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 Peach Tree Health Group, LLC **DATE SURVEY COMPLETED:** April 2, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	
	An unannounced Annual and Complaint Survey was conducted at this facility from March 26, 2024, through April 2, 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 sixty-five (65). The survey sample totaled seventeen (17) reviewed residents. Abbreviations/definitions used in this state report are as follows: Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Bipolar Disorder – mood disorder; CNA – certified nursing assistant; 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; Depakote – medication used to treat seizure disorders, certain psychiatric conditions, and to prevent migraine headaches; Dermabond – a liquid skin adhesive that holds wound edges together; DON – Director of Nursing; ED – Executive Director; Lipitor – medication used to lower cholesterol: a waxy substance found in blood; Metformin – medication used to help to control the amount of glucose (sugar) in blood; Morphine Sulfate – medication used to help relieve moderate to severe pain; RN – Registered Nurse; Schizophrenia – mental disorder with false beliefs of being harmed;		

Provider's Signature [signature] Title Administrator Date 6/10/24

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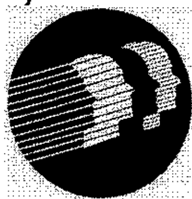
Seroquel – antipsychotic medication used for treatment of certain types of mental health conditions;
Service agreement - document developed with each resident that describes the services to be provided, who will provide the services, when the services will be provided, how the ser-vices will be provided, and if applicable, the expected outcome;
Uniform Assessment Instrument (UAI) – A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations;
Traumatic brain injury – injury that occurs when happens when a sudden, external, physical assault damages the brain;
Zyprexa – medication used to treat psychotic conditions.

Assisted Living Facilities

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 physical needs of those persons; and safety measures which need to be taken with



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	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 facility documentation and interview, it was determined that for one (E9) out of eleven (11) sampled employee files, the facility lacked evidence of annual training pursuant to the memory-impaired resident. Findings include: 7/27/07 – E9 (CNA) was hired and the latest dementia training was completed 6/30/21. The facility lacked evidence of annual training after 6/30/21. 4/1/24 at 12:20 PM – An interview with E1 (ED) and E5 (Human Resources Manager) confirmed that E9 did not have any dementia training after 6/30/21. 4/2/24 – Findings were reviewed with E1 and E2 (DON) at the exit conference, beginning at approximately 2:00 PM.	1. Immediately following identification of this deficiency E9 was made aware and dementia education completed in Relias with Staffing Development Coordinator. All employee education files were reviewed to ensure all staff are in compliance. 2. Staff education will be monitored by our Staff Educator and staff will be alerted to necessary Alzheimer's/Dementia training that isn't complete and will complete to remain on the schedule. 3. Our Staff Educator has begun monitoring completed education and education still due on Relias and is doing weekly notifications to staff and managers to have education completed.. 4. Staff Educator will monitor dementia training in Relias weekly for 4 weeks for 100% compliance and the monthly for 3 mos to ensure 100% compliance.	5/15/24 will be compliance date.
	Infection Control **Infection Prevention and Control Program** **The assisted living facility shall establish an infection prevention and control program with shall be based upon Centers for Disease Control and Prevention and other nationally recognized infection prevention and control guidelines.** **This requirement is not met as evidenced by:**		

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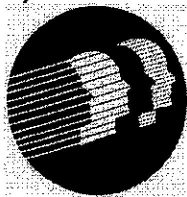

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STATE SURVEY REPORT

NAME OF FACILITY: AL Peach Tree Health Group, LLC **DATE SURVEY COMPLETED:** April 2, 2024

