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: Westminster Village Assisted Living **DATE SURVEY COMPLETED:** July 9, 2014

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 June 25, 2014 and ending July 9, 2014. The facility census on the entrance day of the survey was 57 residents. The survey sample totaled 8 residents and was composed of 7 residents plus a subset of one resident. 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 ALNHA - Assisted Living Administrator DON - Director of Nursing RN - Registered Nurse LPN - Licensed Practical Nurse	
3225	**Regulations for Assisted Living Facilities**	
3225.8.0	**Medication Management**	
3225.8.1	**An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:**	
3225.8.1.2	**Storing and controlling medication;**	
	This requirement is not met as evidenced by: Based on review of clinical records and review of facility documents including incident reports and facility policies and procedures in addition to staff interviews it was determined that the facility failed to ensure that the storage and control of	

Provider's Signature Linda Messersmith Title NHA Date 9/11/14

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	medications prescribed for three residents (R4, R3, and R7) out of eight sampled were consistent with facility policies and procedures. Findings include: The facility policy "Controlled Medication Storage" states "...Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations...At each shift change, a physical inventory of all controlled substances is conducted by two licensed nurses and is documented on the controlled substances accountability record...". 1. Review of a reported facility incident that occurred on 4/27/2013 during a count of controlled medications between the 7-3 and 3-11 shifts revealed that two pills fell out of the "bubble pack" (a package of medications so named for clear plastic containers filled with pills and secured to a cardboard backing) of Tylenol #3 (controlled medication/pain killer) prescribed for R4. Upon closer inspection E8 (RN) and E9 (LPN) discovered the absence of any openings in the back of the "bubble pack" which was the usual manner for release of the pills. Closer examination of the front of the "bubble pack" revealed that the "bubbles" appeared to have cuts along the base or sides secured to the cardboard backing that allowed removal of and/or insertion of replacement pills. Additionally E8 and E9 observed that many of the remaining packaged white pills were unmarked and without "pharmacological identifiers" characteristic of Tylenol #3. Investigative findings of the	3225.8.1.2 A. Resident #R4 was not affected because the resident was discharged to the Health Center on 11/10/12 and did not return to Assisted Living until 6/5/13. Resident #R3 was not affected because the resident was discharged to the hospital on 2/17/13, returned to the Health Center on 2/25/13, and did not return to Assisted Living. Resident #R7 was not affected because the resident did not have any missed doses. B. An audit will be completed by the Resident Services Director for the months of July and August 2014 for all residents for compliance with conducting and documenting narcotic drug counts between all shifts daily. 9/19/14 Attachment #1 C. The Resident Services Director will provide education to all nurses regarding the policy and procedure for conducting and documenting narcotic drug counts between all shifts daily. The procedure for conducting narcotic 9/26/14

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	incident dated 4/27/2013 also revealed that 23 of 29 packaged Tylenol #3 tablets prescribed for R4 were replaced with substitute pills. Review of the pharmacy form "Controlled Substance Proof-of-Use Record" revealed that the initial "bubble pack" of Tylenol #3 was prescribed and delivered for R4 on 11/8/2012 while a resident of the assisted living section of the facility. However review of the clinical record revealed that R4 was discharged to the healthcare section of the facility following hospitalization on 11/10/2012. The clinical record further revealed that R4 returned to the assisted living section of the facility on 6/5/2013. During this four to five month absence from the assisted living facility, the controlled medication, Tylenol #3, initially prescribed for R4 on 11/8/2012, remained in the medication cart located in assisted living. However the facility was unable to determine the occurrence of any irregularities during narcotic shift counts in the packaging of the pills or changes in the pills until 4/27/2013. In an interview conducted with E3 (DON) on 7/9/2014 at approximately 4:00 PM when questioned by this surveyor why the facility failed to destroy the medication while R4 was residing in the skilled healthcare unit, E3 stated R4 was not discharged from the assisted living unit to the healthcare unit and was placed on bed hold due to her expected return to the assisted living unit. The facility failed to maintain adequate storage and control of controlled substances. According to the above referenced incident report the facility initiated an internal investigation and notified the local police	drug counts will be updated to include physical inspection of each bubble in the narcotic medication package. Attachment #2 D. The Resident Services Director to ensure compliance by reviewing documentation of narcotic drug counts between all shifts 3x/week for one month for 15 residents, as well as conduct a physical inspection of each bubble in each narcotic medication package being reviewed. Variances will be investigated immediately following facility policy and results will be reported to the QA committee for review. Attachment #3 10/11/14

