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

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL Milford Place

DATE SURVEY COMPLETED: September 6, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from September 3, 2024 through September 6, 2024. The deficiencies contained in this report are based on observation, interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was fifty-six (56). The survey sample totaled twenty-one (21) residents. Abbreviations/definitions used in this state report are as follows: BOM – Business Office Manager; CSM – Care Services Manager; ED – Executive Director; MCD – Memory Care Director; RA – Resident Assistant; Pneumonia – lung inflammation caused by bacterial or viral infection; Relias – provider of workforce education; UAI – Uniform Assessment Instrument;		
3225.5.0 **3225.5.12** **S/S-E**	**General Requirements** **An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and**	E4, E6, E7, E10 were trained on all required Dementia-related topics by community leadership A review of all employee records was conducted by community leadership. Staff members whose required dementia training occurred greater than 12 months ago were provided additional training on the subject in accordance with regulation. Root cause analysis indicated that bi-annual dementia training utilizing the CARES training system was being utilized for dementia training rather than an annual training. The BOM will be inserviced (Attachment 1) on the need to ensure	10/21/2024

Provider's Signature Laurel Scottyne Title: Executive Director/RN Date 10/9/24
Signing for Dean Reid in his absence.

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	physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code. **This requirement was not met as evidenced by:** Based on review of facility records and staff interview, it was determined that the facility failed to provide dementia specific training each year for four (E4, E6, E7 and E10) out of eight sampled employees. Findings include: 1. 1/11/23 – The hire date of E4 (RA). The facility lacked documentation of dementia training. 3. 2/22/23 – The hire date of E6 (Housekeeping). The facility lacked documentation of dementia training. 4. 5/22/23 – The hire date of E7 (Maintenance). The facility lacked documentation of dementia training. 7. 9/19/23 – The hire date of E10 (RA). The facility lacked documentation of dementia training. 9/6/24 11:50 AM – An interview with E1 (ED) and E2 (CSM) confirmed that there was a lack of facility documentation to show the completed abuse trainings. E1 stated, "we used to use Relias for trainings." 9/6/24 12:05 PM - Findings reviewed with E1, E2, and E3 (MCD) during the exit conference.	staff are trained on Dementia-related topics annually. Additionally, In-Service training on this and other crucial subjects (Attachment 2) will be conducted for all employees annually in addition to the bi-annual CARES training. Documentation of these in-services will be maintained in the employee's file. A random sample of seven employee files will be audited for proof of timely dementia training (Attachments 3 and 4). This audit will be conducted weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance at which point the issue will be determined to have been sufficiently addressed. Results of the audit will be presented at the community's Quality Assurance/Performance Improvement (QAPI) Committee.	
3225.8.0	**Medication Management**	Medication Regimen Reviews (MRR) have since been conducted for R4, R5, R6, R12, and R13	10/21/2024

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3225.8.1 **3225.8.1.5** **3225.8.1.5.3** **S/S-E**	**An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:** **Provision for a quarterly pharmacy review conducted by a pharmacist which shall include:** **Review of each resident's medication regimen with written reports noting any identified irregularities or areas of concern.** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that for five (R4, R5, R6, R12 and R13) out of nine residents reviewed for medication regimen review, it was determined that the facility failed to provide evidence that a medication regimen review was conducted each quarter. Findings include: 1. 6/15/16 – R4 was admitted to the facility. 9/4/24 – A review of the Pharmacist Chronological Record of Medication Regimen Review (MRR) revealed that the pharmacist reviewed R4's medications on 9/27/22, 12/27/22, 3/28/23, 6/27/23, 9/28/23, 2/22/24 and 5/12/24. The MRR lacked evidence of a review occurring in 12/2023 or 8/2024. 2. 4/25/23 – R5 was admitted to the facility. 9/4/24 – A review of the Pharmacist Chronological Record of Medication Regimen Review (MRR) revealed that the pharmacist reviewed R5's medications on 6/27/23, 9/28/23, 2/22/24 and 5/24/24. The MRR	A review of all resident records was conducted and MRRs were completed for all residents of the community on 09/06/2024. Root cause analysis yielded the following: Contract pharmacy was in the midst of recruiting for a new consultant when the community's MRR came due. MRR conducted as soon as new consultant selected. Pharmacy did not immediately notify the community regarding the vacancy in the pharmacy consultant position. Medication Administration Records for all residents of the community were scheduled for pharmacist MRR on 09/16/2024. That MRR was conducted. Future MRRs for all will be conducted at or near the ninetieth day after the most recent previous review. Facility Leadership and Nursing staff shall be in-serviced on the need to ensure Medication Regimen Reviews are conducted timely (Attachment 5). An audit of a random sample of 10% of resident charts (Attachments 6 and 7) will be conducted to ensure that the latest MRRs were completed within the quarter as appropriate. This audit will be completed daily until three consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	

