influenza vaccine, and has no record of resident receiving the vaccine in 2016. B. Current residents have the potential to be affected by the alleged deficient practice. An audit was completed of current resident charts to ensure vaccines were given or declinations were signed. As it is now flu season, our facility opted to have all residents or family members sign new flu consent /declination forms. At this point 80% of forms for 2017 vaccine are signed. All forms will be signed by 10/11/2017.	10/11/2017

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	policy failed to include the recommendations by the Immunization Practice Advisory Committee of the Center for Disease Control, unless contraindicated. In addition, the policy failed to include for those residents refusing the vaccination, the resident must be fully informed by the facility of the health risks involved and the reason for the refusal shall be documented in the resident's medical record. R7 was admitted to the facility on 11/28/16. Record review lacked evidence of an administration or a refusal of the influenza vaccination. On 7/20/17 at approximately 10:30 AM, an interview with E2 (CSM) and E3 (MCD) confirmed the findings. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17.	C. The facility policy was updated on 9/12/2017 to include the recommendations by the Immunization Practice Advisory Committee of the Centers for Disease Control. The Care Services Manager will be in-serviced on the new policy and the requirement to document refusal of the influenza vaccine by 10/1/2017, by the Regional Director of Care Services. D. The Care Services Manager is responsible for sustained compliance. The CSM and/or designee will audit resident records within two weeks of admission to ensure refusal or administration of the influenza vaccination is documented. Audits will be completed weekly times 90 days, then every 2 weeks times 90 days and then monthly for twelve months. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of 100% compliance.	
9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** Based on clinical record review and staff	9.7 A. R6's physician was contacted regarding the pneumococcal vaccination, and has no record of resident receiving the vaccine. R2's physician was contacted regarding the pneumococcal vaccination, and has no record of resident receiving the vaccine.	10/11/2017

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	interviews, it was determined that the facility failed to ensure that the refusal or administration of a pneumococcal vaccination was documented for two residents (R2 and R6) out of seven residents sampled. Findings include: Review of the facility's Infection Control Policy for immunization documented that residents are encouraged to receive immunizations for pneumonia for persons aged 65 years and older, and for persons of any age who have medical conditions that place them at high risk for complications for influenza during the recommended vaccination period. The policy failed to include the recommendations by the Immunization Practice Advisory Committee of the Center for Disease Control, unless contraindicated. In addition, the policy failed to include for those residents refusing the vaccination, the resident must be fully informed by the facility of the health risks involved and the reason for the refusal shall be documented in the resident's medical record. 1. R6 was admitted to the facility on 3/21/17. Record review lacked evidence of an administration or a refusal of the pneumococcal vaccination. On 7/20/17 at approximately 10:30 AM, an interview with E2 (CSM) and E3 (MCD) confirmed the findings. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17. 2. R2 was admitted to the facility on 5/17/17. Record review lacked evidence of an	B. Current residents have the potential to be affected by the alleged deficient practice. An audit was completed of current resident charts to ensure vaccines were given or declinations were signed. Six resident charts were found to be missing declinations. One resident consented to receive vaccine. Appointment was made with her PCP for 9/21/2017. C. The facility policy was updated on 9/12/2017 to include the recommendations by the Immunization Practice Advisory Committee of the Centers for Disease Control. The Care Services Manager will be in-serviced on the new policy and the requirement to document refusal of or prior evidence of the pneumococcal vaccine by 10/1/2017, by the Regional Director of Care Services. D. The Care Services Manager is responsible for sustained compliance. The CSM and/or designee will conduct ongoing audits of resident records within two weeks of admission to ensure refusal or prior administration of the pneumococcal vaccination is documented. Audits will be completed weekly times 90 days, then every 2 weeks times 90 days and then monthly for twelve months. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of 100% compliance.	

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	administration or a refusal of the pneumococcal vaccination. On 7/20/17 at approximately 10:30 AM, an interview with E2 and E3 confirmed the findings. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17.	11.0/11.3 A. The medical evaluations for R6, R1 and R7 were not completed within 30 days prior to admission, but the dates cannot be corrected as it remains outside of the 30 days prior to admission requirement.	10/1/2017
11.0 11.3	**Resident Assessment** **Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that three (R1, R6, and R7) out of seven sampled residents had a medical evaluation completed by a physician, within 30 days prior to admission. Findings include: 1. R6 was admitted to the facility on 3/21/17. Record review lacked evidence of a medical evaluation. The record did reveal a document titled Physician's Plan of Care, dated 2/20/17, which included minimal and incomplete information regarding R6, however, this documentation did not include a medical evaluation. On 7/20/17 at approximately 10:30 AM, an interview with E2 (CSM) and E3 (MCD) confirmed the findings. Findings were reviewed with E1 (NHA), E2, and E3, at approximately 1:30 PM on 7/20/17. 2. R7 was admitted to the facility on 11/28/16. Record review revealed a medical evaluation which was completed on 10/10/16; greater than 30 days prior to admission. On	B. Residents who were newly admitted to the community have the potential to be affected by the deficient practice. An audit was completed of all newly admitted residents from Jan 2017. No additional records were found to be out of compliance. Comprehensive medical evaluations will be completed at the physician discretion after admission. C. The Executive Director and the Care Services Manager will be re-in-serviced on the requirement for a medical evaluation completed by a physician within 30 days prior to admission, as well as ensuring the Physician's Plan of Care is completed in its entirety, by 10/1/2017 by the Regional Director of Care Services. If the resident admission is scheduled after the initial 30 day period has passed, the CSM will ensure a new medical evaluation is completed prior to the day of admission.	