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	Based on interview and record review, it was determined that the facility failed to have an infection control program that monitored and tracked infections. The facility was out of compliance with this requirement prior to and during the survey. It was unknown when the infection control program had last been functioning as required. The facility initiated the infection control program on 4/1/24. Findings include: 3/28/24 9:00 AM – An interview with E2 (DON) confirmed that an infection control program was not in place and a program will be starting on 4/1/24. 3/28/24 10:30 AM – An interview with E1 (ED) confirmed that the infection control program was to start on 4/1/24 and will include monitoring, analysis and tracking of infections throughout the facility. 4/2/24 2:05 PM – Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference. **The individual designated to lead the assisted living facility's infection prevention and control program must develop and implement a comprehensive plan that includes actions to prevent, identify, and manage infections and communicable diseases. The plan must include mechanisms that result in immediate action to take preventative or corrective measures that improve the assisted living facility's infection control outcomes.** **This requirement is not met as evidenced by:** Based on interview and review of other facility documentation, it was determined that	1. Immediately following the identification of this deficient practice, (2) Nurses were identified as the Infection Preventionists and were assigned the CDC course. 2. DON was immediately identified as the Infection Preventionist lead for the facility. Secondary LPN in the facility to be a backup to the DON. 3. CDC provisions and certification for Infection Preventionist will be completed. 4. CDC course (https://www.cdc.gov/longterm-care/training.html) consisting of 23 modules will be completed within 30 days from submission. This course will be documented and any personnel changes will result in onboarding staff complete the education within 30 days of employment.	5/15/24 will be compliance date.

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	the facility lacked an infection control process to prevent, identify, and manage infections. Findings include: 3/28/24 9:00 AM – Interview with E2 (DON) confirmed that the facility did not have a process in place to prevent, identify, and manage infections currently. The facility was in the process of developing a program and it was to be initiated on 4/1/24. 4/2/24 2:05 PM – Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference.		
	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 the facility lacked an orientation and annual in-service program for infection prevention and control program. Findings include: 4/2/24 1:00 PM – An interview with E13 (LPN) confirmed that the facility orientation does not include an infection prevention and control program review. 4/2/24 1:30 PM – An interview with E2 (DON) confirmed that the facility does not complete an annual in-service on infection prevention and control. 4/2/24 2:05 PM – Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference.	1. Immediately following identification of this deficient practice, education was created and begun with the entire staff to be in compliance with infection control standards. 2. All current staff will have completed infection control training through Relias within 30 days of submission. 3. Staff Educator put a process in place to include infection control training in orientation and ALL staff assigned Relias Infection control modules to be completed. 4. Staff Educator will monitor Relias training completion logs weekly for 4 weeks until 100% compliance and then monitor monthly for 3 months to ensure 100% compliance.	5/15/24 will be compliance date.

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	Service Agreements. **The service agreement shall be reviewed when the needs of the resident have changed and minimally, in conjunction with each UAI. Within 10 days, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** Based on interview and record review, it was determined that for two (R6 and R7) out of seventeen (17) sampled residents the facility failed to review and revise the service agreement and the UAI. Findings include: **Cross refer Del 3225.19.1.22** 1. Review of R7's clinical record revealed: 6/9/21- R7 was admitted to the facility. 7/16/23 – An annual UAI documented R7 did exhibit disruptive behaviors. 7/16/23 – A service agreement included verbal altercations with other residents. 2/3/24 – An incident of sexual abuse toward another resident occurred. As of our exit on 4/2/24 the facility had failed to update the service agreement to include a new behavior of inappropriate sexual conduct. 2. Review of R6's clinical record revealed: 3/9/23 – R6 was admitted to the facility. 2/3/24 – An incident of sexual abuse toward R6 occurred. 3/25/24 – An annual UAI documented R6 required psychotherapy or counseling services.	1. Immediately following identification of this deficient practice, the UAIs for both R6 and R7 were reviewed and updated to reflect changes following the complaint. 2. To ensure all residents Care Plans were correct and being followed a 100% audit of all UAIs was completed and compared with the plan of care for each to ensure compliance.. 3. Any time there is a significant change in resident status such as injury or illness or if there are behavioral incidents that occur that change the care plan for any resident a new UAI will be completed and care changes shared with the staff to ensure all care plans are followed as required. 4. Weekly any and all changes in care or significant events will be discussed in management meeting and update POC scheduled. Facility will document all significant changes and care changes in the plan of care and UAIs accordingly on all.	6/19/24 will be compliance date.