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	lacked evidence of a review occurring in 12/2023 or 8/2024. 3. 11/15/15 – R6 was admitted to the facility. 9/4/24 – A review of the Pharmacist Chronological Record of Medication Regimen Review (MRR) revealed that the pharmacist reviewed R6's medications on 5/24/24. The MRR lacked evidence of a review occurring in 8/2024. Additionally, there was a note on top of page, "Where is my old sheet?" This was written on a copied piece of paper, noting that the other MRR's were printed on blue sheets. 4. 3/14/24 – R12 was admitted to the facility. 9/4/24 – A review of the Pharmacist Chronological Record of Medication Regimen Review revealed that the pharmacist reviewed R12's medications on 5/24/24. The MRR lacked evidence of a pharmacy review any time after 5/2024. 5. 7/13/22 – R13 was admitted to the facility. 9/4/24 – A review of the Pharmacist Chronological Record of Medication Regimen Review revealed that the pharmacist reviewed R13's medications on: 9/27/22, 12/27/22, 3/28/23, 6/27/23, 9/28/23 and 2/27/24. The MRR lacked evidence of a pharmacy review in 12/2023 and any time after 2/2024. 9/5/24 1:31 PM – In an interview, the surveyors reviewed the dates of the MRR's with E1 (ED), along with the missing original MRR for R6. E1 confirmed that the pharmacist reviews were not done quarterly.		

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	9/6/24 12:05 PM - Findings reviewed with E1, E2 (CSM), and E3 (MCD) during the exit conference.		
3225.9.0 **3225.9.5** **3225.9.5.2** **S/S-E**	**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 (IGRA 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 was not met as evidenced by:** Based on facility documentation and interview, it was determined that for four (E8, E9, E10 and E11) out of eleven 11 sampled employees, the facility lacked evidence of a base line two step tuberculin skin test (TST), single Interferon Gamma Release Assay (IGRA), or QuantiFeron (tuberculin blood test) prior to employment. Findings include: 1. 7/6/23 – E8 was hired. There was a lack of evidence provided by the facility that a	Quantiferon tests were completed on Employees E8, E9, E10, and E11. None were found to have active tuberculosis. A review of all employee records was conducted to determine if other employees lacked similar documentation. All employees now have appropriate documentation regarding tuberculosis screening in their files. Root cause analysis indicates binder documenting tuberculosis screening results for a very finite period of time was misplaced and unrecoverable. Tuberculosis screening shall continue to be completed for all employees prior to the start of employment. Documentation for these screenings shall be maintained concurrently in the employee's file AND in a binder for easy access to surveyors. The Business Office Manager will be in-serviced (Attachment 1) on the process and the need for this concurrent documentation. An audit will be conducted on a random sample of seven employee personnel files (Attachments 3 and 4) to ensure that tuberculosis screenings were conducted in accordance with State of Delaware regulations. This audit will be completed weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	10/21/2024

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	TST, IGRA, or QuantiFeron test was performed. 2. 7/17/23 – E9 was hired. There was a lack of evidence provided by the facility that a TST, IGRA, or QuantiFeron test was performed. 3. 7/24/23 – E11 was hired. There was a lack of evidence provided by the facility that a TST, IGRA, or QuantiFeron test was performed. 4. 9/19/23 – E10 was hired. There was a lack of evidence provided by the facility that a TST, IGRA, or QuantiFeron test was performed. 9/5/24 3:10 PM – An interview with E1 (ED) and E2 (BOM) confirmed that there was a lack of facility documentation to show the tuberculin testing was completed by new employees. 9/6/24 12:05 PM - Findings reviewed with E1, E2 (CSM), and E3 (MCD) during the exit conference.		
3225.9.7 **S/S-E**	**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 Committee of the Centers for Disease Control, unless 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.**	The community was unable to secure declinations for immunizations that were offered on 05/12/2024 for R1, R3, R4, and R14 after the fact. A vaccine clinic was conducted on 09/18/2024. Documentation of declinations and/or authorizations for vaccines offered for each of these individuals was obtained. A review of all resident charts was conducted to determine if documented authorizations/declinations were on file for all residents of the community. During the 09/18/2024 vaccine clinic documentation of declinations and/or authorizations was obtained for all residents of the community.	10/21/2024