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	and the Office of Narcotics and Dangerous Drugs of the incident. The facility also stated that the local police retained possession of R4's "bubble pack" labeled Tylenol #3. Review of the shift narcotic count sheet for the assigned unit of R4 dated April 2013 revealed that the facility failed to conduct and to document the performance of a narcotic drug count with two licensed nurses between the 3-11 and 11-7 shifts on 4/24/2013 in accordance with facility policy. Further review of the same narcotic count sheet revealed that the facility failed to conduct and to document a narcotic drug count with two licensed nurses between the 7-3 and 3-11shifts and no narcotic drug count with any licensed nurses between the 3-11 and 11-7 shifts in accordance with facility policy on 4/26/2013. The facility also failed to conduct and to document a narcotic drug count with any licensed nurses between the 11-7 and 7-3 shifts on 4/27/2013. The facility failed to ensure that the narcotic drug count on 4/28/2013 was conducted and documented between the 3-11 and 11-7 shifts by two licensed nurses. These findings were reviewed with E1 (ED), E2 (ALNHA), E3, E4 (RN), E5 (LPN) and E6 (LPN) on 7/9/2014 at 4:00 PM. 2. According to a facility incident report dated 4/27/2013 and timed 4:00 PM an audit was conducted of a controlled medication, Tylenol #3, prescribed for R3. The results of the audit conducted by E8 (RN) and E9 (LPN) during the narcotic shift count between the 7-3 and 3-11 shifts on 4/27/2013 revealed that the back of the "bubble pack" remained intact without any punctures while many of the "bubbles"	

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	attached to the front of the "bubble pack" were observed "cut at the bottom or on the sides" and filled with unidentifiable white pills substituted for Tylenol #3 tablets. Review of the "Controlled Substance Proof-of-Use Record" revealed that R3 received a "bubble pack" of 30 tablets of Tylenol #3 on 12/27/2012 one day after readmission to the assisted living section on 12/26/2012 from the healthcare section. However the facility was unable to determine the occurrence of any irregularities during narcotic shift counts in the packaging of the pills or changes in the pills until 4/27/2013. Review of the narcotic count sheet between 4/27/2013 and 4/30/2013 revealed the facility failed to perform and to document any narcotic drug counts with two licensed nurses between the 7-3, 3-11 and 11-7 shifts. These findings were reviewed with E1 (ED), E2 (ALNHA), E3 (DON), E4 (RN), E5 (LPN) and E6 (LPN) on 7/9/2014 at 4:00 PM. 3. Review of a facility incident report dated 12/13/2013 and timed 11:00 AM revealed "missing narcotics". Review of incident attached investigative findings revealed that E9 (LPN) was preparing to administer a prescribed dosage of a controlled medication, Percocet (pain killer), to R7 when she observed that a "bubble pack" with 2 remaining tablets of the medication was missing. Instead E9 observed another "bubble pack" of Percocet for R7 with missing pills and "found it odd that I (would be) using a "bubble pack" that had several missing pills when I recalled leaving two pills in (R7's) old (bubble pack)". However	

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	E9 stated that she administered a Percocet tablet from the second "bubble pack" with several missing pills to R7and intended to sign off the coordinating form, "Controlled Substance Proof-of-Use Record" (narcotic count sheet), with the date, time, amount used, amount remaining and her signature until she observed her name was written on the above referenced form and denied it was hers. E9 notified E3 (DON) of the missing bubble pack with a balance of two Percocet tablets, missing Percocet tablets from R7's second "bubble pack" and a falsified copy of the narcotic count sheet that also included a forgery of her signature as reported by E9. Further review of investigative findings of the incident dated 12/13/2013 also revealed a statement by E11 (LPN) who denied signing the falsified copy of the narcotic count sheet and stated she administered one tablet of Percocet to R7 at 12:00 AM and again at 6:00 AM on 12/12/2013. Although E11 stated that she did sign a narcotic count sheet she denied initiating and signing the top line of the falsified copy of the narcotic count sheet. Additionally review of investigative results documented by E3 (DON) revealed forgery of the signatures of two staff nurses and the absence of four Percocet pills in addition to the absence to the actual narcotic count sheet of the second "bubble pack". Local police and the Office of Narcotic and Dangerous Drugs were contacted in regard to the forgery of signatures, missing narcotic count sheet and R7's missing controlled medications. These findings were reviewed with E1 (ED), E2 (ALNHA), E3, E4 (RN), E5 (LPN) and E6 (LPN) on 7/9/2014 at 4:00 PM.	

