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: Serenity Gardens

DATE SURVEY COMPLETED: January 17, 2013

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility beginning January 10, 2013 and ending January 17, 2013. The facility census on the entrance day of the survey was 9. The survey sample was composed of 3 residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures.	
3225	**Regulations for Assisted Living Facilities**	
3225.5.0	**General Requirements**	
3225.5.9	**An assisted living facility shall not admit, provide services to, or permit the provision of services to individuals who, as established by the resident assessment:**	
3225.5.9.1	**Require care by a nurse that is more than intermittent or for more than a limited period of time;** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to comply with the Delaware State Assisted Living Regulations and admitted one resident (Resident #3) out of three sampled who received care and treatment of a drainage site by a nurse for more than an intermittent or more than a limited period of time. Findings include: Clinical record review revealed that Resident #3 was admitted to the assisted living facility on 12/5/2012 with diagnoses that included dementia, cholecystitis,	**3225.5.9.1 General Requirements** Pertaining to Resident #3. At time of survey several supportive actions were in place to ensure her safety in this current environment a. Home care supplement from a Licensed Nursing Agency (Caring Angels) 2xweek that meet the needs for dressing change b. Vital signs daily c. Flush daily (as ordered) by licensed staff only d. Emptying and documenting on drain by licensed staff only e. Christiana Interventional Radiologist re-evaluation every ninety days for improvement or resolution of condition Corrective supportive actions taken after survey

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	cholecystostomy, hypertension, hypothyroidism, renal disease and history of breast cancer. Review of the initial UAI dated 12/3/2012 revealed that Resident #3 was alert and oriented to person and place and experienced short-term and long-term memory problems. The above referenced UAI revealed that Resident #3 was independent for eating, toileting, mobility and grooming. However Resident #3 required standby assistance for transferring, supervision, cueing or coaching for dressing and setup or occasional assistance with bathing. Although further review of Resident #3's clinical record revealed the presence of a cholecystostomy with tubing for percutaneous (a passageway through the skin) drainage, the initial UAI dated 12/3/2012 revealed absence of the assessment of Resident #3's cholecystostomy with percutaneous drainage. Review of the service agreement dated 12/5/2012 also revealed absence of any measurable goals and specific interventions to address Resident #3's cholecystostomy. Clinical record review also revealed a physician order dated 12/10/2012 that stated "...Change dressing to cholecystostomy every three days (and) prn (when necessary) for soiling, apply 4x4 (gauze) then cover (with) Tegaderm (dressing). Cleanse (cholecystostomy) site with (Normal Saline with) each dressing change...". In an interview conducted between the surveyor and E1 (RN/administrator) on 1/11/2013 she confirmed that Resident #3 was admitted to the assisted living facility on 12/5/2012 with a cholecystostomy and tubing with percutaneous drainage in place. E1 (RN/administrator) also confirmed that	a. Certified Geriatric Nurse evaluation b. Additional documentation from Christiana Interventional Radiologist (they inserted the drain) as to appropriateness of care being provided in our facility At time of admission Physician was in agreement that care was not more than intermittent this documentation was provided at time of survey. In future ***prior*** to resident admission Director of Nursing will require physician documentation and clinical support to ensure that resident does not require more than intermittent care. And if so required will seek and review potential for waiver. #2 At time of survey all resident were reviewed and found to be appropriate for provision of services in Assisted Living Facility. #3 At time of assessment Director of Nursing will ensure that resident are appropriate for provision of services within Assisted Living as outlined in UAI #4 As part of Quality Assurance any resident who are experiencing an increase in care that maybe defined beyond the provision of services will be reviewed on an individual basis for appropriateness. This may include consult with the Division and if necessary placement to facility with higher level of care or if short term request waiver if applicable.

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	she neither questioned requirements for Resident #3's eligibility prior to admission nor did she seek a waiver from the Division after Resident #3's admission to the assisted living facility. During the same interview E1 (RN/administrator) stated all ordered treatments of the cholecystostomy site were performed by her and a home health licensed staff member. Additionally E1 stated that Resident #3's cholecystostomy tube was changed on 12/19/2012 and another tube reinserted during a scheduled procedure (cholangiogram) at an acute care facility approximately two weeks after admission to the assisted living facility. According to E1 (RN/administrator) Resident #3's next appointment for evaluation of her condition is scheduled in three months at an acute care facility. The facility failed to comply with state regulations for assisted living facilities that prohibited the admission of a resident who required care by a nurse for more than an intermittent basis or for more than a limited period of time. This finding was reviewed with E1 on 1/17/2013.	
3225.6.0 **3225.6.1**	**Resident Waivers** **An assisted living facility may request a resident-specific waiver so that it may serve a current resident who temporarily requires care otherwise excluded in section 5.9. A waiver request shall contain documentation by a physician stating that the resident's condition is expected to improve within 90 days.** **This requirement is not met as evidenced by:**	**3225.6.1 Resident Waivers** # At time of survey a resident waiver was immediately requested and later approved by the Division for ninety (90) days. #2 No other Resident at time of survey required a waiver for provision of services. #3 Both at time of assessment prior to admit and through Quality Assurance meeting any resident requiring a potential waiver will be individually review by the Director of Nursing. #4 Any resident currently under waiver will be reviewed monthly by Director of Nursing or designee to document improvement or likelihood of short term. If by that assessment condition is deemed chronic resident placement may be required.