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	This requirement was not met as evidenced by: Based on record review and interview, it was determined for four (R1, R3, R14, and R4) out of nine sampled residents, the facility lacked evidence of all residents' pneumococcal vaccinations being offered or declined. Findings include: 1. 7/9/09 – R1 was admitted to the facility. 5/12/24 – A printed State of Delaware Immunization Record revealed that R1 has not had a pneumococcal vaccination. Additionally, there was no evidence in the electronic chart or paper medical record that the pneumonia vaccination was offered, declined, or accepted. 2. 1/14/16 – R3 was admitted to the facility. 5/12/24 – A printed State of Delaware Immunization Record revealed that R3 has not had a pneumococcal vaccination since 12/30/13. Additionally, there was no evidence in the electronic chart or paper medical record that the pneumonia vaccination was offered, declined, or accepted. 3. 6/30/23 – R14 was admitted to the facility. 5/12/24 – A printed State of Delaware Immunization Record revealed that R14 has not had a pneumococcal vaccination since 4/11/18. Additionally, there was no evidence in the electronic chart or paper medical record	A root cause analysis yielded the following: while the community offered immunization services to all residents, securing documentation for authorizations for services rendered. Authorization for vaccinations received were prioritized over declinations for services that residents declined. An in-service was conducted for all community leadership and nursing personnel (Attachment 5) on the need to ensure appropriate documentation of both authorizations and declinations from residents and/or their responsible party for any immunization services offered by the community. An audit of a random sample of 10% of resident charts (Attachment 6 and 7) will be conducted to ensure that authorizations and/or declinations for the latest immunization services are on file in the chart and completed as appropriate. This audit will be completed daily until three consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	

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	that the pneumonia vaccination was offered, declined, or accepted. 4. 6/15/16 – R4 was admitted to the facility. 5/12/24 – A printed State of Delaware Immunization Record revealed that R4 has not had a pneumococcal vaccination. Additionally, there was no evidence in the electronic chart or paper medical record that the pneumonia vaccination was offered, declined, or accepted. 9/6/24 10:33 AM – In an interview, E2 (CSM) confirmed she was not aware that the pneumococcal vaccination should be offered and the declination or acceptance recorded. 9/6/24 12:05 PM - Findings reviewed with E1 (ED), E2 (CSM), and E3 (MCD) during exit conference.		
3225.9.9 **3225.9.9.3** **S/S-E**	**Infection Prevention and Control Program** **All assisted living facility staff shall receive orientation at the time of employment and annual in-service education regarding the infection prevention and control program.** **This requirement is not met as evidenced by:** Based on interview and review of other facility documentation, it was determined that for seven (E4, E5, E6, E7, E8, E9 and E10) out of eight sampled employees the facility lacked evidence of orientation and annual in-service training education for infection prevention and control program. Findings include:	E4, E5, E6, E7, E8, E9, and E10 were trained on the community's infection prevention and control protocol by community leadership A review of all employee records was conducted by community leadership. All current staff members were in-serviced on the community's current infection prevention and control protocols (Attachment 2). Root cause analysis yielded the following: the community's previous Business Office Manager utilized an online training documentation service (Relias) for the documentation of orientation and annual training subjects. Access to that service and its electronic documentation was suspended when the community changed management companies. Current Business Office Manager will be in-serviced (Attachment 1) on the need to retain hardcopies of training documentation, even if available electronically, point of service. Additionally, Infection Prevention and Control will continue to be a critical part of	10/21/2024

