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

DHSS/DHCQ - DLTCRP
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STATE SURVEY REPORT

NAME OF FACILITY: Peach Tree Health Assisted Living **DATE SURVEY COMPLETED: March 9, 2018**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint survey was conducted at this facility beginning March 6, 2018 and ending March 9, 2018. The facility census on the entrance day of the survey was 20 (twenty) residents. The survey sample was composed of 4 residents and 5 subsampled residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations/definitions used in this state report are as follows:** ED – Executive Director; DON- Director of Nursing; ADON – Assistant Director of Nursing; RN – Registered Nurse; LPN – Licensed Practical Nurse; CNA – Certified Nurse Aide; RA – Resident Aide; FSD – Food Service Director; AIT – Administrator in Training. ° – degrees; Celsius (C) - metric temperature scale; cm (centimeters) – measurement of length; Day–Hab (Day Habilitation) – services that include, but not limited to, explore new areas of interest; become more involved within the community; develop communication and interpersonal skills; set and pursue personal goals; Fahrenheit (F) – temperature scale; Flammable – catches fire easily and burns quickly; HUD – Department of Housing and Urban	

Provider's Signature Kristopher Brown Title Executive Director EO Date 5/11/18

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	Development; LLAM (Limited Lay Administration of Medications) - unlicensed assistive staff trained to assist with administration of medications; MAR (Medication Administration Record) – list of daily medications to be administered; SA – State Agency; UAI (Uniform Assessment Instrument) – assessment form used to collect information about the resident's physical condition, medical status and psychosocial in order to determine eligibility for an assisted living facility.	3225.5.7 A. The Maintenance Director immediately lowered the book holder to be readily accessible to residents, families, and employees B. Because all residents could have potentially been affected by this deficient practice, the Administrator ensured that each resident could reach the book holder with ease that houses the plan of corrections. C. The Administrator will implement measures to ensure that this practice does not reoccur by conducting resident interviews to see if the residents are satisfied with the height of the holder for the plan of correction and they are physically able to reach it. D. The Administrator will monitor corrective actions to ensure effectiveness of these actions, by asking residents during monthly resident council meetings if the height of the book holder is easily accessible to them. This will be monitored monthly and quarterly during quality assurance meeting. Completed 3/10/18
3225.0 **3225.5.0** **3225.5.7**	**Regulations for Assisted Living Facilities** **General Requirements** **Inspection summaries and compliance history information shall be posted by the facility in accordance with 16 Del.C Ch. 11, Subchapter I., Licensing by the State.** **16 Del.C Ch. 11, Subchapter I., Licensing by the State describes § 1108 Posting of inspection summary and other information and public meetings.** **Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors the following:** **The most recent state survey report prepared by the Department of the most recent inspection report for the facility.** **A notice, as required by regulation, in the form prescribed by the Department stating that informational materials relating to the**	

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	compliance history of the facility are available for inspection at a location in the facility specified by the sign and online at a web site specified by the sign. The notice shall also provide the telephone number to reach the Department to obtain the same information concerning the facility. **The compliance history information required to be maintained for public review must be maintained in a well-lighted accessible location. The compliance history material must include all inspection reports produced for that facility during the preceding 3-year period. The information must be updated as each new inspection or other Department report is received by the facility.** Based on observation and interview, it was determined that the facility failed to have inspection reports with plans of correction readily accessible to residents, employees and family, without the need to ask a staff member. The facility also lacked a notice (sign) as to the location of the survey results. Findings include: 3/6/18 (1:20 PM) - A blue notebook holding prior state survey results/plans of corrections was observed in a holder on the wall in the main lobby. The book/holder was not readily visible (labeled) and was located too high for individuals in a wheelchair to reach. In addition, no signage was found in the facility to direct residents, employees and family to where the compliance history was available for review. During an interview on 3/7/18 at 2:45 PM, these findings were confirmed by E2 (DON) and E8	

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	(Maintenance Supervisor). These findings were reviewed with E1 (ED), E2, E4 (AIT) and E8 during exit conference at 11:00 AM on 3/9/18. **Medication Management** **An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:** **Storing and controlling medication.** 2006 - Facility policy entitled Medication Administration (last revised March 2016) included that [refrigerator] temperatures will be monitored daily. 2015 - LLAM policies and procedures from Delaware Board of Nursing included that medications requiring refrigeration should be stored between 36 - 46°F unless otherwise indicated by the labeling. During an interview with E3 (ADON) on 3/7/18 at 1:45 PM, E3 stated that the medication refrigerator was in the nursing administration office due to repairs being completed from water damage in January, 2018. E3 said the facility followed LLAM policies and procedures from the Board of Nursing. March, 2018 - Review of medication refrigerator temperature log revealed there were 4 out of 6 dates when the temperature was less than 36°F. - 3/2/18: 32°F	3225.8.1.2 A.The Director of Nursing was unable to immediately correct the action. B. Because all residents are potentially affected by this deficient practice, nursing staff was retrained as mentioned in the P&P attachment #1 & attachment #9. C. The Director of Nursing will implement measures to ensure that this practice does not reoccur by performing staff training discussing the P&P attachment #1 and new temperature log attachment#2 D. The Director of Nursing or Nurse Supervisor will monitor corrective actions to ensure effectiveness of these action by observing staff filling out the temperature log. This will be monitored daily for a week until 100% success, then continue daily after that. This will be reviewed quarterly during Quality Assurance meeting (Attachment#3)
3225.8.0		
3225.8.1		
3225.8.1.2		

