STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085055		C 04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON SENIOR LIVING CENTER AT HIGHFIELD	4800 LANCASTER PIKE WILMINGTON, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from April 15, 2019 through April 16, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 16. The survey sample size was one. Abbreviations/definitions used in this report are as follows: Allegation - a claim or assertion that someone has done something illegal or wrong; Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; CNA - Certified Nurse's Aide; Delusions - a belief held with strong conviction despite evidence to the contrary; DON - Director of Nursing; Hallucinations - something that seems real but does not really exist; LPN - Licensed Practical Nurse; NHA- Nursing Home Administrator; Parkinson's Disease - a progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination; RN - Registered Nurse;	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		5/3/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 05/03/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other facility documentation as indicated, it was determined that for one (R1) out of one sampled residents, the facility failed to implement the facility's policy to prevent and prohibit abuse. Findings include: The facility's policy entitled, Resident Abuse, last revised 2/25/19, stated, "Investigation complaints of alleged abuse...Investigation guidelines...Initiate investigation. Notify Administrator, DON, Medical Director, Family/Responsible Party ...All employees are obligated to report all incidents which may be resident abuse." Review of facility documentation revealed: 4/10/19- Review of the facilities incident report revealed, R1 self-reported to E3 (RN) in the morning (before breakfast) that she was raped (sexually abuse) by three men sometime that morning between 12:00 AM and 7:00 AM. When E5 (CNA) placed R1 in the dining room to eat breakfast R1 communicated to him/her that she was raped. E5 reported this information to E4 (LPN), who questioned R1 in his/her room at approximately 9:00 AM after breakfast. E4 then reported the allegation to E2 (DON). 4/10/19- A untimed statement by E3 (RN), stated	F 607	Past noncompliance: no plan of correction required.	

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F 607	Continued From page 2 that, while taking R1 from his/her room to breakfast and morning medications R1 stated "I am glad you found me...I was raped by last night by 3 hispanic men with goatees." 4/10/19- An untimed statement by E5 (CNA), stated that R1 was escorted to breakfast by E3 (RN) at 8:00 AM. R1 told E5 that he/she did not want his/her cereal and E5 found that to be strange, and asked R1 what was wrong. R1 then stated, "I guess you didn't hear I was raped!" E5 told R1 he/she needed to report this to the nurse. E5 reported R1's allegation to E4 (LPN), who asked R1 if they could talk in private. 4/16/19 at 10:16- During an interview, E3 (RN) stated that R1 told him/her that he/she was raped and was glad that E3 found him/her. E3 stated that R1 was already dressed and in a chair, so he/she took him/her to the dining room for breakfast. E3 stated that he/she did a quick skin check on R1; however, E3 commented that R1 frequently had delusions and hallucinations and said things that were not true. E1 thought if he/she changed R1's environment that the story R1 was telling may change. E3 stated when he/she found out R1 told E5 (CNA) the same story, and it was reported to E4, he/she reported that R1 had told him/her the same thing. The facility failed to implement the facility's policy to prevent and prohibit abuse as evidenced by E3 (RN) not immediately reporting R1's allegation of abuse to the facility. 4/16/19 approximately 4:00 PM- During the exit conference, findings were reviewed with E1 (NHA) and E2 (DON).	F 607		
F 656	Develop/Implement Comprehensive Care Plan	F 656		5/3/19