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	4/2/24 1:18 PM – During an interview, E1 (NHA) and E3 (DON) confirmed that the Service Agreement and UAI's for R7 and R6 were not reviewed and revised to include the 2/3/24 sexual abuse incident. As of the state agency exit on 4/2/24 the facility had failed to update the service agreement to include the new trauma that R6 experienced and continued to experience. 4/2/24 2:05 PM – Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference.		
	Staffing **Assisted living facility resident assistants shall, at a minimum:** **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 one (E7) 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: 2/1/23 – E7 (CNA) was hired and completed 7.5 hours of in-service education from 2/1/23 to 3/26/24. 3/27/24 12:08 PM – An interview with E1 (ED) confirmed that E7 had 7.5 hours of in-service education and did not complete any	1. Immediately following identification of this deficiency E7 was made aware and dementia education completed in Relias with Staff Educator. All employee education files were reviewed to ensure all staff are in compliance. 2. All employees' education files were reviewed to ensure a minimum of 12hrs training. Staff education will be monitored by our Staff Educator and staff will be alerted to necessary training requirements to meet 12hrs that isn't complete nearing the end of his/her annual hire date and they will complete to remain on the schedule. 3. Our education tool, Relias, is monitored daily by the Staff Educator and training will be completed and documented. 4. Staff Educator will monitor Relias training completion logs weekly for 4 weeks until 100% compliance and then monitor monthly for 3 months to ensure 100% compliance.	6/19/24 will be compliance date.

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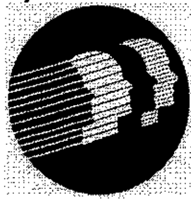

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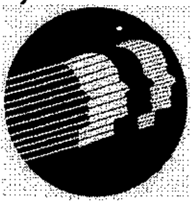
	Relias (software for online continuing education) trainings. E1 stated, "I've already spoken to E2 (DON) about it." 4/2/24 2:05 PM - Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference. **Records and Reports** **Reportable incidents include:** **Medication error or omission which cause or prolongs the resident's discomfort, jeopardizes the resident's health or safety, or requires periodic reassessment of the resident's clinical status by facility professional staff.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for five (R1, R13., R14, R15 and R16) out of five residents reviewed for medication administration, the facility failed to report to the State a medication error necessitating periodic monitoring. Findings include: 1. A review of facilities incident report on 10/24/23 revealed that R1's 6:00 am medications were found on the bed side table and E14 did not verify that R1 received them. Medications included Seroquel 100 mg and Seroquel 25 mg. A physician's order written for professional staff to monitor R1 for any side effects related to missed medication.	1. Immediately following identification of this deficient practice the process for identification and management of medication errors was reviewed by DON/ED and Staff Educator. MAR for R1, R13, R14, R15 and R16 were immediately reviewed for any additional errors and none were found. 2. All other residents were audited following the survey and nursing staff re-educated on medication administration processes that requires nurses to watch all residents take all medications and the nurse is to take the medication cup back out of the room and dispose of. Also re-educated on verifying the medication he/she is giving against the order. 3. All nursing staff were not only trained on the proper way to administer medication but also the process to properly report any and all medication errors. Clinical management will continue to do medication audits moving forward and random narcotic counts moving forward. Audits will be stored in the DON office. 4. To ensure compliance with this practice, weekly audits of medication administration will be conducted and outcomes recorded with the POC for a period of 6 weeks to achieve 100% compliance. Monthly audits will remain in place to ensure 100% compliance moving forward.	6/19/24 will be compliance date.



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	2. A review of facilities incident report on 11/5/23 revealed that R15 received Metformin 500 mg and Lipitor 40 mg in error. A physician's order written for professional staff to monitor vital signs every four hours for the twelve-hour shift. 3. A review of facilities incident report on 12/4/23 revealed that R13 received R17's medication. E14 (LPN) pulled the medications and an agency nurse administered them to the wrong resident. A physician's order written for professional staff to monitor R13's vital signs every thirty minutes for six hours. 4. A review of facilities incident report on 12/4/23 revealed that R14 received duplicate doses of Depakote, Lipitor, and Zyprexa. A physician's order written for professional staff to monitor R14's vital signs every two hours for six hours. 5. A review of facilities incident report on 6/1/23 revealed that R16 received two doses of morphine sulfate at midnight. The report revealed that R16 had no adverse effects determined by professional staff monitoring. The facility failed to report the five medication errors to the state. The facility conducted an in-house investigation of the above instances revealing that E14 was responsible for the errors. At this time, the facility had no evidence of discipline for E14 related to the medication errors. 4/2/24 2:05 PM – Findings were reviewed with E1 and E2 (DON) at the exit conference.		