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	- 3/3/18: 34°F - 3/5/18: 32°F - 3/7/18: 34°F During a follow-up interview with E3 on 3/7/18 at 2:10 PM, E3 confirmed there had been eye drops stored in this refrigerator during the month of March but they were removed for resident use the evening before (3/6/18). When asked for previous temperature logs for the medication refrigerator, E3 stated they were destroyed by water damage in January, 2018. During an interview with E2 (DON) on 3/8/18 at 1:00 PM, E2 confirmed that the medication refrigerator temperatures were not within acceptable range on March 2, 3, 5, and 7 and that no corrective action was taken on those dates. This finding was reviewed with E1 (ED), E2, E4 (AIT) and E8 (Maintenance Supervisor) during exit conference at 11:00 AM on 3/9/18.	3225.9.5.2 A. The Administrator instructed E11 to complete her 2-step ppd. E11 has no results of the 2 -step ppd in her employee file. B. Because all the residents are potentially affected by this deficient practice, an audit was completed on the rest of the employee files. The rest of the files have results of 2-step ppds. C. The administrator will implement measures to ensure that this practice does not reoccur which included an audit to all employee files was conducted to ensure that all employees had 2 step PPDs upon hire. Those who do not comply will obtain 2-step PPDs and documents will be added to their file. Reading over the P&P that states all employees will have a 2-step ppd or chest x-ray prior to employment. D. The Administrator will monitor corrective actions to ensure effectiveness of these actions which includes auditing new employee files before initial start date and monthly audits until 100% success. This will be monitored monthly and reviewed quarterly during Quality Assurance meeting. Completed: 3/10/18
3225.9.0	**Infection Control**	
3225.9.5	**Requirements for tuberculosis and immunizations:**	
3225.9.5.2	**Minimum requirements for pre-employment require all employees to have a base line two-step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA) or TB blood test) such as QuantiFeron.** Based on interview and review of other facility documentation it was determined that the	

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	facility failed to ensure that one (E11) out of 1 newly-hired employees had documented results from the pre-employment two-step TST. Findings include: March 6 – 9, 2018 - Request for the facility to complete the personnel audit sheet for E11 went unaddressed by E4 (AIT) and E1 (ED) in spite of repeated inquiries. The personnel audit sheet, usually completed by the facility with dates: adult and child abuse registry check, drug test result receipt, and each of the two-step TST. This finding was reviewed with E1, E2 (DON), E4 and E8 (Maintenance Supervisor) during the exit conference on 3/9/18 around 11:00 AM. E1 presented E11's employee file to the surveyor for review. Review of E11's (Day-Hab aide) employee file after the exit conference found no results from the two-step TST. E11's first day in the facility was 9/11/17. The facility was aware of the missing TST results since E8 brought E11 to the surveyor. During an interview with E11 on 3/9/18 around 12:10 PM, E11 stated that a two-step TST was done prior to employment. E11 showed a copy of the result for the TST administered 9/8/17. E11 indicated that this was the second TST and was trying to obtain evidence of the first test result. E11 added that s/he was given a TST that day (3/9/18). It was unclear why the facility did not have the	3225.9.6 A. The Director of Nursing obtained declination form for the influenza vaccine signed by R3.(Attachment #4) B. Because all residents are potentially affected by this deficient practice, an audit was done on all resident charts by the Director of Nursing and Pharmacist to ensure all residents have a signed consent/declination form for the influenza vaccine. C. The Director of Nursing/Assistant Director of Nursing will implement measures to ensure that this practice does not reoccur by reviewing the revised P&P attachment #5. D. The Director of Nursing/Assistant Director of Nursing will monitor corrective actions to ensure effectiveness by auditing resident charts monthly until 100% success. This will be monitored on monthly basis and reviewed quarterly during Quality Assurance meeting. Completed: 3/10/18

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	two-step TST results pre-employment, potentially exposing residents to tuberculosis.	
3225.9.6	**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 record review and interview, it was determined that the facility failed to ensure that refusal or administration of an influenza (flu) vaccination was documented for one (R3) out of 4 sampled residents. Findings include: Review of R3's clinical record revealed: The face sheet included an entry of 10/12/17 next to flu shot. However, there was no evidence of the actual administration of the influenza vaccination for the 2017–2018 flu season. During an interview with E2 (DON) on 3/8/18 at 10:00 AM, E2 stated s/he remembered that R3 received an influenza vaccination on 10/12/17 in the facility by a pharmacist, but records of flu vaccinations were damaged by water in January, 2018. E2 added s/he would request a copy of the administration records for all residents receiving a flu vaccination in October, 2017	