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	1. 1/11/23 – The hire date of E4 (RA). The facility lacked documentation of infection prevention and control training. 2. 1/19/23 – The hire date of E5 (RA). The facility lacked documentation of infection prevention and control training. 3. 2/22/23 – The hire date of E6 (Housekeeping). The facility lacked documentation of infection prevention and control training. 4. 5/22/23 – The hire date of E7 (Maintenance). The facility lacked documentation of infection prevention and control training. 5. 7/6/23 – The hire date of E8 (RA). The facility lacked documentation of infection prevention and control training. 6. 7/17/23 – The hire date of E9 (Dietary Cook). The facility lacked documentation of infection prevention and control training. 7. 9/19/23 – The hire date of E10 (RA). The facility lacked documentation of infection prevention and control training. 9/6/24 11:50 AM – An interview with E1 (ED) and E2 (CSM) confirmed that there was a lack of facility documentation to show the completed infection prevention and control training. E1 stated, "we used to use Relias for trainings." 9/6/24 12:05 PM - Findings reviewed with E1, E2, and E3 (MCD) during the exit conference.	the community's orientation and annual employee training. An audit of infection prevention and control training (Attachments 3 and 4) will be conducted on a random sample of seven employee files weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance at which point the issue will be determined to have been sufficiently addressed. Results of the audit will be presented at the community's Quality Assurance/Performance Improvement (QAPI) Committee. R1's Uniform Assessment Instrument (UAI) was reviewed with the responsible party on 09/06/2024. A review of all resident charts was conducted to identify any other residents for whom there was no documentation that the latest UAI had been reviewed with the Resident and/or Responsible Party. All current UAIs now reflect that such discussions have occurred. Root Cause Analysis yielded the following: While the UAI and care plan were discussed with the resident's responsible party, the community neglected to secure signatures to reflect the discussion. Moving forward documents including UAIs that reflect a change in resident care will be accompanied by a Resident Status Change Form (Attachment 8) to ensure vital signatures	10/21/2024
3225.11.0 **3225.11.4** **S/S-D**	**Resident Assessment** **The resident assessment shall be completed in conjunction with the resident.**		

Provider's Signature _____ Title: Executive Director_____ Date _____

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	This requirement is not met as evidenced by: Based on interview and record review it was determined for one (R1) out of nineteen residents reviewed, the facility failed to provide evidence the resident participated in the resident assessment. 11/8/23 – R1 was admitted to the facility and UAI was completed. 9/4/24 1:30 PM – A review of R1's UAI revealed the assessment lacked evidence of resident participation. 9/5/24 1:50 PM – An interview with E3 (MCD) confirmed R1's UAI lacked evidence of participation. 9/6/24 12:05 PM - Findings reviewed with E1 (ED), E2 (CSM), and E3 (MCD) during the exit conference.	are obtained. Community leadership and nurses were in-serviced on the need to secure signatures on UAIs and Care Plans timely (Attachment 5) An audit of a random sample of 10% of resident charts (Attachments 6 and 7) will be conducted to ensure that the current UAI is signed by the resident and/or responsible party, reflecting that the document has been shared with them. This audit will be completed daily until three consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	
3225.11.5 **S/S-D**	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that for two (R2 and R13) out of nineteen (19) residents reviewed, the facility failed to complete an UAI update 30 days after admission or annually. Findings include: 1. 7/29/24 – R2 was admitted to the facility and initial UAI was completed.	R2 and R13 have resided in the community for a period greater than 30 days. A review of their current UAI was conducted. A review of all initial resident UAI was conducted to ensure they were reviewed with the resident/responsible party. This shall be the process for all future UAIs. A Root Cause Analysis yielded: With regard to R1, nursing leadership did not sign the UAI at the 30-day assessment point. With regard to R2, the Memory Care Director believed (errantly) that the admission date for the resident was revised when the resident moved from the Memory Care Wing to the Assisted Living Wing, and the resident was not yet due for a 30-post admission UAI review. An in-service (Attachment 5) was provided to Community leadership and nursing staff on the need to ensure a resident's initial UAI is reviewed approximately 30 days subsequent to admission to ensure the	10/21/2024

