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.
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STATE SURVEY REPORT

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: August 26, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from August 21, 2024, through August 26, 2024. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was fifty-three (53). The survey sample totaled eighteen (18) residents. Abbreviations/definitions used in this state report are as follows: Admin – Administrator; CEU – Continuing Education Units; CNA – Certified Nursing Assistant; DON – Director of Nursing; RN – Registered Nurse; TST – Tuberculin Skin Test; Alzheimer's Disease – degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Blood sugar – amount of sugar or glucose in the blood; Dementia – a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Diabetes Mellitus – (DM) – disease where sugar levels are too high; Levemir Insulin – a long-acting Insulin used to control blood sugar;		

Provider's Signature Timothy Yoder Title NHA Date 9/26/24

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	Novolog Insulin – a rapid-acting insulin used to lower blood sugar/glucose; Relias – provider of workforce education; Tuberculosis (TB) – a serious infectious disease that affects the lungs.		
3201 3201.5.6 3201.5.6.1	**Regulations for Skilled and Intermediate Care Facilities** **Results of Dementia Training** **Nursing facilities that provide 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. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.**	**A. Individual/Resident Impacted** Healthcare Providers who are required to participate in CEU programs (CNA, RN, LPN) that care for residents with dementia. **B. Identification of Other Residents with the potential to be affected.** All residents with the diagnosis of dementia. **C. System Changes** CRH will provide the required dementia specific training each year to those healthcare providers who must participate in continuing education programs (CEUs). The mandatory training will include such resources as "In the Know," "Relias" and in-service dementia training (such as those provided by Hospice). **D. Success Evaluation** Human Resources will be required to monitor/record the specific training each year for those healthcare providers both in their individual file and on a spreadsheet.	10/01/2024
3201.5.6.2	**The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.** **This requirement was not met as evidenced by:** Based on interview, record review and review of other facility documentation, it was determined that for two (E10 and E12) out of five sampled employees for dementia training the facility lacked evidence of dementia training being completed. Findings include: 1. 4/16/21 – E10 (CNA) was hired. Review of E10's Relias transcript revealed that E10 last completed dementia training on 11/30/22.		

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	2. 10/17/22 – E12 (CNA) was hired. Review of E10's Relias transcript revealed that E10 last completed dementia training on 9/29/22. 8/26/24 11:15 AM In an interview, E2 (DON) and E5 (Admin Assistant) confirmed that dementia training is done upon hire. There is no policy that this training be done annually. E5 revealed he was trying to locate documentation on Relias that would confirm that staff have had this training. 8/26/24 12:50 PM – In an interview, E1 (Admin) stated he was not aware that CNA's need to have completed required dementia training. E1 stated he believed that many CNAs complete the required CEU's before they are due for licensure recertification. 8/26/24 2:30 PM – Findings were reviewed with E1 (Admin) and E2 during exit conference.		
3201.6.0	**Services to Residents**		
3201.6.3	**Nursing Administration**		
3201.6.3.3	**Within 14 days of admission, the facility shall make a comprehensive assessment of each resident's needs. This assessment shall include, at a minimum, the following information:** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for one (R3) out of fifteen residents in the investigative sample the facility failed to complete a comprehensive assessment within 14 days from admission. Findings include: 8/14/23 – R3 was admitted to the facility.	**A. Individual/Resident Impacted** Resident (R3) **B. Identification of other residents with the potential to be affected.** All current residents and future admissions. **C. System Changes** E2 (DON) determined that the admitting nurse on 8/21/2023 chose the wrong reason for assessment for R3, she checked quarterly instead of Admission on the form. To prevent this from reoccurring, a "Full Admission Order Set" has been programmed in the EMR (Sigmacare) which includes all assessment forms, labs, physician orders, etc. that must be completed on each admission. Thus, eliminating the chance of choosing the wrong form.	09/23/2024