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	from the pharmacist who administered them. During an interview on 3/9/18 at 10:30 AM, E2 confirmed that the documentation provided by the pharmacy did not include R3's influenza administration. This finding was reviewed with E1 (ED), E2, E4 (AIT) and E8 (Maintenance Supervisor) during exit conference at 11:00 AM on 3/9/18.	2101.11 A. The Administrator was unable to immediately correct the action. B. Because all residents are potentially affected by this deficient practice, the Administrator hired a new cook and reviewed the staff schedule to ensure there was a cook during food operation hours seven days a week. C. The Administrator will implement measures to ensure that this practice does not reoccur by reviewing the staff schedule to ensure there is a cook during all food operation hours seven days a week. D. The Administrator will monitor corrective actions to ensure effectiveness of these actions by observing the cooking staff that is in the kitchen as well as reviewing the schedule to ensure adequate coverage for food operations hours. This will be done monthly until 100% success. This will be monitored monthly and reviewed quarterly during Quality Assurance meeting
3225.12.0	**Services**	
3225.12.1	**The assisted living facility shall ensure that:**	
3225.12.1.3	**Food service complies with the Delaware Food Code;** Based on observation, interview and review of other facility documentation it was determined that the facility failed to comply with at least 9 (nine) sections of the Delaware Food Codes. Findings include: **1. Delaware Food Code 2-101.11** **Except as specified in paragraph (B) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE, or shall designate a PERSON IN CHARGE, and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation.** During an interview with E5 [FSD] around 10:35 AM on 3/7/18, E5 stated that food is prepared and plated in individual portions to be served by other staff (nursing) on the weekends and other times when E5 is not present to prepare and	2-102.11 A. The Administrator was unable to immediately correct the action. B. Because all residents are potentially affected by this deficient practice, the administrator hired a part time cook to make sure that there is always someone

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	serve meals. Breakfast is self-serve by the residents. **2. Delaware Food Code 2-102.11** **Based on the risks inherent to the FOOD operation, during inspections and upon request; the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, applications of the HAZARD ANALYSIS, and CRITICAL CONTROL POINT principles and the requirements of this CODE. The PERSON IN CHARGE shall demonstrate this knowledge by:** **A) Comply with this Code by having no violations of PRIORITY ITEMS during the current inspection;** **B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM; or,** **C) Responding correctly to the inspector's questions as they relate to the specific FOOD operation.** During an interview with E5 [FSD] on 3/7/18 around 10:35 AM, E5 stated that the other staff did not meet any of the aforementioned requirements to allow them to be eligible as a PERSON IN CHARGE of the food operation. **3. Delaware Food Code 2-402.11** **Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD;**	who is safeserve certified and meets the requirements to have a person in charge during all food operation hours seven days a week. C. The Administrator will implement measures to ensure that this practice does not reoccur by having the cooks take refresher courses through safe serve to make sure their proficiency is up to par. D. The Administrator will monitor corrective actions to ensure effectiveness of these actions by observing the cooks in their kitchen elements, auditing their certifications to make sure they are up to date, and looking over their safeserve refresher courses. This will be done monthly until 100% success. This will be monitored monthly then quarterly during quality assurance meeting. Completed 3/20/18 2-402.11 A. Hair nets were placed in a visible area by the Food Service Director. B. Because all residents are potentially affected by this deficient practice, all staff have through training on proper food attire in the kitchen. C. The Food Service Director will implement measures to ensure that this practice does not reoccur, which include staff training on the proper food attire in the kitchen (attachment #10). D. The Food Service Director will monitor corrective actions to ensure effectiveness of these actions include observing staff having their hairnets on while in the kitchen daily. This will be done daily until 100% success. Then will be monitored daily and reviewed quarterly during

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	clean EQUIPMENT, UTENSILS, and LINEN, and unwrapped SINGLE-SERVICE and SINGLE-USE articles. During observations on 3/6/18 and 3/7/18 between approximately 11:00 AM – 1:00 PM several staff entered the kitchen during food preparation and service and served unpackaged ready to eat food to residents without wearing an acceptable hair covering of any type. The surveyor observed no hair nets for use by staff or anyone entering the kitchen area were visible in or near the area. During an interview with E5 (FSD) on 3/8/18 around 9:35 AM E5 confirmed hair covering was not used by staff entering the kitchen area. **4a. Delaware Food Code 3-401.11** **Except as specified under ¶ (B) and in ¶¶ (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked:** **4b. Delaware Food Code 3-401-13** **Plant Food Cooking for Hot Holding.** **Fruits and vegetables that are cooked for hot holding shall be cooked to a temperature of 57°C (135°F).** August, 2017 – March, 2018 - Review of food temperature logs discovered numerous weeks were missing from the past seven months and	Quality Assurance meeting Completed 3/17/18 3-401.11 A. The Food Service Director was unable to correct immediately. B. Because all residents are potentially affected by this deficient practice, staff training was conducted for all cooks on documenting food temperatures on the food temperature log. C. The Food service director will implement measure to ensure that this practice does not reoccur which include training for cooks on the importance of documenting on the food temperature log. D. The Food Service Director will monitor corrective actions to ensure effectiveness of these actions which include observing cooks to make sure they are recording food temperatures daily. This will be done daily until 100% success. This will be monitored daily and reviewed quarterly during Quality Assurance meeting. Completed:3/10/18