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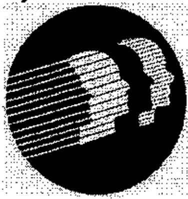
	Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents **Definitions.** **(1) "Abuse" means the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and includes all of the following:** **a. *Physical abuse.* —** **"Physical abuse" means the unnecessary infliction of pain or injury to a patient or resident. "Physical abuse" includes hitting, kicking, punching, slapping, or pulling hair. If any act constituting physical abuse has been proven, the infliction of pain is presumed.** **This requirement is not met as evidenced by:** Based on record review and staff interview, it was determined that for one (R1) out of eleven (11) residents sampled for physical abuse, the facility failed to provide services necessary to avoid physical harm. Findings include: 1. 3/22/23 – R1 was admitted to the facility with traumatic brain injury, schizophrenia, bipolar disorder and seizures. 3/22/23 – A Service Agreement documented that R1 required moderate assistance of one person for mobility in the room, the facility and outside the facility. 4/22/23 – A 30-day Uniform Assessment Instrument (UAI) documented that R1 required supervision, cuing, and coaching for mobility while he could propel himself. The UAI also documented that R1 had anxiety, schizophrenia, delusions, and hallucinations.	



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	9/19/23 – Video footage from a camera in the dining room of the facility revealed E4 (CNA) was waiting in the dining room at the elevator on 9/19/23 at approximately 6:59 AM. The elevator doors opened and R1 exited the elevator, while seated in a manual wheelchair, then an intense verbal interaction was exchanged with E4. While the verbal interaction is commencing between R1 and E4, E4 waved her right hand in front of R1. Then R1 rolls closer to E4 waves her hands in front of the resident. Then R1 reaches out with his left arm and swipes at E4. Then R1 continues to reach out at E4 while E4 is smacking R1's hands away when R1 grabs E4's left arm. E4 attempts to pull her arm out of R1's grasp, however, R1 pulls E4 into the open elevator with himself. Then E12 (dietary aide) tried to assist in separating R1 and from E4 (this blocks the view of the video footage between R1 and E4). Then E12 is seen leaving R1 and E4 to go get help. Then R1 and E4 are still in the elevator where R1 had E4's left arm and E4 is aggressively pulling her arm away. While E4 is attempting to pull her arm away R1 is pulling her hair causing E4 into bend down into R1's chest. Then E4 took her right hand and proceeded to raise it up over her head and swings down onto R1. Then R1 raised his hand and swung it into E4 multiple times while he held her head into his chest. Then E16 (Security guard) is seen running to the elevator where he quickly separates R1 and E4. The incident ended at approximately 7:01 AM. 9/19/23 7:12 AM – A State Police report documented E4 was struck by R1 for unknown reasons in the elevator of the facility. E1 suffered small cut to the bridge of her nose and swelling to her forehead. The report noted that prosecution was declined.	1. R1 did receive an abrasion following the interaction, but no other residents were harmed due to this deficient practice. Immediately following the incident, E4 was suspended pending the investigation and subsequently terminated and reported to the adult abuse registry. 2. All staff were re-educated on what constitutes abuse and neglect and techniques to de-escalate situations to avoid any further interactions. 3. Staff Educator will monitor all onboarding staff to ensure they receive proper abuse and neglect training. 4. To ensure compliance, all staff will receive additional training to prevent any abuse and neglect within 60 days of POC to achieve 100% compliance facility wide. Monthly monitoring following to ensure compliance moving forward.	6/15/24 will be compliance date.

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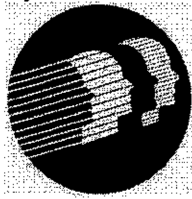

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NAME OF FACILITY: AL Peach Tree Health Group, LLC

DATE SURVEY COMPLETED: April 2, 2024

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	9/19/24 9:53 AM – An emergency room visit summary for R1 documented an abrasion to the face. 9/19/24 10:19 AM – An emergency room visit summary for E4 documented an injury to the head and abrasion to the face without any infection. 9/19/23 11:15 AM – A progress note by E17 (LPN) documented R1 was transported to an emergency room after an altercation with staff and that R1 had a small scratch to the right side of his cheek. R1 returned at approximately 11:30 AM, the same day, with no new orders from the provider. 9/26/23 – A facility follow-up incident report documented that E4 was terminated and placed on the adult abuse registry. 3/28/24 12:55 PM – An interview with E12 confirmed that R1 and E4 had a verbal altercation just prior to the physical altercation began. E12 confirmed that both R1 and E4 had hit each other in the physical altercation. 3/28/24 2:42 PM – In an interview with R1, he stated that he could not remember the exact details of the event. R1 stated that E4 did not grab him to take him to the dining room. R1 stated when he got down to the dining room on the elevator E4 passed me and she said something that he could not remember. R1 stated that he pulled E4's hair and that E4 was "throwing blows at me…". 4/1/24 12:25 PM – An interview with E1 (ED) stated this incident occurred prior to her hire date. E1 confirmed that she watched the video footage and stated that		

