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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Ivy Gables: Assisted Living

DATE SURVEY COMPLETED: December 29, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from December 27, 2017 to December 29, 2016. The facility census on the entrance day of the survey was 22 residents. The survey sample was composed of two residents. The deficiencies cited in this report are based on observations, record reviews, staff interviews, and review of other facility documentation. Abbreviations used in this state report are as follows: NHA – Nursing Home Administrator DHW – Director of Health and Wellness RN – Registered Nurse LPN – Licensed Practical Nurse DDS – Director of Dining Services	The following is the Plan of Correction for Ivy Gables LLC regarding the Statement of Deficiencies dated January 25, 2017 for Annual Survey ending 12/29/16. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	
3225.0 **3225.9.0** **3225.9.7**	**Regulations for Assisted Living Facilities** **Infection Control** **The assisted living facility shall have on file evidence of**	3225.9.7 1. The DHW and/or designee will offer the pneumococcal vaccine to residents R2 The administration or refusal of the vaccine will be documented in their medical record.	3/1/17

Provider's Signature _____ Title Executive Dir. Date 1/30/17

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	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 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 it was determined that the facility failed to ensure that refusal or the administration of pneumococcal vaccination was documented for one resident (R2) out two residents sampled. Findings include:	2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3 3. A 100% audit of current resident files will be conducted by the licensed nurse/designee to verify all current residents have either documentation of being offered the Pneumococcal Vaccine (along with being informed of the risks and benefits of refusal) or will be offered the opportunity to obtain the vaccine for 2017. Proper documentation will be placed in the resident's medical record. Results of the review will be shared with the Executive Director to assure compliance with the regulation. Corrective action will be taken for records found not in compliance which will include documentation of administration or refusal and re-training of staff on the importance of proper documentation. 4. The DHW and/or designee will be responsible for completing audits of new move-ins as well as annual audits to verify ongoing compliance. 25 % of the medical records will be reviewed weekly until 100% compliance has been achieved and then weekly until 100% compliance has been achieved for 3 consecutive weeks at which time the deficiency will be considered resolved. Results of these audits will be provided to the Executive Director for review. The Executive Director will be responsible for directing additional corrective actions which will include re-training and disciplining of staff that did not document properly based on audit findings. The ED will be responsible for monitoring the POC.	

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	Clinical record review revealed that documentation of the administration or refusal of the pneumococcal vaccination for R2 was absent for the year 2016. Additionally the facility failed to document any discussion with R2 regarding the health risks involved due to refusal of the pneumococcal vaccine and to document reasons expressed by R2 for refusal of the pneumococcal vaccine or to document reasons why the pneumococcal vaccine was not recorded in the clinical record. These findings were reviewed with E1 (NHA), E2 (Owner), E3 (DHW/RN), E4 (LPN) and E5 (DDS) on 12/29/2016 at approximately 3:15 PM.		
3225.18.0	**Emergency Preparedness**		
3225.18.2	**Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.** **This requirement is not met as evidenced by:**	3225.18.2 1. No corrective action can be taken for the missing fire drills. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. Required fire drills will be conducted according to regulation and staff attendance will be recorded after	3/1/17

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	Based on review of facility documented fire drills and staff interview it was determined that the facility failed to conduct fire drills quarterly on each shift. Findings include: Review of documented fire drills conducted between December 2014 and November 2016 revealed the absence of fire drills conducted on a quarterly basis on all shifts. Findings revealed that 11 of 12 documented fire drills recorded between December 2014 and November 2015 were conducted between 7:00 AM and 7:00 PM. Additionally seven of 12 fire drills were recorded during the 7:00 AM to 7:00 PM shift and 3 of 12 fire drills were conducted during the 7:00 PM to 7:00 AM shift between December 2015 and November 2016. Further review of recorded fire drills also revealed no documentation of fire drills in September 2016 and October 2016 on either shift. In an interview conducted with E1	each drill. The Executive Director will review Fire Drill Reports to determine that the drills are being held at least quarterly on each shift and the drills are being conducted at different times each shift. Corrective action will be taken if drills have not been conducted. Additional drills will be conducted as necessary to assure compliance. 4. The Executive Director will continue to review Fire Drill Reports for 3 months or until 100% compliance has been achieved at which time the deficiency will be considered to be resolved. The ED will be responsible for monitoring the POC.	

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	(NHA/Nursing Home Administrator) on 12/28/2016 at approximately 10:15 AM this surveyor was informed that the facility which consisted of two 12-hour shifts was missing the performance of fire drills on either 7: AM to 7:00 PM shift or the 7:00 PM to 7:00 AM shift. These findings were reviewed with E1 (NHA), E2 (Owner), E3 (DHW/RN), E4 (LPN) and E5 (DDS) on 12/29/2016 at approximately 3:15 PM.		
3225.18.3	**Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a digital format and it must conform to the template prescribed by the Division.** **This requirement is not met as evidenced by:** Based on observation and	3225.18.3 1. A separate emergency food inventory and water supply is being maintained by the facility. 2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking the corrective action(s) outlined below in #3. 3. The DDS and/or designee will conduct a monthly review of emergency food and water inventory to determine whether the existing inventories are adequate to meet the	3/1/17

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	interview, it was determined that the facility failed to have an emergency plan for evacuation and sheltering in place. Findings include: During the tour of the kitchen on 12/27/16 at 11:55 AM, both E5 (Director of Dining Services/Chef) and E1 (Executive Director) were asked if the department had an emergency plan and emergency food and water. E5 stated he did not know about an emergency plan. E1 indicated he was not aware of any other contingency for food and water. E1 stated the department had a contract with a water distributor that would make emergency delivery, but that no extra water was stored in the kitchen.	needs of the residents. The emergency food will match the emergency menu which is kept with the emergency food supplies. The DDS will take corrective action to update the inventories if needed. The Monthly reviews will be shared with the Executive Director. 4. The Executive Director will conduct audits of the emergency food and water inventories for three months or until 100% compliance has been achieved at which time the deficiency will be considered resolved. The ED will be responsible for monitoring the POC.	

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