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3225.8.1.4	**Administration of medication, self-administration of medication, assistance with self-administration of medication, and medication management by an adult family member /support person.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to ensure that the administration of medication to two residents (R1 and R7) out of eight sampled was consistent with facility policy and procedure. Findings include: 1. Review of the clinical record revealed a nurse's noted dated 7/18/2013 and timed 2:58 PM that stated "At 11:15 AM (R1) received Metoprolol (used to treat high blood pressure) 25 milligram (mg) by mouth. (Physician's office notified.)" Further review of the clinical record revealed a "Physician Order Record" dated 7/2013 with no order for the above referenced medication. Additionally the clinical record review revealed no order for Metoprolol 25mg with route and time of administration recorded on R1's Medication Administration Records (MARs) dated 7/1/2013 through 7/31/2013. Review of the facility incident report dated 7/18/2014 and with attached statements revealed that E6 (LPN) failed to adhere to the five rights of medication administration and failed to identify R1 prior to the administration of the Metoprolol 25mg pill. According to the investigative statement prepared by E6 she administered the Metoprolol 25mg pill to R1 who answered to the name of the rightful resident to	3225.8.1.4 A. Resident #R1 was not adversely affected. Physician was notified and instructions followed. B. Resident Services Director will conduct med pass observations 3x/week for 4 weeks for 15 residents. Attachment #4 — 10/3/14 C. The Resident Services Director will provide education to all nurses regarding facility policy for Medication Administration Guidelines. Photos were added to the Medication Administration Records within the last several months. The nurses will verify the identity of residents by viewing the photo prior to giving the medications. Attachment #2 — 9/26/14 D. The Resident Services Director to ensure compliance by conducting med pass observations 2x/month for 1 month for 27 residents. Variances will be corrected and results will be reported to the QA committee for review. Attachment #5 — 11/3/14

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	receive the poured medication. The facility policy "Medication Administration General Guidelines" states "...Administration:...Residents are identified before medication is administered. Methods of identification include: Checking photograph attached to clinical record or Medication Administration Record (MAR); Calling resident by name; If necessary, verifying resident identification with other facility personnel...". These findings were reviewed with E1 (ED), E2 (ALNHA), E3 (DON), E4 (RN), E5 (LPN) and E6 on 7/9/2014 at 4:00 PM. 2. Clinical record review revealed a nurse's note dated 3/17/2014 and timed 3:09 PM that stated "...[name of R7] reported to Certified Nurse Aide (CNA) and E9 (LPN) that she had not received her 6:00 AM medication...found in med drawer poured in a cup...[name of R7] informed that meds were found...". The facility policy "Medication Administration General Guidelines" states "Administration:...Medications are administered at the time they are prepared. Medications are not pre-poured...". Additionally one of the poured medications found in the drawer of the medication cart was a controlled substance that was improperly stored and required a double lock. Review of the facility report with attached statements also revealed that the Medication Record dated 3/1/2013 through 3/31/2013 indicated the two missed medications scheduled for administration at 6:00 AM on 3/17/2014 were documented as given at 6:00 AM.	3225.8.1.4 A. Resident #R7 was not adversely affected. Physician was notified with no specific instructions. B. Resident Services Director will conduct med pass observations and audits of all med carts to check for pre-poured medications 3x/week for 4 weeks for 15 residents. 10/3/14 Attachment #4 C. The Resident Services Director will provide education to all nurses regarding facility policy for Medication Administration Guidelines. 9/26/14 The Resident Services Director to ensure compliance by conducting monthly med cart audits for all med carts monthly to check for pre-poured medications. ongoing Attachment #8 D. The Resident Services Director to ensure compliance by conducting med pass observations and med cart audits to check for pre-poured medications 2x/month for 1 month for 27 residents. 11/3/14 Variances will be corrected and results will be reported to the QA committee for review. Attachment #5