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	9/4/24 – A review of R2's UAI revealed that a 30-day update was not completed. 9/5/24 1:50 PM – An interview with E3 (MCD) confirmed that R2 did not have a 30-day update completed related to R2 moving from the Memory Care unit to the Assisted Living side. E3 stated that the admission date changed when R2 changed rooms. 2. 7/13/22 – R13 was admitted with a diagnosis of Parkinson's. The facility lacked evidence of an annual UAI for 2023. 9/6/24 11:10 AM – An interview with E2 (CSM) confirmed the facility was unable to locate the UAI for 2023 for R13. 9/6/24 12:05 PM - Findings reviewed with E1 (ED), E2, and E3 (MCD) during the exit conference.	plan of care found in the UAI remains appropriate for the resident's needs. An audit of a random sample of 10% of resident charts (Attachment 6 and 7) will be conducted to ensure that the admission UAI was reviewed at or near the 30-day mark to ensure the plan of care found in the UAI remains appropriate for the resident's needs. This audit will be completed daily until three consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S-F**	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** Based on observation, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **Delaware Food Code 3-401.11 Raw Animal Foods: (A) Except as specified under (B) and in (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for**	Unable to complete temperature checks for meals that occurred prior to survey. New coverings were immediately placed over the food and secured in place of the covering that had slipped off prior to the surveyor's observation. All debris was immediately removed from the floors of the freezer. Food temps now documented for all meals made in the community's kitchen facilities. No other items were found to be uncovered. Other walk-in and reach-in refrigerators and freezers were found to be free of debris A root cause analysis yielded the following: 1. During a very finite period of time some chefs were not completing all temperature logs appropriately although being trained to do so at orientation to the kitchen. Since that time chefs have been counselled on proper documentation of meal temperatures. 2. Food items referenced in	10/21/2024

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	a time that complies with one of the following methods based on the FOOD that is being cooked. 9/03/24 10:15 AM - During the survey of the facility, a review of food temperature logs revealed the facility failed to provide food temperature readings for 39 mealtime temperatures out of 282 meals served between June 1, 2024 – September 2, 2024. **Delaware Food Code 3-305.14 Food Preparation: During preparation, unpackaged FOOD shall be protected from environmental sources of contamination.** 9/03/24 – 10:45 AM – A tour of the facility kitchen revealed uncovered slices of cake and individual servings of pudding uncovered on food cart in the walk-in refrigerator, and a tray containing dishes of ice cream uncovered in the walk-in freezer. **Delaware Food Code 6-501.114 Maintaining Premises, Unnecessary Items and Litter. The PREMISES shall be free of (A)Items that are unnecessary to the operation or maintenance of the establishment such as EQUIPMENT that is nonfunctional or no longer used; and (B) Litter.** 9/03/24 – 10:55 AM – A tour of the facility kitchen revealed pieces of cardboard, plastic, paper and other debris on the floor of the walk-in freezer.	the citation were initially covered however, the covering failed to stay in place when the Walk-in's doors were opened. Additionally, at the time of the kitchen survey the weekly food delivery had just been completed. Some debris from items that were recently delivered had not been removed from the floor. An in-service was provided to the Dining Serviced Director and all chefs (Attachment 9) regarding the covering of food, cleanliness of refrigerators and the proper documentation of food temperatures. Temperature logs will be maintained by the Dining Services Director and routinely checked to ensure they are properly completed. An audit of food temperature logs, prepped food coverings and refrigerator cleanliness (Attachment 10) will be conducted to ensure that food temperatures are taken at each meal, as appropriate. This audit will be completed daily until seven consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	
3225.13.0 **3225.13.1** **S/S-B**	**Service Agreements** **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**	The current service agreements for R2 and R3 have been signed by the resident and/or responsible party. A review of current service agreements for all residents was completed. All current service agreements reflect signatures and/or concurrence via telephone.	10/21/2024

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	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 is not met as evidenced by:** Based on interview and record review it was determined for two (R2 and R3) out of nineteen residents in the investigative sample, the facility failed to provide evidence of a resident signature on a service agreement. 1. 7/29/24 - R2 was admitted to the facility. 7/29/24 – R2 had a service agreement completed. 9/4/24 – A review of R2's service agreement lacked a signature from resident or resident representative. 9/5/24 1:50 PM – An interview with E3 (MCD) confirmed R2's service agreement lacked a signature. 2. 1/14/16 – R3 was admitted to the facility. 3/6/24 – R3 had a service agreement completed. 9/5/24 1:30 PM – A review of R3's service agreement lacked a signature from resident or resident representative. 9/5/24 1:50 PM – An interview with E3 (MCD) confirmed R3's service agreement lacked a signature.	Root Cause Analysis yielded the following: Care Service Manager and Executive Director did not secure the appropriate signatures on these documents timely, per company policy on service agreements. An in-service was conducted for community leadership and nursing staff regarding the importance of securing documentation of concurrence between the community's clinical leadership and the resident/responsible party on the resident's plan of care and service agreement (Attachment 5). An audit of a random sample of 10% of resident charts (Attachments 6 and 7) will be conducted to ensure that the current service agreement has either a. the signature of the resident or responsible party or b. a note from the nurse stating the service agreement was communicated telephonically to the responsible party. This audit will be completed daily until three consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	

