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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor Assisted Living

DATE SURVEY COMPLETED: July 13, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning July 5, 2017 and ending July 13, 2017. The facility census on the entrance day of the survey was 12 residents. The survey sample totaled 2 residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations used in this state report are as follows:** **ED - Executive Director** **RSD – Resident Service Director** **DON-Director of Nursing** **RN - Registered Nurse** **CNA – Certified Nurse Aide** **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 _____ Title _____ Date 8/14/17

8/21/17

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3225.0 3225.9.0 3225.9.5 3225.9.5.2	**Assisted Living Facilities** **Infection Control** **Requirements for tuberculosis and immunizations:** **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 (GRA 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 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. This requirement is not met as evidenced by:** Based on review of facility documentation and staff interview the facility failed to ensure that two employees (E8 and E10) out of eight employees sampled had received the pre-employment baseline two step tuberculin test. Findings include: 1. Review of facility documentation revealed that E10 was hired on 11/30/2015 and received the initial	3225.9.5.2 (1) E8 and E10 have received the two-step tuberculin test and the dates and administration of both steps and results of those tests have been documented. (2) All employees of Shipley Manor have the potential to be effected. The facility has conducted an audit of all employee files to verify the tuberculin testing documentation of administration of a two-step PPD is present. Any employee whose file does not have evidence of the PPD testing will be given the two-step PPD and documentation of administration and results will be maintained in their employee file. (3) The Human Resources Director/designee will ensure that all current employees identified are tested and all newly hired employees receive the two-step PPD prior to hire. (4) The Director of Human Resources/ designee will conduct quarterly audits verifying the PPD requirement is being enforced. Audit result thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17

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	tuberculin skin test on 10/14/2015. The result of the skin test was read and documented on 10/16/2015. However further review of facility documentation revealed the absence of the date and results of the second step of the baseline tuberculin skin test. This finding was reviewed with E1(ED), E2 (DON) and E3 (RSD) 2. Review of facility documentation revealed that E8 was hired on 3/7/2016 and received the initial tuberculin skin test on 2/17/2016. The result of the skin test was read and documented on 2/19/2016. However further review of facility documentation revealed the absence of the date and results of the second step of the baseline tuberculin skin test. These findings were reviewed with E1 (ED) and E2 (DON) on 7/13/2017 at approximately 1:12 PM.	3225.9.5.2.4 (1) E4, E5, E6, E7, and E9E8 and E10 have received the two-step tuberculin test and the dates and administration of both steps and results of those tests have been documented and are maintained in the employees' files. (2) All employees of Shipley Manor have the potential to be effected. The facility has conducted an audit of all employee files to verify the tuberculin testing documentation of administration of a two-step PPD is present. Any employee whose file does not have evidence of the PPD testing will be given the two-step PPD and documentation of administration and results will be maintained in their employee file. (3) The Human Resources Director/designee will ensure that all current employees identified are tested and all newly hired employees receive the two-step PPD prior to hire and that the documentation and results of the administration are maintained in employee files.
3225.9.5.2.4	**A report of all test results shall be kept on file at the facility of employment.** **This requirement is not met as determined by:** Based on review of facility documents and staff interview the facility failed to ensure that tuberculin test results for five employees (E4, E5, E6, E7 and E9) out of eight sampled were kept on file. Findings include: In an interview conducted on	(4) The Director of Human Resources/ designee will conduct quarterly audits verifying the PPD documentation is complete and filed in the employees files. Audit result thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17