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	that only 20 weeks were available. Most of the log pages were not dated and numerous entries were incomplete. Temperatures of cooked foods were not always taken before being served. Fish, meat and poultry must be heated to an appropriate temperature depending on the cooking method and type of food. Vegetables must be heated to 135°F. During an interview on 3/6/18 around 2:25 PM, E5 [FSD] confirmed that food temperatures had not been consistently taken and recorded and entries were, "sporadic at best". **5. Delaware Food Code 3-403.11** **Reheating for Hot Holding.** **READY-TO-EAT TIME / TEMPERATURE CONTROL FOR SAFETY FOOD that has been commercially processed and PACKAGED in a FOOD PROCESSING PLANT that is inspected by the REGULATORY AUTHORITY that has jurisdiction over the plant, shall be heated to a temperature of at least 57°C (135°F) when being reheated for hot holding.** During an interview with E5 (FSD) on 3/6/18 around 11:47 AM, E5 stated that s/he prepared weekend meals before the weekend and the meals were reheated by other staff (nursing) before being served. Reheated food temperatures were not consistently taken or recorded in the food temperature logs. Multiple weeks of temperature logs were missing. When reheated, the food is to reach 135°F for 15 seconds. E5 confirmed that reheated food temperatures were seldom taken or recorded in the Food Temperature log book.	3-403.11 A. The Food Service Director was unable to be immediately correct the action. B. Because all residents are potentially affected by this deficient practice, staff training will be conducted on the proper way to record reheated food temperatures. C. The Food Service Director will implement measures to ensure that this practice does not reoccur which include staff training on the proper way of reheating food to the correct temperature. D. The Food Service Director will monitor corrective actions to ensure effectiveness of these actions by observing staff reheating the food, taking the temperature of food, making sure it is the correct temperature and recording documenting daily. This practice will happen daily until 100% success. Then will be monitored weekly. This will be reviewed quarterly during Quality Assurance meeting. Completed 3/10/18

Provider's Signature Kristopher Brown Title Executive Director ED Date 5/11/18

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	6. Delaware Food Code 3-501.13 **Thawing** **Except as specified in ¶ (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed:** **A) Under refrigeration that maintains FOOD temperature at 5°C (41°F) or less; or** **B) Completely submerged under running water:** **1) At a water temperature of 21°C (70°F) or below,** **2) With sufficient water velocity to agitate and float off loose particles in an overflow, and** **3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5°C (41°F), or** **4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under ¶ 3-401.11(A) or (B) to be above 5°C (41°F), for more than 4 hours including:** **a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking, or** **b) The time it takes under refrigeration to lower the FOOD temperature to 5°C (41°F);** 3/7/18 (9:35 AM – 12:45 PM)- Observation of thawing beef: - E5 [FSD] placed around 20 individually wrapped steaks in a large stainless steel bowl, ran cold water over the steaks, and turned water off when bowl was filled. - Steaks were not entirely submerged in	3-501-13 A. The Food Service Director was unable to immediately correct the action in question. B. Because all residents could have been affected by this deficient practice, a staff in-service was provided on proper food thawing techniques. The Food Service Director was in attendance and signed off on it. C. The Food Service Director will implement measures to ensure that this practice does not reoccur by giving in-service training to new cooks as well as annually about proper food thawing techniques. D. The Food Service Director will monitor corrective actions to ensure effectiveness of these actions by observing the cooks techniques on thawing food. This will be done on a weekly basis for four weeks until 100% success. Then will be monitored monthly and reviewed quarterly during the Quality Assurance meeting. Completed 3/20/18

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	water. - There was no water running over the beef for the duration of the thawing time. - E5 did not check the water temperature during the thawing period. - At approximately 11:00 AM, the surveyor observed the temperature of the water surrounding the meat to be 47°F. - Around 12:45 PM, E5 placed the steaks into the refrigerator. During an interview with E5 (FSD) on 3/8/18 around 9:35 AM, E5 confirmed the thawing process used for the beef was not appropriate. **7. Delaware Food Code 3-501.16** **(A) *Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19,* and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, *except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130°F) or above;* or (2) At 5ºC (41ºF) or less.** 3/6/18 (8:45 AM) – Observed the storage refrigerator filled with gallons of milk and containers of orange juice. March 2018 - Review of temperature log hanging on the front of the refrigerator door found two dates when the temperature was out of range:	3-501.16 A. The Food Service Director immediately lowered the temperature dial in the refrigerator. B. Because all residents are potentially affected by this deficient practice, staff training was provided on time/temperature control and safety of foods. (attachment #12) C. The Food Service Director will implement measures to ensure that this practice does not reoccur by performing staff training for new employees and annually to staff on time/temperature control and safety of foods. D. The Food Service Director will monitor corrective actions to ensure effectiveness of these actions by observing staff documenting the temperatures of the refrigerator, in the temperature logs, and auditing the temperature logs. This will be monitored on a weekly basis for four weeks, monthly, then quarterly. This will be reviewed during the Quality Assurance meeting. Completed: 3/6/18