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3225.16.0 3225.16.14 3225.16.14.2 3225.16.14.2.1 S/S-E	9/6/24 12:05 PM - Findings reviewed with E1 (ED), E2 (CSM), and E3 (MCD) during exit conference. **Staffing** **Assisted living facility resident assistants shall, at a minimum.** **Participate in a facility-specific orientation program that covers the following topics:** **Fire and life safety, and emergency disaster plans.** **This requirement was not met as evidenced by:** Based on observation and interview, it was determined that the facility failed to provide proof of Emergency Preparedness training at orientation for 7 (seven) (E4, E5, E6, E7, E8, E9, and E10) out of 8 (eight) staff members sampled. Findings include: 1. 1/11/23- Hire date for E4 (RA). The facility lacked proof of fire and life safety and emergency disaster plan training. 2. 1/19/23 - Hire date for E5 (RA). The facility lacked proof of fire and life safety and emergency disaster plan training. 3. 1/22/23- Hire date for E6 (Housekeeping). The facility lacked proof of fire and life safety and emergency disaster plan training. 4. 5/22/23- Hire date for E7 (Maintenance). The facility lacked proof of fire and life safety and emergency disaster plan training.	E4, E5, E6, E7, E8, E9, and E10 were trained on the community's Fire, Life Safety and Disaster Plans by community leadership A review of all employee records was conducted by community leadership. All current staff members were in-serviced on the community's current Fire, Life Safety and Disaster Plans. Root cause analysis yielded the following: the community's previous Business Office Manager utilized an online training documentation service (Relias) for the documentation of orientation and annual training subjects. Access to that service and its electronic documentation was suspended when the community changed management companies. Current Business Office Manager will be in-serviced (Attachment 1) on the need to retain hardcopies of training documentation, even if available electronically, point of service. Additionally, Fire, Life Safety and Disaster Plans will continue to be a critical part of the community's orientation and annual employee training. An audit of Fire, Life Safety and Disaster Plans training (Attachment 3 and 4) will be conducted weekly on a random sample of 15 employee files until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance at which point the issue will be determined to have been sufficiently addressed. Results of the audit will be presented at the community's Quality Assurance/Performance Improvement (QAPI) Committee.	10/21/2024

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

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STATE SURVEY REPORT

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	5. 7/6/23- Hire date for E8 (RA). The facility lacked proof of fire and life safety and emergency disaster plan training. 6. 7/17/23- Hire date for E9 (Cook). The facility lacked proof of fire and life safety and emergency disaster plan training. 7. 9/19/23- Hire date for E10 (RA). The facility lacked proof of fire and life safety and emergency disaster plan training. 9/6/24 12:05 PM - Findings reviewed with E1 (ED), E2 (CSM), and E3 (MCD) during the exit conference.		
3225.16.14.2.9 **S/S-E**	**16 Del.C. Ch. 11, pertaining to residents' rights; reporting of abuse, neglect, mistreatment, and financial exploitation; and the Ombudsman Program;** **This requirement was not met as evidenced by:** Based on facility documentation and interview, it was determined a review of seven (E4, E5, E6, E7, E8, E9 and E10) out of eight sampled employees the facility lacked evidence of training pursuant to abuse, neglect and mistreatment. Findings include: 1/11/23 – The hire date of E4 (RA). The facility lacked documentation of abuse training. 2. 1/19/23 – The hire date of E5 (RA). The facility lacked documentation of abuse training. 3. 2/22/23 – The hire date of E6 (Housekeeping). The facility lacked documentation of abuse training.	E4, E5, E6, E7, E8, E9, and E10 were trained on Residents' Rights; Reporting of Abuse, Neglect, Mistreatment, Financial Exploitation; and the Ombudsman Program by community leadership. A review of all employee records was conducted by community leadership. All current staff members were in-serviced on Residents' Rights; Reporting of Abuse, Neglect, Mistreatment, Financial Exploitation; and the Ombudsman Program. Root cause analysis yielded the following: the community's previous Business Office Manager utilized an online training documentation service (Relias) for the documentation of orientation and annual training subjects. Access to that service and its electronic documentation was suspended when the community changed management companies. Current Business Office Manager will be in-serviced (Attachment 1) on the need to retain hardcopies of training documentation, even if available electronically, point of service. Additionally, Residents' Rights; Reporting of Abuse, Neglect, Mistreatment, Financial Exploitation; and the Ombudsman Program will continue to be a critical part of the community's orientation and annual employee training.	10/21/2024