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	E4 did not follow the proper training techniques to deescalate a situation. E1 stated that it is never right for an employee to hit a resident. 2. Review of R7's clinical record revealed: 6/9/21 – R7 was admitted to the facility with diagnoses that included traumatic brain injury traumatic brain injury and bi-polar disorder (mood disorder). 7/16/23 – An annual UAI documented that R7 exhibited disruptive behaviors. 2/3/24 – R6 reported to E19 (LPN) that R7 had been in her room and had "tried to take her clothes off" and was trying to touch her in a sexually inappropriate way. R6 did not want to engage in this type of contact. Following this incident R6 approached E19 and told her what had just happened. E19 stated "did you tell him you are a lesbian" and stated she did not want anything to do with it. E19 did not report this to the DON or Administrator at that time. 2/5/24 – A State Police report documented R6 alleged R7 came into her room and "tried to take her clothes off." No prosecution occurred. 2/5/24 – A statement written by R6 documented, "I kept telling him no ...I thought he was going to watch a movie with me." 2/5/24 – A statement by E18 (Therapist) documented that R6 had disclosed that on 2/3/24, R7 had come into her room, and they were watching a movie. R7 started trying to take off her clothes. Following this incident, R7 was moved to another floor in the	

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	building and in addition, was referred to other facilities for placement. 2/5/24 – A statement written by E13 (LPN) documented that R6 had verbally reported this incident on the day of the incident to E19. 2/7/24 – A facility investigation package documented that E19 was terminated. 2/8/24 – The incident was reported to the State agency. 3/15/24 – A facility incident report revealed that R7 and R6 were both in the outdoor smoking area and R7 inappropriately touched R6. 3/27/24 2:15 pm – During an interview E20 (RN) stated that even though R7 was moved to a different floor both residents would go to the smoking area and the sexual abuse continues to be an issue. She also confirmed that the resident had been given a discharge notice to protect all female residents. 3/28/24 11:55 AM – During an interview, E2 (DON) confirmed that residents are allowed to go out to smoke at any time, except after 9:00 PM. They have to have security open the door to the smoking area. He also confirmed that there are no staff that go outside in that area. There are cameras that are placed outside and are constantly monitored. 3. Review of R6's clinical record revealed: 3/9/23 – R6 was admitted to the facility with diagnoses that included traumatic brain injury and bi-polar disorder.		

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	3/28/24 1:56 PM – During an interview, E3 (ADON) confirmed that R7 continues to inappropriately touch R6. She stated that even though they had moved R7 to a different floor he still pursues her and makes inappropriate gestures. When asked if the facility has put any other measures in place to prevent further incidents. She stated that they do go out to smoke but it's hard to police that. Residents are allowed to go out anytime to smoke. If a staff member notices either one is outside in the smoking area, then they try to redirect the other so that they are not out there at the same time. 3/28/24 2:36 PM – During an interview, R6 confirmed that R7 makes her feel anxious. She said when he had entered her room, the first incident of sexually inappropriate behaviors she went to E19 and told her what had happened, her response to R6 was she didn't want anything to do with it. 4/2/24 9:40 AM – During an interview, E1 (NHA) and E2 (DON) when asked if the perpetrator was placed on a 1:1 supervision following either of these incidents. Both responded "no" and E1 said that they had moved R7 to another floor, they don't put a resident on 1:1 supervision unless it's a medical concern. Plus, they really don't have the staff to provide that. In addition, she said that there was a resident in the facility that was currently a 1:1 for a medical reason and care. E1 also added that R6 tries to engage in conversation with R7 as they both go out to smoke but staff try to redirect one or the other if they are both seen communicating. There are no other measures in place such to ensure they are not going outside	1. Following the report from R6 that R7 was being inappropriate with her R7 was immediately moved to a different floor and staff educated R6 on keeping her door locked to ensure she felt safe. 2. R7 was subsequently put on 1:1 care when not in his room or in a group session where there was monitoring staff to ensure he made no physical contact with R6 or any other resident. 3. Staff Educator and DON educated all staff on the importance of monitoring any interactions between R6 and R7 (R6 seeks out R7 in the smoking area) and documenting all interactions. 4. To ensure compliance, clinical staff will monitor R7 for 6 mos and document any further issues to determine if 1:1 needs to be a permanent care plan. Documentation will be kept with the POC.	5/15/24 will be compliance date.