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	3/1/18 = 42°F 3/5/18 = 42°F During an interview with E3 (ADON) and E8 (Maintenance Supervisor) on 3/6/18 at 9:10 AM, when shown the March 2018 temperature log, they confirmed that food temperatures should be 41°F or less. When asked what was done in response to the two days when refrigerator temperatures was noted to be 42°F, E3 admitted to recording those temperatures and did not notice they were out of acceptable range. E8 immediately lowered the temperature dial in the refrigerator. **8. Delaware Food Code 3-501.17** **Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.** **A) Except when PACKAGIIG FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME / TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.** **B) Except as specified in ¶¶ (E) - (G) of this section, refrigerated, READY-TO-EAT TIME / TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD**	3-501.17 A. The bowl of pasta salad and the container of spaghetti were immediately discarded. B. Because all residents are potentially affected by this deficient practice, all food in the refrigerator was audited for proper labeling as well as staff training on proper food labeling and storage. (attachment# 13) C. The Food Service Director will implement measures to ensure that this practice does not reoccur which include staff training for new staff members and annually about proper food labeling. D. The Food Service Director will monitor corrective actions to ensure effectiveness of the actions by observing staff properly labeling food before it goes into the refrigerator and retrain staff immediately if the process is not followed correctly. This will be monitored on a daily basis for four weeks, monthly, and then quarterly and will be addressed during the Quality Assurance meeting. Completed 3/10/18

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	PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day / date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. a. Kitchen Refrigerator 3/6/18 (around 8:45 AM) - Observed clear glass bowl in the bottom of the kitchen refrigerator filled with a mayonnaise-based pasta salad. The glass bowl was half covered with loose plastic wrap and was not labeled or dated with a "use by" date. During an interview with E5 (FSD) on 3/8/18 around 9:35 AM E5 confirmed the pasta salad had been discarded shortly after discovery. b. Storage Refrigerator 3/6/18 (8:45 AM) – Observed a small plastic container of spaghetti in the bottom drawer of the storage refrigerator, The lid was labelled with a "K" and had no date. This refrigerator held many gallons of milk and several containers of orange juice for resident use and the freezer section was filled with loaves of bread. It was	5-501.113 A. The sides of the dumpsters were immediately closed by the Maintenance Director. B. Because all residents are potentially affected by this deficient practice, the Maintenance Director will do daily rounds on the dumpsters to ensure that the sides and lids are closed. C. The Maintenance Director will implement measures to ensure that this practice does not reoccur this includes staff training for new employees and annually on the importance of making sure the dumpster's sliding doors and lids are closed always. D. The Maintenance Director will monitor corrective actions to ensure effectiveness of these actions which include daily rounds on the dumpsters as well as immediate retraining to staff if they leave the dumpster lids / doors open. This will be monitored Daily as well as addressed during the Quarterly Assurance meeting. Completed:3/10/18

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	unclear if the spaghetti belonged to a resident of a staff member. During an interview with E3 (ADON) and E8 (Maintenance Supervisor) on 3/6/18 at 9:10 AM, they confirmed the refrigerator was used for storing resident food and confirmed that the spaghetti should not have been there. **9. Delaware Food Code 5-501.113** **Receptacles and waste handling units for refuse [trash], recyclables, and returnables shall be kept covered: (B) with tight fitting lids or doors if kept outside the FOOD ESTABLISHMENT.** 3/8/18 (4:10 PM) – Observation of dumpster used for discarding kitchen and other facility waste with the sliding door on the side wide open and no activity by facility staff. 3/9/18 (8:04 AM) – Dumpster remained with sliding door wide open and no staff present. The facility failed to ensure the garbage dumpster was kept closed when not in use to prevent access and harborage by insects and rodents. During an interview with E8 (Maintenance Supervisor) on 3/9/18 around 8:20 AM E8 stated that trash is added to the dumpster early in the morning by night shift and the end of the day by E5 (FSD). E8 added that nursing and, sometimes residents, add trash in the afternoon.	3225.15.0 A. The Administrator was unable to immediately correct this action. B. Because all residents are potentially affected by this deficient practice, the administrator implemented a satisfaction survey for 2018. The survey will be presented to the residents annually. C. The Administrator will implement measures to ensure that this practice does not reoccur by meeting with the residents during their upcoming resident council meeting to remind them that the annual resident satisfaction survey will be available soon. D. The Administrator will monitor corrective actions to ensure effectiveness of this action by using the resident census sheet, count how many current residents reside in the facility, then measure the total amount of completed surveys that were handed in. This will be monitored quarterly during the Quality Assurance meeting and annually. Completed 3/10/18