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3225.9.7	7/13/2017 at approximately 10:00 AM between this surveyor and E3 (facility human resource personnel) it was stated that difficulties were encountered while trying to locate the requested information. The difficulties included missing documentation of tuberculin testing and test results. 1. Review of facility documents revealed that tuberculin testing results were unavailable for E4 (employee). 2. Review of facility documents revealed that tuberculin testing results were unavailable for E5 (employee). 3. Review of facility documents revealed that tuberculin testing results were unavailable for E6 (employee). 4. Review of facility documents revealed that tuberculin testing results were unavailable for E7 (employee). 5. Review of facility documents revealed that tuberculin testing results were unavailable for E9 (employee). These findings were reviewed with E1 (ED) and E2 (DON) on 7/13/2017 at approximately 1:12 PM. **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**	3225.9.7 (1) The Resident identified (R1) had received the pneumococcal vaccine at the resident's personal physician, and therefore refused the vaccine offered by the facility. The resident transferred from the facility's skilled nursing section and the documentation relative to the offering and refusal did not accompany the resident's records when he was admitted to our assisted living section. (2) All residents of Shipley Manor's assisted living have the potential to be effected. The facility has conducted an audit of all assisted living residents files to verify the administration or refusal of the pneumococcal vaccine. Any resident without administration/refusal documentation will be offered the vaccine and results documented. (3) The Resident Services Director/designee will ensure that all current residents and any new admissions are offered the pneumococcal vaccine and documentation is kept in their resident chart. (4) The Resident Services Director/ designee will conduct quarterly audits verifying the Pneumococcal vaccine is offered and appropriate documentation is maintained in the resident's chart. Audit result thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17

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	Committee of the Centers for Disease Control, unless specifically, 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. This requirement is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility failed to document reasons for the absence or refusal of a pneumococcal vaccine and discussion of health risks involving refusal of the pneumococcal vaccine for one resident (R1) out of two residents sampled. Findings include: Clinical record review revealed absence of a documented placement date for R1's pneumococcal vaccine or refusal of the pneumococcal vaccination by R1. Additionally the clinical record revealed no documentation of reasons expressed by R1 for refusal of the pneumococcal vaccine or discussion between R1 and the facility regarding health risks involved due to refusal of the pneumococcal vaccine This finding was reviewed with E1 (ED) and E2 (DON) on 7/13/2017 at approximately 1:12 PM.	

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3225.12.0 3225.12.1	**Services** **The assisted living facility shall ensure that:** **3225.12.1.3 Food service complies with the Delaware Food Code; and** **2-3 Personal Cleanliness** **2-301.14 When to Wash** **FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLESP and:** **(E) After handling soiled EQUIPMENT or UTENSILS; P** **(F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P** **(F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.** **This requirement is not met as evidenced by:** Based on observation the facility failed to ensure that handwashing was performed before gloves were changed between tasks to prevent cross-contamination. Findings	~~3225.12.1~~ (1) Based upon observation the facility failed to ensure that all staff complied with required hand-washing before changing of gloves and when gloves should be changed and used. (2) All residents of Shipley Manor's assisted living have the potential to be effected. The facility's Staff Development Coordinator in conjunction with the Food and Beverage Director and the Food and Beverage Assistant Director have conducted in-service education for all Dietary staff on proper hand-washing including documented demonstration of correct technique. (3) The Dietary Management Team comprised of Food and Beverage Director and Assistant will ensure that all Dietary staff have received in-service education on hand-washing and that the correct procedures and being followed by observation. (4) The Dietary Management staff will monitor daily meal preparation and service for the correct usage of gloves and hand-washing procedures. Results of monitoring thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17

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	include: During lunch service in the kitchen on 7/5/2017 between 12:00 PM and 12:30 PM, E13 and E14 were observed changing gloves between tasks without first washing their hands before putting on new gloves. On 7/5/17 at 9:15 AM E12 was observed in the dishwasher area of the kitchen prepping dirty dishes, utensils and equipment for washing, barehanded. After removing dirt from the surfaces of the dirty articles, he moved the tray containing the soiled items into the compartment for washing. Upon completion of the rinse cycle, E12 went over to the other end of the machine to retrieve the cleaned items and began to handle each one to put away, without handwashing and wearing gloves. These findings were reviewed with E1 (ED) on 7/10/2017 at 4:30 PM.	3-304.15 (1) Based upon observation the facility failed to ensure that all staff complied with proper glove usage. (2) All residents of Shipley Manor's assisted living have the potential to be effected. The facility's Staff Development Coordinator in conjunction with the Food and Beverage Director and the Food and Beverage Assistant Director have conducted in-service education for all Dietary staff on proper glove usage. (3) The Dietary Management Team comprised of Food and Beverage Director and Assistant will ensure that all Dietary staff have received in-service education on glove usage and that the correct procedures and being followed by observation. (4) The Dietary Management staff will monitor daily meal preparation and service for the correct usage of gloves and related hand-washing procedures. Results of monitoring thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17
3-3 3-304.15	**PROTECTION FROM CONTAMINATION AFTER RECEIVING** **Gloves, Use Limitation** **(A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.** **This requirement is not met as evidenced by:**	