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	8/14/23 – A review of facility assessments for R3 revealed a quarterly assessment was completed. 8/23/24 10:16 AM – An interview with E2 (DON) revealed that R3 did not have an admission assessment completed post admission and staff completed a quarterly assessment. E2 confirmed this is not standard. The facility lacked evidence of an admission assessment for R3. 8/26/24 2:30 PM - Findings were reviewed with E1 (Admin) and E2 during exit conference.	**D. Success Evaluation** E2 (DON) also audited remaining current residents to ensure the proper comprehensive admission assessment was completed. No other deficits found.	
3201.6.3.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.** **This requirement is not met as evidenced by:** Based on interview and record review, it was determined that for one (R2) out of eighteen residents in the investigative sample the facility failed to develop and implement a comprehensive resident centered care plan for an identified care area. Findings include: 6/21/24 – R2 was admitted to the facility under Hospice care. 6/25/24 – A care plan was initiated for R2.	**A. Individual/Resident Impacted** Resident R2 **B. Identification of other residents with the potential to be affected.** Remaining current residents and future resident admissions. **C. System Changes** E2 (DON) confirmed that when completing a comprehensive care plan, she usually addresses all CAA areas triggered first, then writes specialty care plans (such as Hospice) next. In the case of R2, she believes she was interrupted and the Hospice care plan was not completed. On 8/23/24 when brought to the attention of E2 that the comprehensive care plan was lacking the Hospice care plan, she added the care plan on 8/24/24. To help prevent this omission from reoccurring, E2 (DON) has created an admission care plan tool to decide which care plans required on assessment (see attached). **D. Success Evaluation** E2 (DON) completed an audit of all remaining current residents care plans to determine all needs assessed were	09/23/2024

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	8/23/24 – A review of R2's care plan revealed that R2 did not have a care plan for Hospice services. 8/23/24 10:24 AM – An interview with E2 (DON) confirmed R2 did not have a care plan for Hospice services and E2 stated it will be corrected. 8/26/24 2:30 PM - Findings were reviewed with E1 (Admin) and E2 during exit conference.	properly care planned. To address future Hospice residents, E2 (DON) will maintain a list of all current Hospice residents and will ensure each resident on the list has an appropriate Hospice care plan.	
3201. 6.8	**Medications**	Past Non-compliance	03/09/23
3201. 6.8.1	**Medication Administration**		
3201. 6.8.1.5	**Medications shall be given only to the individual resident for whom the prescription or order was issued and shall be given in accordance with the prescriber's instruction.** **This requirement was not met as evidenced by:** Based on interview, record review and facility provided documentation, it has been determined that for one (R5) out of one sampled resident for medication errors the facility failed to administer the correct insulin as ordered by the physician resulting in R5 being sent to the emergency room for evaluation and treatment for a blood sugar of 67. Due to the facility's corrective measures following the incident, this is being cited as past non-compliance with an abatement date of 3/9/23. Findings include: 1/23/23 – R5 was admitted to the facility with diagnoses including but not limited to, dementia, diabetes, and hypertension. 1/27/23 2:31 PM – A physician's order written for R5 documented "Levemir (long-acting		

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	insulin that lowers the level of glucose in the blood) U-100 Insulin 100 unit/ml subcutaneous (beneath and under the layers of skin) solution Dispensed: Levemir FlexTouch U-100 Insulin 100 unit/ml (3ml) subcutaneous pen SIG: inject 20 units by subcutaneous route once daily at bedtime call if FS greater than 400 Monitoring: Blood Sugar." 2/25/23 9:43 PM – A nurses progress note documented... "at 8:00 PM the nurse on duty gave 20 units Novolog (fast acting mealtime insulin) instead of 20 units Levemir. Blood sugar was 135. He has been given glucose 15 grams and a glass of OJ (orange juice) with 2 packs of sugar in it. 9:15 p.m. BS (blood sugar) 70. Team Health has been called. Waiting for return call. DON (Director of Nursing) and recommends sending to ER (Emergency Room). 911 called at 9:30 PM. Wife is aware. Resident is alert and talking as his normal." 2/25/23 11:19 PM – A nurses progress note documented... "Resident given 20 units of Novolog instead of 20 units of Levemir at 8:05 p.m. BS 135. Juice and candy bar given BS 130 8:40 p.m. Juice, glucose gel and cookies given BS 83 9:00 p.m. another candy bar BS 70 at 9:15 p.m. More juice and glucose gel given BS 67, VS (Vital Signs) 174/85 P90 (Pulse), resident alert and talking with n/s (sic) hypoglycemia. BS 68 at 9:45 p.m. BS 74 at 9:50 p.m. by paramedics. Resident alert and talkative was transported to hospital for precaution. Family made aware. Administration made aware." 2/26/23 1:57 AM – A nurses progress note documented... "Hospital nurse called with report. Resident's BS was 59 upon arrival. They tried to put an IV (Intravenous) in to possibly give IV glucose. They were not able to get IV times 2 attempts. With oral carbs and juice		