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	7/20/17 at approximately 10:30 AM, an interview with E2 and E3 confirmed the findings. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17. 3. R1 was admitted to the facility on 4/22/17. Record review revealed a medical evaluation which was completed on 2/6/17, greater than 30 days prior to R1's admission. On 7/20/17 at approximately 10:30 AM, an interview with E2 and E3 confirmed the findings. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17.	D. The Care Services Manager is responsible for sustained compliance. The CSM and/or designee will audit new resident files prior to admission to check for the completed physician's evaluation. Audits will be completed weekly times 90 days, then every 2 weeks times 90 days and then monthly for twelve months. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 100% compliance after 12 months.	
19.0 19.6	**Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** Based on staff interview and review of facility policy, it was revealed, that the facility failed to ensure that the policy indicated, for suspicion or an allegation of abuse, neglect or financial exploitation would be reported immediately , which shall be within eight hours of the occurrence of the incident, to the State Agency. Findings include: On 7/13/17, the surveyor was provided a copy of the facility's policy entitled, Abuse, Neglect and Exploitation by E1 (ED). The policy incorrectly indicated that reportable incidents, such as a suspicion or an allegation of abuse, neglect would be reported within 24	19.0/19.6 A. The facility policy for reporting reportable incidents was changed to within 8 hours, on 7/20/2017. B. Current residents have the potential to be affected by the alleged deficient practice. Audit of incident reports from Jan 2017 forward was completed. No incidents were reported outside of the 8 hour regulation. C. Staff will be in-serviced on the policy change by 10/1/2017 by the Executive Director and/or designee. D. The Executive Director and the Care Services Manager will review policies on an annual basis to ensure policies meet Delaware requirements and maintain 100% compliance.	10/15/2017

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19.7 19.7.2	hours. Subsequently on 7/14/17, the surveyor was provided a revised policy, which indicated that an allegation of abuse, neglect would be reported within eight hours. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17. **Reportable incidents include:** **Neglect as defined in 16 Del. C. §1131.** Based on record review, interviews, review of facility policy, other documentation and review of State Survey Agency Intake records, it was determined that for one (R3) out of seven sampled residents, the facility failed to immediately report to the State Survey Agency, an incident involving neglect, in accordance with the State law. Findings include: The facility's policy entitled, Abuse, Neglect and Exploitation with an effective date of 9/1/16, documented the definition of neglect as a pattern of conduct or inaction of a care that fails to provide goods or services that maintain physical or mental health or that fails to avoid or prevent physical or mental harm or pain, or an act of omission that constitutes a clear and present danger to health, welfare or safety of a resident. On 7/19/17 at approximately 3:30 PM, an interview with E2 (CSM) revealed that R3 had verbalized an incident dated 5/13/17, in which E5 (LPN) refused to provide R3's	19.7/19.7.2 A. E2 is no longer employed at the community. B. Current residents have the potential to be affected by the alleged deficient practice. Audit of all incident reports from Jan. 2017 forward was completed. All incidents requiring investigation were complete and no incidents that were documented were not reported per regulation. C. Current staff will be in-serviced regarding the reporting and investigation of suspected neglect by 10/1/2017 by the Executive Director and/or designee. D. The Executive Director is responsible for sustained compliance. The Care Services Manager will audit reportable events weekly for 30 days, monthly for 90 days and then quarterly to ensure timely reporting. CSM will report during monthly QI meetings to discuss reporting events timely, ensuring protection, and thorough investigation. The QI Committee will determine if continued auditing is necessary based on 12 consecutive months of 100% compliance.	10/15/2017

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	medication, in R3's room as the resident was not feeling well and was not able to go to the Wellness Center, to obtain her scheduled medications. E2 verbalized that she had discussed this with E5 and that the expectation was that if a resident is not able to come down to the Wellness Center, that staff would go to the resident's room to provide the medication. E2 further indicated that E5 documented in the clinical record, that E3 had refused her 1:00 PM medication. Review of the May 2017 Medication Administration Record revealed, that E5 documented at 2:25 PM, R3 refused all oral medications at 1:00 PM. The medications refused and not administered were two to treat high blood pressure and one medication to treat acid reflux disease. Subsequently, on 7/20/17 at approximately 9:00 AM, E2 provided the surveyor, a copy of a written statement dated 5/18/17 by E5 related to 5/13/17 incident. The statement documented that R3 voiced no concerns regarding not feeling well on 5/13/17 and that R3 had refused her scheduled medications for 1:00 PM. Although R3 verbalized to E2 about the above incident, the facility failed to identify this as an allegation of neglect, which resulted in lack of reporting, lack of protection, and lack of thorough investigation. Findings were reviewed with E1, E2, and E3, at approximately 1:30 PM on 7/20/17.		

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