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3-305.11	Based on observation the facility failed to ensure staff was changing gloves between tasks to prevent cross contamination. Findings include: During breakfast service in the kitchen on 7/6/2017 at 8:40 AM, E15 was observed wearing gloves as she wiped a tray with a towel she retrieved from a cabinet, rinsed a glass and poured milk for a resident in the dining room; handled a cereal jar and filled it with cereal, reached inside a bread bag and took out a slice of bread to put in a toaster, and dipped breakfast items from the steam table onto a plate for a resident. All of these activities were done with the staff wearing the same gloves. These findings were reviewed with E1 (ED) on 7/10/2017 at 4:30 PM. **Food Storage** **(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:** **(2) Where it is not exposed to splash, dust, or other contamination.** **This requirement is not met as evidenced by:** Based on observation the facility failed to ensure food was stored properly in the refrigerator and freezer to prevent contamination of food. Findings include: Inspection of the walk-in refrigerator on 7/5/2017 at 11:20 AM revealed two	**3-305.11** (1) The rolls of raw ground beef have been moved, and the pan of cooked chicken was immediately properly covered and relocated in the walk-in refrigerator. The ice cream was immediately covered. (2) All residents of Shipley Manor's assisted living have the potential to be effected by this deficient practice. The facility's Staff Development Coordinator in conjunction with the Food and Beverage Director and the Food and Beverage Assistant Director have conducted in-service education for all Dietary staff on proper food storage. (3) The Dietary Management Team comprised of Food and Beverage Director and Assistant will ensure that all Dietary staff has received in-service education on correct food storage and that the correct storage procedures are being followed by daily observation of the walk-in refrigerator and freezer. (4) The Dietary Management staff will audit the walk-in refrigerator and freezer daily for proper food storage. Results of audits thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17

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		4-501.112
	rolled packages of raw ground meat stored on the shelf directly above a partially uncovered pan of cooked chicken. In the kitchen, four 3-gallon containers of ice cream were found to be only partially covered by their respective lids. These findings were reviewed with E1 (ED) on 7/10/2017 at 4:30 PM.	(1) Service by a contracted vendor was immediately provided to the dishwasher so that the correct sanitizing rinse temperature was consistently met. In addition, a booster heater for the hot water has been ordered to increase the hot water temperature entering the dish washer. (2) All residents of Shipley Manor's assisted living have the potential to be effected. The Food and Beverage Director and the Food and Beverage Assistant Director have conducted in-service education for all Dietary staff on correct dishwasher temperatures and the need to immediately report any variances.
4-5	**MAINTENANCE AND OPERATION**	
4-501.112	**Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures.** **(A) Except as specified in ¶ (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90 degrees C (194 degrees F), or less than:** **(2) For all other machines, 82 degrees C (180 degrees F). Pf This requirement is not met as evidenced by:** Based on observation and interview, the facility failed to ensure that the final rinse of the dishwasher reached a temperature of not less than 180 degrees F to effectively sanitize dishware and equipment. Findings include: Warewashing in the dishwasher on 7/6/2017 at 10:30 AM showed a final rinse temperature of 152 degrees. Repeat washing resulted in a final	(3) The Dietary Management Team comprised of Food and Beverage Director and Assistant will ensure that all Dietary staff has received in-service education on correct dishwasher temperatures, temperature recording and that any variances are reported so that service is immediately obtained. (4) The Dietary Management staff/ designees will audit the dishwasher temperature log daily for 4 weeks and weekly thereafter for correct hot rinse temperatures. Results of audits thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17