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3225.8.8.2	These findings were reviewed with E1 (ED), E2 (ALNHA), E3, E4 (RN), E5 (LPN) and E6 (LPN) on 7/9/2014 at 4:00 PM. **Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;** **This requirement is not met as evidenced by:** Based on observations, review of facility policy and procedure and staff interview it was determined that the facility failed to ensure that one resident (RSS1) out of eight sampled received a medication as prescribed by her physician. Findings include: Observation of the administration of medications on 7/9/2014 revealed that E10 (LPN) prepared a solution without following the special instructions for mixture of the medication. Review of the label of the prescribed medication read "Miralax (laxative) 17Grams (Gm) in 8 ounces (oz) of choice of liquid) and take by mouth once a day...". However E10 added 17Gm of the powdered medication to 4 oz of juice before the administration of the mixture to RSS1. Clinical record review also revealed a "Physician Order Record" dated July 2014 that included the order "Miralax Oral Powder 17 Grams by mouth, one time a day 8:30 AM Special Instructions: Mix with 8oz beverage of choice...". Review of the facility policy "Medication Error Policy" states "...A medication error is generally defined as medication administered to a resident that deviates from the physician's orders...Medications shall be administered according to	3225.8.8.2 A. Resident #RSS1 was not adversely affected. B. Resident Services Director will conduct med pass observations 3x/week for 4 weeks for 15 residents. Attachment #4 — 10/3/14 C. The Resident Services Director will provide education to all nurses regarding facility policy for Medication Administration Guidelines. Attachment #2 — 9/26/14 The Resident Services Director to ensure compliance by conducting med pass observations monthly. Attachment #9. — ongoing D. The Resident Services Director to ensure compliance by conducting med pass observations 2x/month for 1 month for 27 residents. Variances will be corrected and results will be reported to the QA committee for review. Attachment #5 — 11/3/14

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	established nursing practice standards...". These findings were reviewed with E1 (ED), E2 (ALNHA), E3 (DON), E4 (RN), E5 (LPN) and E6 (LPN) on 7/9/2014 at 4:00 PM.	3225.13.5 A. Resident #R2 is no longer at the facility. B. Resident Services Director will conduct an audit of current service agreements for all current residents who are at risk for falls to ensure appropriate goals and interventions are in place. Attachment #6 9/26/14
3225.13.0	**Service agreement**	
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by:** Based on clinical record review, review of facility documents and staff interviews it was determined that the facility developed a service agreement that failed to address fall risk with measurable goals and specific interventions for one resident (R2) out of eight sampled who was admitted to the assisted living facility following repair of a fractured right hip. Findings include: Clinical record review revealed that R2 was admitted to the assisted living facility with diagnoses that included dementia (memory loss) and hypertension (high blood pressure). According to the initial Uniform Assessment Instrument/UAI (assessment) dated 9/27/2012 R2 was oriented to time, place, and person and experienced short-term and long-term memory problems. Review of the UAI dated 9/27/2012 also revealed that R2 required transfer assistance during toileting and supervision during ambulation. R2 used a walker or manual wheelchair to assist for ambulation. Additionally the above referenced UAI	C. Residents determined to be at risk for falls will be reviewed to determine appropriate goals and interventions. The Service Agreements will reflect this determination. The Resident Services Director will provide education to the nurses on this process. Attachment #2 9/26/14 The Resident Services Director to ensure compliance by reviewing all residents monthly to determine residents at risk for falls and reviewing the service agreements for residents identified to be at risk for falls for appropriate goals and interventions. Attachment #10 ongoing D. The Resident Services Director to ensure compliance by conducting service agreement audits for 7 residents/week for 8 11/26/14

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	revealed that R2 was at risk for falls due to the confusion and a fall sustained in the last 31 - 180 days resulting in surgical repair of a fractured right hip prior to admission to the assisted living facility. Further review of the clinical record revealed that a "Safety Risk Scale" completed on 9/27/2012 indicated that R2 was at high risk for falling. Clinical record review also revealed a nurse's note dated 5/31/2013 and timed 1:19 PM that stated R2 "...found...on the floor in the bathroom (at 2:50 AM)...stated... she (R2) was trying to use the bathroom without her walker and she slipped and fell...in too much pain to sit up...stated she felt better laying down...felt nauseous...(physician) informed...". R2 was transported by ambulance to an acute care facility for evaluation. Investigative findings of the facility incident with attached statements revealed that R2 would not be returning to the assisted living following hospitalization. for surgery and rehabilitation. Review of the initial service agreement dated 10/1/2012 revealed that the facility failed to develop measurable goals and specific interventions that addressed the potential for falls or actual falls sustained by R2.	weeks. Variances will be corrected and results will be reported to the QA committee for review. Attachment #7
	These findings were reviewed with E1 (ED), E2 (ALNHA), E3 (DON), E4 (RN), E5 (LPN) and E6 (LPN) on 7/9/2014 at 4:00 PM.	