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	4. 5/22/23 – The hire date of E7 (Maintenance). The facility lacked documentation of abuse training. 5. 7/6/23 – The hire date of E8 (RA). The facility lacked documentation of abuse training. 6. 7/17/23 – The hire date of E9 (Dietary Cook). The facility lacked documentation of abuse training. 7. 9/19/23 – The hire date of E10 (RA). The facility lacked documentation of abuse training. 9/6/24 11:50 AM – An interview with E1 (ED) and E2 (CSM) confirmed that there was a lack of facility documentation to show the completed abuse trainings. E1 stated, "we used to use Relias for trainings." 9/6/24 12:05 PM - Findings reviewed with E1, E2, and E3 (MCD) during the exit conference.	An audit of training on these topics (Attachments 3 and 4) will be conducted weekly on a random sample of 7 employee files until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance at which point the issue will be determined to have been sufficiently addressed. Results of the audit will be presented at the community's Quality Assurance/Performance Improvement (QAPI) Committee.	
3225.16.14.3 **S/S-E**	**Receive, at a minimum, 12 hours of regular in-service education annually which may include but not be limited to the topics listed in 16.14.2;** **This requirement is not met as evidenced by:** Based on record review and staff interview, it was determined that for five (E4, E5, E8, E10 and E11) out of five sampled resident assistants for annual in-service education, the facility failed to employ resident assistants that received a minimum of 12 hours of regular in-service annually. Findings include:	E4, E5, E8, E10 and E11 completed the community's annual training and are on track to achieve a minimum of 12 hours of regular annual in-service (to include the above referenced annual training topics) within 12 months of the anniversary of their hire date. A review of employee records was conducted by community leadership. Current staff members will have participated in annual training in-service by the date of substantial compliance and will be on track achieve a minimum of 12 hours of regular annual in-service within 12 months of the anniversary of their hire date. Root cause analysis yielded the following: the community's previous Business Office Manager utilized an online training documentation service (Relias) to document orientation/annual training. Access to that service was suspended	10/21/2024

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	1. 1/11/23 – E4 (RA) was hired and completed 1 hour of in-service education from 1/11/23 to 9/6/24. 2. 1/19/23 – E5 (RA) was hired and completed 4 hours of in-service education from 1/19/23 to 9/6/24. 3. 7/6/23 – E8 (RA) was hired and completed 1 hour of in-service education from 7/6/23 to 9/6/24. 4. 7/24/23 – E11 (RA) was hired and completed 3 hours of in-service education from 7/24/23 to 9/6/24. 5. 9/19/23 – E10 (RA) was hired and completed 1 hour of in-service education from 9/19/23 to 9/6/24. 9/6/24 11:50 AM – An interview with E1 (ED) and E2 (CSM) confirmed that there was a lack of facility documentation that shows in-service trainings to total 12 hours each year. E1 stated, "we used to use Relias for trainings." 9/6/24 12:05 PM - Findings reviewed with E1, E2, and E3 (MCD) during exit conference.	when the community changed management companies. Current Business Office Manager will be in-serviced (Attachment 1) on the need to retain hardcopies of documentation, even if available electronically. Current annual training procedure will be revised to ensure employees achieve at least the minimum 12 hours of annual training by the anniversary of their hire date. An audit of Employee Annual Training Records (Attachments 3 and 4) will be conducted to ensure employees receive sufficient orientation and/or annual training within the past 12 months or is on track to complete at least 12 hours of annual training by the anniversary of their date of hire. This audit will occur weekly on a random sample of 15 employee files until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance at which point the issue will be determined to have been sufficiently addressed. Results of the audit will be presented at the community's Quality Assurance/Performance Improvement (QAPI) Committee.	
3225.19.0 **3225.19.1** **S/S-B**	**Records and Reports** **The assisted living facility shall be responsible for maintaining appropriate records for each resident...** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for three (R19, R20, R21) out of nine residents sampled in the survey, the facility did not maintain accurate medical records. Findings include:	The hard copy resident health charts for R19, R20, and R21 were reviewed in their entirety. No additional documentation for any other resident was uncovered in these charts. A review of all resident charts was conducted prior to survey exit and file errors addressed. No current hard copy resident charts include any records for anyone other than the subject of that chart. Root Cause Analysis yielded the following: Facility demonstrated an error in its legacy filing system and in the filing of third-party documentation. An in-service was conducted for community leadership and nursing staff regarding the	10/21/2024