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3225.15.0	This finding was reviewed with E1 (ED), E2 (DON), E4 (AIT) and E8 at the exit conference on 3/9/18 at 11:00 AM. **Quality Assurance** **The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction.** Based on interview and review of other facility documentation it was determined that the facility failed to measure resident satisfaction. Findings include: During an interview with E1 (ED) on 3/9/18 around 10:40 AM E1 stated that resident and family/guardian satisfaction surveys were usually completed every other January and was last was done in 2016. E1 indicated that an outside company mails the surveys and reviews the responses, providing the facility with detailed results. E1 confirmed that satisfaction surveys were not completed in January 2018 as scheduled. This finding was reviewed with E1, E2 (DON), E4 (AIT) and E8 (Maintenance Supervisor) during the exit conference on 3/9/18 at 11:00 AM.	3225.17.0 A. The item was relocated from in front of the electrical panels by the Maintenance Director. B. Because all residents are potentially affected by this deficient practice, daily facility rounds by the Maintenance Director are conducted to ensure that the facility is complying with applicable federal, state, and local laws when it comes to the environment and physical plant of the facility. C. The Maintenance Director will implement measures to ensure that this practice does not reoccur by performing staff training for new staff and annually about the importance of not covering or obstructing the electrical panels. D. The Maintenance Director will monitor corrective actions to ensure effectiveness, which include daily facility rounds to ensure there is nothing obstructing the electrical panels and retrain staff immediately when not in compliance. This will be monitored daily. As well as reviewed during Quality assurance meeting Completed: 3/9/18
3225.17.0 3225.17.1	**Environment and Physical Plant** **Each assisted living facility shall comply with**	

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	applicable federal, state and local laws. Based on observation and interview it was determined that the facility failed to maintain a minimum of clear distance of 36 inches in front of the electrical panels as per the National Electrical Code. Findings include: 3/6/18 (8:55 AM) - Observation on the initial tour of the facility found a two-drawer vertical file cabinet and a large popcorn maker stored on the floor directly in front of the two electrical panels in the maintenance room. During an interview with E8 (Maintenance Supervisor) on 3/8/18 at 8:20 AM E8 stated that the HUD inspector indicated storing the items in front of the electric panels was okay since the panel doors could be opened. Surveyor informed E8 that the Fire Marshall would be emailed to provide guidance. 3/8/18 (8:41 AM) – Fire Marshall emailed with picture of items stored in front of the electric panel. This finding was reviewed with E1 (ED), E2 (DON), E4 (AIT) and E8 during exit conference at 11:00 AM on 3/9/18. 3/12/18 (12:49 PM) – Email from the Fire Marshall included there should be nothing stored within 36 inches of the electric panels even if the panel doors can be opened. Email forwarded to E8. 3/12/18 (2:41 PM) – E8 confirmed receipt of the	3225.17.2.3 A. The maintenance door was closed and locked by the Maintenance Director. B. Because all residents are potentially affected by the deficient practice, the Maintenance Director is doing facility rounds to ensure the door is always secure as well as staff training to re-emphasize the importance of ensuring the maintenance area door is locked. C. The maintenance director will implement measures to ensure that this practice does not reoccur which includes staff training annually and for new employees about the importance of keeping the maintenance door locked and daily facility rounds to ensure the door is locked. An automatic closing mechanism was also installed on the door. D. The Maintenance Director will monitor corrective actions to ensure effectiveness of these actions by conducting facility rounds and observing staff when they go into the maintenance area door to ensure it is locked after use. This will be a daily practice as well as reviewed quarterly during Quality Assurance meeting. Completed:3/9/18

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3225.17.2 3225.17.2.3	email and indicated the items in front of the electric panels will be relocated. **Assisted living facility shall:** **Have a hazard-free environment;** The plan of correction for the annual survey ending July 26, 2017 included that the lock on the maintenance room door would be changed to one requiring a key to open since the door was found to be unlocked during that survey. Based on observation and interview it was determined that the facility failed to ensure the door to the maintenance area was closed and secured. Findings include: 3/6/18 (8:55 AM) - Observation during the initial tour of the facility found the maintenance room door propped open along with a ladder standing against the wall in the hallway to the right of the open door. Potentially hazardous items in the maintenance room included, but not limited to: - Biohazard cardboard box with lid lined with red disposable plastic liner; - ¾ gallon Eco-Lyzer (disinfectant cleaner); - 8 containers of Purell hand sanitizer; - Large box of Windex window cleaner; - 3 housekeeping carts; - Power equipment: vacuum, floor dryer fan, several floor cleaners; - Two large hot water heaters with water temperature reading 130°F on the outflow thermometer;	

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3225.17.8	- Outside door deadbolt unlocked with door leading to yard outside smoking patio; - Unlocked chest freezer half full of assorted frozen food items; - Utility sink. 3/6/18 (8:55 AM – 9:40 AM) - During the time the surveyor was in the maintenance room documenting the contents and inspecting the laundry room across the hall, no facility staff walked by or entered the area. The door remained propped open for an hour while residents were in the building and SS5 walked by the room two times. 3/6/18 (9:55 AM) - The maintenance room door was observed to be closed and secured. Review of Safety Data Sheets found: - Eco-Lyzer: can lead to irreversible eye damage or skin burns; may be fatal if swallowed. - Windex: flammable, eye irritation. - Purell: flammable, eye irritation. During an interview with E8 (Maintenance Supervisor) on 3/8/18 at 3:25 PM, E8 confirmed that the lock on the door was one that could not be manually unlocked, requiring a key to open. Regarding the door being propped open during the initial tour, E8 said that "it may have been the carpet guys or myself." This finding was reviewed with E1 (ED), E2 (DON), E4 (AIT) and E8 during the exit conference on 3/9/18 around 11:00 AM.	3225.17.8 A. The water temperature was adjusted to 120 degrees by the Maintenance Director. B. Because all residents could have potentially been affected by the deficient practice, the Maintenance Director took the water temperature reading of all the areas where a resident could either bath or wash their hands to ensure the temperature did not exceed 120 degrees. C. Maintenance Director will implement measures to ensure that the practice does not reoccur by conducting resident interviews to ensure that the water temperature is not too hot for the residents during hand washing and bathing and also by recording daily temperature of the water. D. Maintenance Director will monitor the corrective action to ensure effectiveness of these actions by conducting daily checks for water temperatures for a week until 100% success, three times a week until consistently 100% success at, then once a week reaching 100% and continue with weekly checks. Water temp logs and resident's Feedback will be reviewed quarterly Quality Assessment meeting.