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	his BS has been steadily climbing. It was 139 at 1:00 AM. He had high BP (Blood Pressure) so was given Metoprolol 25mg. (milligrams). BP now 158/97." 2/26/23 7:29 AM – A nurses progress note documented... "Resident returned from [hospital] at 2:30 AM. No new orders." The facility provided the following measures in response to this incident: 2/26/23 – E7 (RN) was given one on one education by E2 (DON) which started with the 10 rights of medication. E2 demonstrated the correct method of preparing insulin for administration and then E7 was asked to do a return demonstration. A medication audit tool was used to audit the return demonstration. A blank copy of the audit tool was left for E7 to use as a future reference. 2/26/23 - E2 asked E7 to pass medications for three residents, one which included R5 and insulin administration. Diabetic in-service materials were added to the "Physician's Book" which allows it to be at each nurses' fingertips to refer to when they have questions. Education content included: Medication pass competency and guidelines for medication pass, preparation, and administration. Diabetic protocol for hypoglycemia level one and level two. Focus on identification and treatment of hypoglycemia. American Diabetes Association definitions of hypoglycemia.		

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	Using insulin pen delivery systems for flex pen injection in pre-filled pen. Considerations for injectable medications. Considerations for insulin administration. Insulin storage parameters (storage of pens/cartridges at room temperature, storage of related non-insulin injectable medication at room temperature). Commonly expired medications and supplies (refrigerated). Storage of medications. Glucometer cleaning. 2/26/23 – 3/9/23 - All nurses full-time, part-time and PRN (As Needed) were educated on the same diabetic protocol and other medication education content. 2/28/23 2:00 PM – R5 was seen by Endocrinologist (medical doctor that specializes in the study of body hormones) for appointment. 3/1/23 – A physician's progress note documented R5 was seen for follow up for transport to emergency room on 2/26/24. 8/23/24 10:33 AM – During an interview E2 confirmed, E7 called E2 and said, "she gave the wrong insulin to [R5]." 8/26/24 2:30 PM - Findings were reviewed with E1 (Admin) and E2 (DON) during exit conference.		
3201.6.9.2	**Specific Requirements for Tuberculosis**		

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3201.6.9.2.4	**Minimum requirements for pre-employment tuberculosis (TB) testing 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)...** **This requirement is not met as evidenced by:** Based on interview and review of other facility documentation it was determined that the facility failed to ensure TB testing was completed timely for three (E14, E15 and E16) out of five sampled employees receiving TB skin testing when employed. Findings include: Review of a State Agency form entitled Personnel Audit Sheet completed by E5 (Administrative Assistant), revealed three employees did not have their first step of the two-step TST conducted timely (prior to the first day in the facility / date of TST): 1. E14 (CNA): 6/20/24. TST 6/20/24. 2. E15 (Dietary): 5/26/24. TST 5/26/24. 3. E16 (LPN): 4/14/24. TST 4/14/24. 8/26/24 12:30 PM – In an email correspondence, E5 (Administrative Assistant) stated, "After new employees take their TB test on their first day, they have been moving right into orientation, which includes participating in giving care," with residents although the TST results were not yet available. 8/26/24 2:30 PM - Findings were reviewed with E1 (Admin) and E2 (DON) during exit conference.	A. Individual/Employee Impacted E14, E15, and E16 B. Identification of other employees with the potential to be Affected. All current and future CRH employees. C. System Changes Human Resources (HR) (E5) will ensure all employees will have a documented two-step tuberculin skin test (TST), which includes a negative result for at least step one before they start work. The second-step TST administration will be scheduled within 10-14 days of the first step administered. D. Success Evaluation HR will develop and use a monitoring tool and spreadsheet to ensure these requirements are met with each employee and become part of each employee's HR file. This tool and spreadsheet will be implemented by 10/1/2024 and be on-going.	10/01/2024

Provider's Signature Timothy Yoder Title NHA Date 9/26/24