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	rinse of 160 degrees F. According to E11 (7/6/2017 at 10:35 AM), sanitization of kitchenware was through hot water, requiring a final rinse of 180 degrees F. These findings were reviewed with E1 (ED) on 7/10/2017 at 4:30 PM.	5-501.113 (1) The door to the dumpster/compactor was immediately closed. (2)
5-5 5-501.113	**REFUSE, RECYCLABLES, AND RETURNABLES** **Covering Receptacles** **Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered:** **(B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.** **This requirement is not met as evidenced by:** Based on observation the facility failed to ensure that the garbage dumpster/compactor was kept covered when not in use to prevent access and harborage by insects and rodents. Findings include: On 7/5/2017 at 11:45 AM and on 7/6/2017 at 10:50 AM, the door to the dumpster/compactor outside the facility was observed to be open, even though no activity involving the dumpster was taking place. These findings were reviewed with E1 (ED) on 7/10/2017 at 4:30 PM.	All residents of Shipley Manor's assisted living have the potential to be effected. The Food and Beverage Director and the Food and Beverage Assistant Director and the Housekeeping Supervisor have conducted in-service education for all Dietary, Housekeeping and Maintenance staff on keeping the dumpster/compactor lid closed. (3) The Management Team of Shipley Manor will ensure that all staff has been educated on the need to keep the dumpster closed. Any variances observed are to be reported so that the lid is immediately closed. (4) The Maintenance Director/designee will audit the dumpster for lid closure daily for 2 weeks and then during weekly Maintenance rounds. Results of audits thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17
6-5 6-501.12	**MAINTENANCE AND OPERATION** **Cleaning, Frequency and Restrictions.** **(A) PHYSICAL FACILITIES shall be cleaned as often as necessary to**	

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	6-501-12 **keep them clean.** **This requirement is not met as evidenced by:** Based on observation the facility failed to maintain clean the production area, walk-in refrigerator and freezer, and ceiling vents in the main kitchen, as well as the kitchen refrigerator and freezer. Findings include: Observation periods on 7/5/17, 7/6/17 and 7/10/17 between 8:30 AM and 1:30 PM revealed the kitchen floors and walk-in refrigerator and freezer of the main kitchen littered with food debris, and kitchen ceiling vents that were coated with grey or black matter from collected dust and grime. In the Assisted Living kitchen, both refrigerator and freezer compartments had spillage on the bottom shelf. These findings were reviewed with E1 (ED) on 7/10/2017 at 4:30 PM.	(1) All areas identified in both the Main kitchen and the Assisted Living kitchen has been thoroughly cleaned. (2) All residents of Shipley Manor's assisted living have the potential to be effected. The Food and Beverage Director and the Food and Beverage Assistant Director and the Housekeeping Supervisor have conducted in-service education for all Dietary, Housekeeping and Maintenance staff on maintaining the cleanliness of the kitchens. (3) The Food and Beverage Director/designee will ensure that all staff has been educated on maintaining the cleanliness of the kitchen and that all areas are addressed daily through the use of a cleaning checklist and visual observation. (4) The Food and Beverage Director/designee will audit the cleanliness of the kitchen daily until the audit results meet the audit thresholds established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17
3225.13.0 3225.13.5	**Service Agreement** **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 clinical record review and staff interview it was determined the facility developed service agreements for two residents (R1 and R2) out of two residents sampled that failed to	