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	Hot water at resident bathing and hand-washing facilities shall not exceed 120 degrees Fahrenheit. Water temperatures at the resident self-serve sink (in the dining area): 3/6/18 - 10:50 AM: 124.3°F. - 12:58 PM: 123.3°F. 3/7/18 - 12:47 PM: 123.4°F. 3/8/18 - 3:42 PM: 123.7°F. During an interview with E8 (Maintenance Supervisor) on 3/8/18 around 4:00 PM to review the water temperatures, E8 stated that s/he will adjust the water temperature. During an interview with E8 on 3/9/18 around 8:30 AM to verify the current water temperature at the self-serve sink, the water was measured to be 117.7 – 118.1°F. This finding was reviewed with E1 (ED), E2 (DON), E4 (AIT) and E8 during the exit conference on 3/9/18 around 11:00 AM.	Completed: 3/10/18 3225.19.1 A. Assistant Director of Nursing was not able to immediately correct the action. B. Because all residents could have potentially been affected by the deficient practice, Assistant Director of Nursing will place all new orders on MAR for any one-time only changes for clarification moving forward. C. Assistant Director of Nursing will implement measures to ensure that this practice does not reoccur which include staff training on P&P and Review of Llam policy and procedure with staff. D. Assistant Director of Nursing will monitor corrective actions to ensure effectiveness of these actions by overseeing medication passes and documentation weekly x6, then monthly x2 until 100% success. This will be reviewed quarterly during quality assessment meeting. Completed:3/15/18
3225.19.0 **3225.19.1**	**Records and Reports** **The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service agreement for each resident.**	

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	Based on observation, record review and interview it was determined that the facility failed to ensure clinical records were accurate for two (R1 and R4) out of 4 sampled residents. For R1, medication administration documentation was not accurate. For R4, a pressure ulcer was not followed-up on after discovery. Findings include: 1. Review of R1's clinical record revealed: 3/5/18 – Physicians' orders included nothing by mouth after midnight on 3/5/18 for a medical test. Hold medicines (on 3/6/18) until the test was complete. 3/6/18 (9:45 AM) - Medication administration observation by E9 (CNA, LLAM) gave R1 four medications at 9:45 AM after R1 returned from having the test. March, 2018 - Review of the MAR found that E9 signed off the medications at 7:30 AM (usual administration time). During an interview with E3 (ADON) on 3/7/18 at 11:40 AM, E3 stated that the facility followed the LLAM policies and procedures. The policy for Missed Medications included that staff should circle the missed time, initial and document reason medication was missed. During an interview on 3/7/18 at 3:00 PM, E9 stated that there was a physician's order to give the medications when R1 returned from the test, but E9 was not aware of how to document	3225.19.1 A. Director of Nursing could not immediately correct the action. B. Because all residents are potentially affected by this deficient practice, education and training/in-service will be presented during nursing staff meeting on 4/24/18 on documentation process C. Director of Nursing will implement measures to ensure that this practice does not reoccur which is implementation of new P&P following staff education/training meeting (Attachment # 7) D. Director of Nursing will monitor corrective actions to ensure effectiveness of these actions, implementation of the new P&P. (Attachment #7) Will be reviewed monthly and quarterly at Quality Assurance meeting. Completed:4/25/18

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	the medications were not given at the time indicated on the MAR. E9 added s/he signed them off for 7:30 AM since the order to give the medication upon return to the facility was not transcribed on the MAR. During an interview on 3/7/18 at 3:30 PM, E2 (DON) confirmed that documentation was not accurate and the actual time of medication administration should have been recorded. 2. Review of R4's clinical record revealed: 1/15/18 (11:00 PM) – Nursing note documented that R4 had a small open area to left buttocks / gluteal fold [area where the buttock meets the back of thigh – known as ischial or ischium]. Measured 0.2 cm x 0.5 cm x less than 0.1 cm in depth with no drainage. The documentation did not identify this area as a pressure ulcer over the left ischium, nor was there ongoing assessment to determine if treatment was effective or needed to be changed. 1/16/18 – 3/6/18 – Review of nursing notes found seven notes, however none of them mentioned R4's open area. There was no evidence of reassessment. During an interview with E2 (DON) on 3/8/18 at 2:10 PM E2 acknowledged that R4's skin was currently intact, without any open areas and confirmed the clinical record did not document when the area healed.	3225.19.6 A. Director of Nursing could not immediately correct the issue. B. Because all residents could have been potentially affected by this deficient practice, education (attachment #14) was provided to nurses on regulations and what to do if state website is shut down and revised P&P (Attachment #3.) C. Director of Nursing will implement measures to ensure that this practice does not reoccur by revising P&P (Attachment #3) and staff education (Attachment #14.) D. Administrator and Director of Nursing will monitor corrective actions to ensure effectiveness of these actions by reviewing incident logs reviewed monthly and quarterly at Quality Assessment meeting. Completed 4/25/18