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F 656 SS=D	Continued From page 3 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 4 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of one sampled resident, the facility failed to develop and implement care plan interventions to address R1's hallucinations. Review of R1's clinical record revealed: R1 was admitted to the facility on 10/10/17 with diagnoses that included Parkinson's Disease, Alzheimer's, and delusional disorder. Review of R1's care plan revealed that starting on 10/24/17, R1 had multiple focuses for behavioral disturbances, however there was no focus pertaining to hallucinations. Review of R1's Behavior/Intervention Monthly Flow Records for March 2019 and April 2019, revealed that R1 had been monitored for hallucinations. 4/16/19 at 1:02 PM - During an interview, R1's daughter stated, "My feeling is that R1 had hallucinated quite a lot lately. He/she had hallucinated over the past four years. It had gotten better, but over the previous week had gotten worse". The facility failed to develop and implement a care plan intervention to address R1's hallucinations. Findings were discussed with E1 (NHA) and E2 (DON) on 4/16/19 at 4:00 PM during the exit conference.	F 656	A. R1□s clinical record cannot be retroactively corrected. R1 was not adversely affected by not having a care plan for hallucinations. RNAC & DON (E2) updated R1□s care plan specific to hallucinations with measurable goals. B. All residents exhibiting hallucinatory behaviors have the potential to be affected. C. E2/DON reviewed all residents being treated for hallucinations to ensure a hallucination care plan is developed and implemented after diagnosis of hallucinatory behavior is made, and medication orders to be reviewed. E2/DON or designee to educate nursing staff on developing and implementing a comprehensive care plan with measurable goals for residents diagnosed with hallucinations, and the medication administered per MD order with interventions in place, if necessary. D. E2/DON or designee will audit the care plans of residents who are currently being treated for hallucinating behaviors to ensure a care plan was developed with intervention five days per week until three consecutive weeks of 100% compliance is achieved. Thereafter, monitoring will take place monthly until 100% compliance has been achieved for 6 consecutive months. The Plan of Correction will be discussed at the monthly QA meeting for three months to determine if the plan is functioning as intended and if not, more intense observations will be installed to	

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F 656	Continued From page 5	F 656	ensure regulatory compliance. This corrective action will be completed Friday, May 3, 2019.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it was determined that the facility failed to provide treatment and care in accordance with professional standards of practice when the facility did not immediately contact and communicate with the hospice staff regarding a significant change for one out of one sampled resident. Findings include: Review of R1's clinical record revealed: 10/10/17 - R1 was admitted to the facility. 10/13/17 - There was a physician's order for R1 to be admitted to hospice. 4/10/19 - R1 self reported an allegation of rape and was transported to the emergency room. 4/16/19 at 9:30 AM - During an interview, E2 (DON) stated that psychiatric services and social work services were provided through hospice.	F 684	A. Facility is unable to retroactively correct not contacting Hospice services immediately regarding E2s status change. B. All residents receiving hospice services have the potential to be affected C. E2/DON reviewed all residents receiving Hospice services and educated staff on the immediate requirement to report to Hospices any incident/occurrence/allegations of abuse, neglect, exploitation and misappropriation of property observed on shift, which would also designate a change in condition. Hospice services to be implemented on care plan/interventions and MD orders reviewed to incorporate immediate necessity to notify Hospice as indicated if any of the above should occur within two hours of being notified. An alert in POC and Cardex will be a monitoring tool D. E2/DON or designee to audit the facility's current 4 residents under hospice services to ensure proper notification is	5/3/19

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F 684	Continued From page 6 4/16/19 at 1:20 PM - During an interview, E7 (hospice social worker) stated he/she generally sees R1 one to two times per month. E7 stated that he/she was at the facility on 4/12/19, and he/she was not informed of R1's allegation of rape or R1's emergency room visit. E6 (hospice nurse) stated that the facility did not notify them of R1's allegation of rape and subsequent emergency room visit until 4/15/19. The facility failed to communicate with the hospice staff regarding a significant change for R1. Findings were reviewed with E1 (NHA) and E2 (DON) on 4/16/19 at 4:00 PM during the exit conference.	F 684	being done in the event of a change in condition. Having an alert in POC and Cardex as well as task set up in PCC as an order to contact Hospice with any changes , new order, appointment, care plan, skin tag/tear and wound update. By completing these tasks, the facility shall successfully prevent the incident of not communicating with Hospice from reoccurring. DON will review and monitor hospice residents status weekly x 4 and then ongoing monthly until 100% compliance to ensure Hospice services are being contacted immediately. This corrective action will be completed Friday, May 3, 2019.	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Weston Senior Living Center At Highfield

DATE SURVEY COMPLETED: April 16, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from April 15, 2019 through April 16, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 16. The survey sample size was one.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	Scope	Cross-refer POC to CMS 2567-L survey completed April 16, 2019: F561, F607, and F610.	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey completed April 16, 2019: F561, F607, and F610.		

Provider's Signature Bruce Nestus Title NHA Date 5/16/19