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	9/4/24 approximately 1:30 PM – A review of R6's clinical record revealed that the following documents were incorrectly filed: Resident Dining Profile form for R20, Wellness Visit dated 6/6/24 for R21 and Wellness Visit dated 6/5/24 for R19. 9/4/24 2:05 PM – In an interview, the Surveyor confirmed with E2 (CSM) that the above documents were in the wrong chart. 9/6/24 12:05 PM - Findings reviewed with E1 (ED), E2 (CSM), and E3 (MCD) during exit conference.	importance of ensuring the integrity of residents' health charts and making sure documents are filed in the appropriate residents' chart (Attachment 5). An audit of a random sample of 10% of resident charts (Attachment 6 and 7) will be conducted to ensure that 100% of the documents contained in the chart is relevant to the subject resident and that no information for other residents was found in the chart. This audit will be completed daily until three consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	
16 Del. Code Part II Ch. 11, Subchapter IV **§ 1142** **S/S-E**	**Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act.** **Mandatory drug screening.** **(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(d) An agency, including temporary agencies, must provide the drug screening results it receives regarding an applicant referred to work in a facility to that particular facility so that the facility is better able to make an informed decision whether to accept the referral.** **(e) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **This requirement was not met as evidenced by:** Based on review of facility documentation and interview, it was determined that the	Drug screenings were conducted on E4, E5, E6, E7, E8, E9, E10, and E11. A review of all employee records was conducted to determine if other employees lacked similar documentation. All employees now have appropriate documentation regarding drug screening in their files. Root cause analysis indicates previous BOM relied upon digital access to drug screening vendor's portal. Access to the portal was halted when the community experienced a change in management companies. Drug screening shall continue to be completed for all employees prior to the start of employment. Hardcopy documentation for these screenings shall be maintained in the employee's file. The Business Office Manager will be in-serviced (Attachment 1) on the process and the need for this documentation. An audit of employee drug screenings will be conducted on a random selection of seven personnel files (Attachments 3 and 4) to ensure	10/21/2024

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	facility failed to ensure that eight (E4, E5, E6, E7, E8, E9, E10 and E11) out of eleven sampled staff members reviewed had confirmation of drug screening. Findings Include: 1. 1/11/23 – The hire date of E4 (RA). The facility lacked documentation of drug screening confirmation. 2. 1/19/23 – The hire date of E5 (RA). The facility lacked documentation of drug screening confirmation. 3. 2/22/23 – The hire date of E6 (Housekeeping). The facility lacked documentation of drug screening confirmation. 4. 5/22/23 – The hire date of E7 (Maintenance). The facility lacked documentation of drug screening confirmation. 5. 7/6/23 – The hire date of E8 (RA). The facility lacked documentation of drug screening confirmation. 6. 7/17/23 – The hire date of E9 (Dietary Cook). The facility lacked documentation of drug screening confirmation. 7. 7/24/23 – The hire date of E11 (RA). The facility lacked documentation of drug screening confirmation. 8. 9/19/23 – The hire date of E10 (RA). The facility lacked documentation of drug screening confirmation. 9/5/24 3:10 PM – An interview with E1 (ED) and E2 (BOM) confirmed that there was a lack of facility documentation to show confirmation of drug screening for employees. E1 stated they did not have access to the	screenings are completed in accordance with State of Delaware regulations. This audit will be completed weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting.	

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	portal they used to use since they switched companies. 9/6/24 12:05 PM - Findings reviewed with E1, E2 (CSM), and E3 (MCD) during exit conference.		