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3225.19.6	These findings were reviewed with E1 (ED), E2, E4 (AIT) and E8 (Maintenance Supervisor) during the exit conference on 3/9/18 around 11:00 AM. **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 directed by the Division.** Based on interview and review of other facility documentation it was determined that the facility failed to report two falls with injuries (SS1 and SS2) to the Division / State Agency [SA] within 8 hours. In addition SS2's incident occurrence time was not included on the report submitted to the SA. Findings include: 1. Review of SS2's clinical record and facility incident report packet revealed: 9/6/17 (7:50 AM): Nursing note included that R6 seen with "bump on forehead" during breakfast, resulting from a fall by slipping on wet floor in the bathroom and hitting head. 9/6/17 (5:30 PM) - Facility incident report faxed to the SA did not include the time of occurrence. The fax cover sheet indicated 5 attempts to send the information electronically prior to faxing it at 5:30 PM (over 8 hours after discovery time). During an interview with E2 (DON) on 3/8/18 at 2:10 PM to review the fall, E2 confirmed the incident time was missing for SS2 and it was not	3225.19.7.13.2 A. The Administrator was not able to immediately correct the action. B. 2 residents were relocated within the facility and more residents could have potentially been affected by this deficient practice. Water, structural or any other damage of any kind that can impact resident's health, safety and comfort will be reported immediately to the state. c. The Administrator will implement measures to ensure that this practice does not reoccur, by reviewing the P&P on reportable incidents. Should an area of the facility become uninhabitable a decision to evacuate would be made. D. The Administrator will assess initial damage/incident, evaluate internal/external sources needed; assess equipment and systems and establish communication with outside emergency responders. The Administrator will coordinate relocation of residents to another facility if necessary. The Administrator will monitor corrective actions to ensure effectiveness monthly and quarterly during Quality Assurance meeting.

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	reported within 8 hours. 2. Review of SS1's clinical record and facility incident report packet revealed: 10/5/17 (7:20 AM): SS1 was found lying on the floor with a small scalp abrasion and loose right great toenail. 10/5/17 (3:32 PM): This incident reported to the SA over 8 hours from occurrence. During an interview with E2 (DON) on 3/8/18 at 2:10 PM to review the fall, E2 confirmed the fall was not reported within 8 hours. These findings were reviewed with E1 (ED), E2, E4 (AIT) and E8 (Maintenance Director) during the exit conference on 3/9/18 around 11:00 AM **Reportable incidents include:** **Water damage which impacts resident health, safety or comfort.** Based on interview and review of incidents submitted to the Division / State Agency it was determined that the facility failed to report significant water damage that temporarily displaced two residents from sleeping in their rooms, prohibited all smokers from using the smoking lounge for several days and noise from drying fans interrupted sleep for at least one resident. Findings include: 3/6/18 (8:35 AM) – Upon entry into the facility, E10 (Administrative Assistant) informed the	
3225.19.7 **3225.19.7.13.2**		

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	surveyors that a pipe burst 1/6/18 and that the conference room was out of order. During an interview with R1 on 3/6/18 at 3:00 PM, R1 stated when pipes burst, the smoking lounge was down and we [the smokers] "had to stand out in the freezing cold for a couple of days" while they fixed the smoking lounge. [There were 7 residents in the facility who smoked.] During an interview with E8 (Maintenance Supervisor) on 3/7/18 at 8:20 AM to discuss the water damage, E8 clarified that SS3 and SS4 were displaced one night from their rooms and slept in the lounge area in recliners. The residents were able to return to their rooms the next night after their carpets were dried out. E8 added that SS4's room carpet was being changed today (3/7/18). During an interview with E1 (ED) on 3/7/18 at 9:25 AM E1 stated that SS3 and SS4 stayed up late with staff and watched movies. E1 added that it was "no big deal" and "did not impact them [residents] since the damage was on the staff wing." However two resident (SS 3 and SS4) rooms in another hallway got wet and there were four resident rooms at the end of the staff wing. During an interview with R4 on 3/7/18 at 9:45 AM to inquire about the effect of the water damage on the resident, R4 indicated the staff closed the door and water did not enter R4's room. The resident added the machine that	

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	pushed the water out of the door next to R4's room and the floor dryer in the hall was noisy and "I didn't get much sleep that night." During a follow-up interview with E8 on 3/7/18 at 12:20 PM to inquire if air quality testing (to look for mold) was completed, E8 stated that the "claims adjustor did not recommend an air quality test" since the day after the pipe burst, the contractor was in and removed the drywall from the lower part of the walls and they (walls) were dried out. E8 added that a small area of mold was found within the staff breakroom wall, which was removed, and the wood framing was treated. This finding was reviewed with E1, E2 (DON), E4 (AIT) and E8 during the exit conference on 3/9/18 around 11:00 AM.	