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	provide services that responded to physical and psychosocial needs identified upon assessment. 1. Review of the initial service agreement dated 3/13/2017 revealed the provision of services for R1's activities of daily living including dining, toileting and walking were inappropriate to meet the same needs identified in the initial UAI (Uniform Assessment Instrument) dated 3/6/2017. According to the initial UAI dated 3/6/2017 R1 was alert and oriented to time, place and person with intact long-term memory and short-term memory problems. The initial UAI dated 3/6/2017 also revealed that R1 was independent for dining, toileting and walking with an assistive device. However the initial service agreement dated 3/13/2017 revealed that the facility provided services requiring staff assistance for escort to and from dining daily and when needed; every 2 hour checks and change for toileting daily and when needed; and walking with staff assistance daily and when needed. The facility failed to ensure that the service agreement reflected services that were developed to meet the assessed needs of R1. This finding was reviewed with E1 (ED) and E2 (DON) on 7/13/2017 at approximately 1:12 PM. 2. Review of the annual service agreement dated 4/21/2017 revealed the provision of services for R2's	3225.13.5 (1) The Service Agreements and UAI for R1 and R2 have been updated and revised. R1 was independent when the initial UAI was completed and the Service Agreement reflected R1 status when admitted. The UAI and services Agreement now match in the services needed and provided. R2's Service Agreement and UAI did not accurately reflect the services provided and now match Resident2's need. (2) All residents of Shipley Manor's assisted living unit have the potential to be effected. The Resident Services Agreement and UAI for all current Assisted Living residents has been reviewed and updated, as needed, by the Resident Services Director. In-service education for all licensed Assisted Living staff on the need to update both documents upon change of services/resident conditions (3) The Resident Services Director will ensure all Assisted Living licensed staff is trained. The Resident Services Director will audit all resident charts monthly for 3 months to ensure accuracy in the UAI and Service Agreements (4) Results of audit thresholds are established at 100%. Findings will be reviewed with the N.H.A. with corrective action, as needed, and reviewed during the quarterly QAPI Meetings. 9-4-17

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	activities of daily living, including dining, toileting and transferring, were inappropriate to meet the same needs identified in the initial UAI (Uniform Assessment Instrument) dated 4/21/2017. According to the annual UAI dated 4/21/2017 R2 was alert and oriented to time, place and person with intact short-term memory and long-term memory. The annual UAI dated 4/21/2017 also revealed that R2 was independent for dining, toileting and transferring. However the annual service agreement dated 4/21/2017 revealed that the facility provided services requiring staff assistance for escort to and from dining, daily and when needed; staff assistance for checks prior to bed and between 6:00 AM and 6:30 AM for toileting "at times", daily and when needed; and staff assistance for transfers "at times", daily and when needed. The facility failed to ensure that the service agreement reflected services that were developed to meet the assessed needs of R2. This finding was reviewed with E1 (ED) and E2 (DON) on 7/13/2017 at approximately 1:12 PM.	3225.15.0 (1) Review of Assisted Living documentation determined that the unit failed to track performance and measure of resident satisfaction, (2) All residents of Shipley Manor's assisted living have the potential to be effected. The Assisted Living Unit at Shipley Manor is a part of the Continuing Care Retirement Community and Assisted Living participates in Quarterly QAPI Meetings. The Assisted Living Unit reports on performance measures to the QAPI Committee. Documentation is maintained electronically as well as on paper in the Executive Director/Administrator's office. A Satisfaction Survey is being used by the community. Results of those surveys are maintained electronically. (3) The Administrator will ensure that all residents received Satisfaction Surveys and that the results are available. (4) The Administrator or designee will audit 1) Assisted Living attendance and reporting at QAPI Meetings quarterly x 1 year and 2) the distribution of Resident Satisfaction Surveys until compliance is at 100%. Findings will be reviewed by the N.H.A. with corrective action, as needed, and reviewed during the CCRC's quarterly QAPI Meetings. 9-4-17
3225.15.0	**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**	

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	tracks performance and measures resident satisfaction. **This requirement is not met as evidenced by:** Based on review of facility documents and staff interview it was determined that the facility failed to track the performance and measures of resident satisfaction. Findings include: In an interview conducted with E1 (ED) on 7/5/2017 at approximately 10:15 AM it was acknowledged that the results of any program developed to track performance and measures of resident satisfaction during the year 2016 were unavailable. This finding was reviewed with E1 (ED) and E2 (DON) on 7/13/2017 at approximately 1:12 PM.	