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	together. Corporate has sent out several referrals for placement for R7. The facility cannot discharge him until suitable placement is found. 4/2/24 2:05 PM – Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference. **(10) "Medication diversion" means the knowing or intentional interruption, obstruction, or alteration of the delivery or administration of a prescription drug to a patient or resident, if both of the following apply:** **1. The prescription drug was prescribed or ordered by a licensed independent practitioner for the patient or resident.** **2. The interruption, obstruction, or alteration occurred without the prescription order of a licensed independent practitioner.** **This requirement was not met as evidenced by:** Based on interview, record review and review of other facility documentation, it was determined that the facility failed to recognize a pattern of medication errors that resulted in missing medications. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 12/14/23. Findings include: 12/11/23 – A facility incident report revealed that R12 was missing twenty (20) tablets of Xtampza (pain medication, narcotic). The staff was unable to locate the twenty tablets and notified management.		

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	12/11/23 – A facility incident report revealed that R12 should have received eighty (80) tablets of Xtampza on 11/17/23. The nurse, E14, who received the medication documented sixty tablets received. 12/11/23 – A review of the pharmacy packing slip confirmed that eighty tablets were sent to the facility and received. A review of the narcotic administration sheet confirmed that nurse received medication and confirmed that sixty (60) tablets were documented. 12/11/23 1:15 PM – A review of the police report confirmed that twenty narcotic tablets were missing from the facility. 12/11/23 3:50 PM – A review of facility disciplinary sheet revealed that E14 was suspended pending investigation related to missing narcotic medications. 12/12/23 8:42 AM – A review of an electronic communication revealed that E14 resigned immediately. 12/14/23 1:00 PM – A review of the facilities plan of correction revealed that the facility determined that twenty (20) tablets were missing and could not confirm if E14 verified the delivery, as E14 refused to give a statement. The result of the investigation concluded that the State Police were taking over the investigation at this time. The facility gathered witness statements and suspended E14 upon discovery of the missing medication. The facility initiated random cart audits from 12/11/23 through 3/14/24. The cart audits will continue at random. 3/27/24 1:30 PM – An interview with E1 (ED) confirmed the employee was suspended and	

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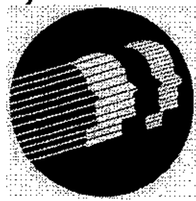
	the facility accepted E14's resignation. E1 confirmed that E14 had a history of medication errors. 4/2/24 1:00 PM – An interview with E13 (LPN) confirmed that the facility provided education related to narcotic medication handling, policy, and procedure, and how to report a discrepancy. 4/2/24 2:05 PM – Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference. 4/4/24 3:00 PM - Based on the Surveyor's review of the facility's thorough investigation, documented response, completion of audits from 12/11/23 to 3/14/24, staff interviews and no further medication incidents, R12's medication diversion was determined to be past non-compliance. **(12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **This requirement was not met as evidenced by:** Based on interview, record review and review of other facility documentation, it was determined that for one (R12) out of three (3) residents reviewed for neglect, the facility failed to follow a prescribed treatment plan that led to a fall with a major injury. Findings include:	1. Immediately following detection of missing narcotics, R12's medications were ordered and no doses were missed. 2. Upon discovering a medication discrepancy for R12's narcotic medication, noting a different amount recorded as received on the MAR than on the packing slip from the pharmacy: received, verified and entered incorrectly by E14, E14 was suspended pending investigation and the DSP began a criminal investigation. E14 resigned the following day. Medication audits were immediately conducted on all residents that were prescribed a narcotic medication to ensure no additional discrepancies existed. 3. All nursing staff was educated by the Staff Educator on proper procedures to document medication administration and any medication errors. