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: Cadbury at Lewes Assisted Living

DATE SURVEY COMPLETED: August 11, 2011

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 August 9, 2011 and ending on August 11, 2011. The facility census on the entrance day of the survey was thirty-nine (39) residents. The survey sample was composed of four (4) residents. In addition, one (1) sub-sampled resident was included.	
3225.0	**Assisted Living Regulations**	
3225.13.0	**Service Agreements**	
3225.13.1	**A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for two (R3 and R4) of 5 sampled residents the facility failed to have their Service Agreements signed by their Durable POA (power of attorney). Findings include: 1. R3 was admitted to the facility on 5/20/09. R3 was a resident in the Safe Harbor Unit for Residents with Memory	1. R3 was admitted to Safe Harbor unit on 5/20/09. On 5/20/11, a service agreement was completed for R3. The service agreement for R3 was signed by Durable POA 8/18/11 (See Attachment A). 8/18/11 R4 was admitted to facility on 3/3/10. On 3/3/11 a service agreement was completed for R4. The Durable POA for R4 signed the service agreement on 8/18/11 (See Attachment B). 2. All residents are at risk of not having service agreements signed by the Durable POA or responsible party. Audit of all Cadbury Assisted Living and safe Harbor residents service agreements verify resident or Durable POD/responsible party signature (See Attachment C). 8/23/11 3. E2, and assigned nurses in Assisted Living/Safe Harbor will be inserviced on the service agreement criteria which must be completed upon admission and annually thereafter. 9/15/11

Provider's Signature Title Adm. & CEO Date Aug 30, 2011

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	Impairment. On 5/20/11 a UAI and Service Agreement were completed for R3. Review of the Service Agreement revealed the Durable POA for R3 did not sign this Service Agreement. 2. R4 was admitted to the facility on 3/3/10. R3 was a resident in the Safe Harbor Unit for Residents with Memory Impairment. On 3/3/11 a UAI and Service Agreement were completed for R4. Review of the Service Agreement revealed the Durable POA for R4 did not sign this Service Agreement. Review of this information with E2 (AL-DON) on 8/11/11 at 1:30 PM confirmed the Service Agreements for R3 and R4 were not signed. E2 immediately audited all the residents' charts. E2 called and faxed POAs/family members for any resident in the facility whose Service Agreement was not signed.	4. Audits will be completed monthly for all admissions to verify service agreements are signed by resident or Durable POA/responsible party and reported monthly until 100% compliant and then quarterly at QI (See Attachment D). 10/22/11
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 tracks performance and measures resident satisfaction.** **This requirement was not met as evidenced by:** Based on interview and review of the outcome of the resident satisfaction survey for the facility it was determined that the	1. No corrective action can be done at this time 2. All residents are at risk of not having satisfaction survey concerns followed-up, with resolution or brought to facility QI. A tracking form will be implemented to verify all concerns have been addressed and brought to QI (See Attachment E). 10/31/11 3. E3 and nurses will be inserviced on satisfaction survey process. 9/15/11 4. Audits will be completed monthly on satisfaction surveys and reported to quarterly QI. 10/22/11

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	facility failed to develop, implement and adhere to quality assurance programs in order to correct concerns identified through the resident satisfaction program process. Findings include: Review of the summary of the resident satisfaction survey for the facility with E3 (AL-DON) on 8/11/11 at approximately 1:00 PM revealed a few concerns from the residents or their family members. E3 was then asked what programs were put in place to address concerns identified by the resident satisfaction survey she stated each department is notified of the concern that affected them. However, no one had been developing, implementing or internally tracking the plans for correcting the concerns identified by the resident satisfaction survey.		
3225.17.0	**Environment and Physical Plant**	A pad-lock was installed on the gate right after the incident.	7/4/10
3225.17.1	**Each assisted living facility shall comply with applicable federal, state and local laws including:**	All of the maintenance and security staff will be inserviced about locking the gate at all times. The gate will be locked even when staff are working on the roof. The staff was instructed to lock the gate behind them after they enter the roof area to perform maintenance. A key to the lock was provided to all maintenance and security staff. It was determined that the door entering the patio area would be locked at all times and there would be limited keys to open the door. An escort would have to accompany anyone who wished to enter the patio area.	8/29/11
3225.17.2	**Assisted living facilities shall:**		
3225.17.2.3	**Have a hazard-free environment; and** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that the facility failed to have a hazard-free environment when one resident (R4) unlatched an unsecured gate and went out to an unsecure area on the roof.		