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	Cross refer 3225. 5, 3225.5.9, 3225.5.9.1. Based on clinical record review and staff interview it was determined that the facility failed to request a waiver that was specific for one resident (Resident #3) out of three sampled with a cholecystostomy with percutaneous drainage. Findings include: Although the facility was aware that Resident #3 had a cholecystostomy with percutaneous drainage prior to admission it failed to submit a request for a waiver in order to provide services and to meet the needs of the resident. In an interview conducted on 1/17/2013 E1 (RN/administrator) acknowledged failure to develop a waiver or to request a waiver for Resident #3 who required monitoring and dressing changes of a cholecystostomy with percutaneous drainage.	
3225.13.0 **3225.13.5**	**Service Agreements** **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 a service agreement that failed to address a cholecystostomy with percutaneous drainage for one resident (Resident #3) out of 3 sampled. Findings include:	**3225.13.5 Service Agreement** An immediate correction was made for the affected Residents which included updated Service Agreement. (see attachment) #2 All other residents Service Agreement was replaced with the revised Service Agreement approved during time of survey. #3 For corrective measures see revised policy and procedure regarding Service Agreement. #4 To prevent further deficiency Director of Nursing will be the responsible designee for ensuring Quality Assurance in this area. Quality Assurance will include sample audit of 10% monthly of current resident for accuracy until satisfactory compliance is maintained for a period of six months.

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	Review of the clinical record revealed that the initial service agreement dated 12/5/2012 and developed for Resident #3 failed to address a cholecystostomy with percutaneous drainage that was present on Resident #3's admission to the assisted living facility on 12/5/2012. Further review of the service agreement dated 12/5/2012 also revealed that the facility failed to include measurable goals and specific interventions to address a cholecystostomy with percutaneous drainage sustained by Resident #3. This finding was reviewed with E1 (RN/administrator) on 1/17/2013.	
3225.19.0	**Records and Reports**	
3225.19.5	**Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:**	
3225. 19.5.1	**All reportable incidents.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to complete and failed to retain a reportable incident report of substantiated resident abuse committed by one resident (Resident #1) out of three sampled. Findings include: Review of the clinical record revealed that a documented nurse's note dated 1/2/2013 and timed (12:10 PM) revealed an incident of substantiated resident to resident abuse committed by Resident #1.	**325.19.5.1 Incident Report** #1 All event reports are on file with Director of Nursing. This finding was unavailable at time of survey since it was not reported. See response below for reportable incidents.

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	In an interview conducted with E1 (RN/administrator) on 1/10/2013 it was stated that a report of the above referenced incident was unavailable. This finding was reviewed with E1 (RN/administrator) on 1/17/2013.	
3225.19.6	**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.** **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 an incident of substantiated resident to resident abuse committed by one resident (Resident #1) out of three sampled was reported to the Division within eight hours. Findings include: In an interview conducted with E1 (RN/administrator) on 1/10/2013 it was confirmed that the facility failed to report an incident of resident to resident abuse observed on 1/2/2013 to the Division within eight hours. This finding was reviewed with E1 (RN/administrator) on 1/17/2013.	**325.19.6 Reportable Incidents** #1 A late entry incident report was submitted on the event noted during time of survey. #2 No other resident was affected by this deficiency. Late incident report is on file with the Director of Nursing (See attachment) #3 Measures put in place to avoid repeat deficiency includes in-service to staff on events that may be reportable. #4 The Director of Nursing will review consistently all source of reported events not limited to but inclusive of grievances log, 24hour reports, service notes and other documented reports by staff to determine report ability and any missed reports that may need to be forwarded to the state i.e. a concern regarding missing item may have been determined as alleged theft and now reportable to the state.
3225.19.7	**Reportable incidents include:**	
3225.19.7.1	**Abuse as defined in Del.C. Section 1131.**	
3225.19.7.1.1	**Physical abuse.**	

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3225.19.7.1.1.2	**Resident to resident with or without injury.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to complete an incident report of substantiated resident to resident abuse committed by one resident (Resident #1) out of three sampled. Findings include: Review of Resident #1's clinical record revealed a nurse's note dated 1/2/2013 and timed (12:10 PM) that included observations of Resident #1 noticeably upset, verbally abusive and using foul language directed toward Resident #SS1 who was occupying his (Resident #1) assigned seat at the dining table prior to the lunch meal. Upon request for the written report of the incident the facility informed this surveyor of the absence of a completed report of the above referenced incident. This finding was reviewed with E1 (RN/administrator) on 1/17/2013.	**3225.19.7.1.1.2** Physical abuse #1As noted in prior deficiency a late report was submitted on this event. #2 No other resident event was identified that should have been reported #3 All staff were in-serviced on revised incident/event report and educated on what is reportable. Staff were also reeducated on resident abuse. Staff were also educated on abuse prevention and reporting. (see attachment) #4 All staff will be in-serviced on Resident Abuse

Provider's Signature H. James RN Title Director of Nursing Date 3/6/13