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	Findings include" Cross refer 16 Del.C. Chap. 11 §1131 Neglect example #1 Review of the facility's incident report revealed on 7/4/10 an activity was held on the roof patio area. At the conclusion of the activity at approximately 11:00 AM R4 was observed unsupervised walking towards the roofs edge outside the patio area on the unsecure side of the roof. Further information revealed R4 who was alert and oriented to her self only walked over to the gate that lead to the unsecured side of the roof. R4 unlatched the gate, went through the gate and began walking to the edge of the roof. Two staff members E5 (CNA) and E6 (LPN) observed R4 from the window and ran outside to R4. The two staff members assisted R4 inside the building. Review of the incident with E4 (Director of Support Services) on 8/11/11 at approximately 10:00 AM revealed that maintenance staff go through the gate to the other side of the roof in-order to maintain the units for the building located on the roof. E4 stated that the gate had a latch on it. The gate did not lock. As soon as the facility was aware of the incident, which was within one hour, a pad lock was put on the gate. E4 continued to state that he was evaluating the patio area located on the roof in-order to identify any other possible accident hazards.	
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8**	

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	hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.	1. R4 was redirected by E5 (CNA) and E6 (LPN) back into the building. R4 was safely returned to Safe Harbor secure unit. 7/4/10
3225.19.7 3225.19.7.2	**Reportable incidents include:** **Neglect as defined in 16 Del.C. Chap. 11 §1131.** **This requirement was not met as evidenced by:** Based on record review, review of other facility documents and interview it was determined that the facility failed to notify DLTCRP (Division of Long Term Care Residents Protection) for one (R4) out of 5 sampled residents of an allegation of neglect within 8 hours after R4 was found unsupervised on an unsecured area of the roof after an activity program. Finding include: Cross refer 16 Del.C., Chap.11 §1131 example #1. Review of the facility's incident report revealed on 7/4/10 at approximately 11:00 AM an activity was held on the second floor patio located on the roof of the facility. At the conclusion of the activity in the patio area, R4 was observed outside the patio area unsupervised on the roof walking towards the edge of the roof. When E5 (CNA) and E6 (LPN) observed R4 walking unsupervised to the edge of the roof they ran out to the roof and brought her into the facility.	2. All residents are at potential risk of entering an unsecured area. The facility immediately had a padlock put on the gate and had the door to the patio locked. A sign was posted on the door instructing people to contact the nurse if they want to go out to the patio area (Attachment G). 3/3/11 R4's service agreement was revised indicating she was a wander risk and she was not to go to activities on the 2nd floor (Attachment H). 3. All staff were inserviced on wandering/elopement (Attachment I – Inservice Sheets), (Attachment J – Agenda/Powerpoint). 7/30/11 4. Random elopement drills have been conducted and reviewed at meetings (Attachment K).

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	Review of the incident report sent to DLTCRP revealed the facility failed to notify the division that the facility neglected to provide supervision for R4 on 7/4/10. DLTCRP was not notified until 7/6/10 almost 48 hours later. Review of the incident report and information with E3 (AL-DON) on 8/11/11 at approximately 1:00 PM confirmed the facility failed to notify DLTCRP in 8 hours of this allegation of neglect for R4. **16 Del. C. Chap. 11 § 1131** **Definition** **(9) Neglect** **(a) Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals, and safety.** **This requirement was not met as evidenced by:** Based on clinical record review, observation, review of other facility documentation, and interview it was determined that 2 (R4 and R2) out of 5 sampled residents experienced neglect. The facility neglected to supervise R4 who unlatched a gate, entered an unsecure area on the roof and began walking to the edge of the roof. R2 stated she wanted to commit suicide and the facility neglected to ensure R2 had a psychiatric consult. Findings include: 1. R4 was admitted to the facility with	1. No corrective action can be taken at this time. Resident sustained no mental or physical injury related to this incident. 2. All residents are at potential risk of not having an incident report faxed to DLTCRP. The AL nurse will review the reportable incident report with the AL nurse manager or Skilled Unit charge nurse and will fax all reportables to DLTCRP per criteria (Attachment L). — 9/1/11 3. All nurses shall be inserviced on reporting criteria and the incident report investigations. — 9/15/11 4. Audits will be completed monthly on all reportables to verify DLTCRP notification and thorough investigations completed are brought to quarterly QI (Attachment M) — 10/22/11

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	diagnoses that included Alzheimer's Dementia. R4 resided on the Memory Impairment Unit. Review of R4's initial UAI dated 3/11/10 revealed R4 required one person to physically assist her during an emergency. The UAI also stated on the fall risk assessment that R4 was assessed as being confused. It also stated under Psychological/Social/Cognitive Information that she was orientated to herself only and she had short-term memory problems. The UAI also stated R4 was independent for ambulation and transferring herself. Review of the facility's incident report summary documented by E10 (RN) for 7/4/10 revealed that on Sunday July 4, 2010 E7 (Activity Assistant), E9 (ALCNA) and E8 (ALCNA) took residents from the assisted living and Safe Harbor (Memory Impaired Unit) which included R4 outside to the second floor patio located on the roof for an activity. At approximately 11:00 AM at the conclusion of the activity E9 (ALCNA) took a resident in the elevator to return them to the unit. E7 and E8 were left assisting the remaining residents preparing to return to the building. While E7 and E8 were assisting other residents, R4 unlatched the gate and entered the unsecured area of the roof. E5 (CNA) and E6 (LPN) observed R4 from the window outside the patio area to be on the unsecured side of the roof walking very close to the edge of the roof. They ran outside and assisted R4 into the building.	

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	Review of written statements from E5, E6, E7, E8, and E9 confirmed E10's summary of the 7/4/10 incident. Review of the incident with E3 (ALDON) on 8/11/11 at approximately 1:15 PM confirmed that the facility neglected to supervise R4 in a fashion that would have prevented her from leaving the secured patio area of the roof. The facility immediately had a padlock put on the gate and had the door to the patio locked. A sign was posted on the door instructing people to contact the nurse if they want to go out to the patio area. The facility also provided education to the staff to prevent the incident from occurring again. R4's Service Agreement was revised indicating she was a wander risk and she was not to go to activities on the "2nd floor due to her wander risks". 2. R2 was admitted to the facility on 1/28/11 with diagnoses that included hypothyroidism, anxiety and depression. R2's UAI dated 1/19/11 and reviewed again on 2/19/11 revealed R2 was alert and oriented to person, place and time. It also stated R2 had short-term memory problems. The UAI showed no behavioral problems for R2. Review of R2's nurses notes revealed on 7/29/11 at 1:30 PM that R2 "expressed desire to commit suicide this morning when speaking with activity staff. " Review of the consultation/physician order that was faxed to R2's physician date	1. R2's PCP was faxed on 7/29/11; follow-up with the PCP was done on 8/22/11. Contract psychiatric services, APRN, BC visited R2 on 8/19/11 (Attachment N). 8/22/11 2. All residents are at risk of not having follow-through with the PCP when a significant change occurs. A. The facility implemented a "bright orange folder" to hold all PCP notifications and fax transmittals (Attachment O). B. A guideline for notification and faxing PCP was established (Attachment P). Tracking criteria established (Attachment Q).

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	7/29/11 revealed that the facility faxed the physician that R2 expressed a desire to commit suicide. R2 improved after spending time with the staff. They also let the physician know that R2 had a history of anxiety and was taking Zoloft, for depression. They closed the communication form by asking the physician to "Please Advise'. Review of R2's clinical record failed to document a response from the physician or that the facility followed up with the physician for R2. On 8/9/11 at approximately 2:10 PM R2 was observed in her room. R2 was very upset and confused. It took her several minutes to identify family members in a picture. She would cry for a while then talk for a while. R2 appeared to be very confused and frightened about her future. She kept stating her husband left her and her brother was supposed to take care of her. This information was provided to the staff at the desk. Review of this incident with E2 (ALDON) and E3 (SNFDON) at 8/10/11 at 11:20 AM revealed the facility neglected to follow up with R2's physician in order to get a psychiatric evaluation for R2. E2 immediately contacted the physician and received an order on 8/10/11 for a psychiatric evaluation for R2.	C. If it is a psychiatric emergency we will use Vista Services Form and call Dr. Dulofksy (Attachment R). D. Facility implemented suicidal risk policy and suicide risk check list (Attachments S & T). 3. All nurses and CNA's will be inserviced on: • PCP notification, follow-up and faxing criteria • Tracking form for MD notification and follow-through • Vista Psychiatric Form review and Dr. Dulofsky psychiatrist contact information. All nurses and CNA's will be inserviced on suicidal risk policy and suicide risk check list. 4. Audit will be completed monthly to verify that the PCP was notified and that the follow-through was completed. Audit will be presented at quarterly QI.	9/15/11 10/22/11

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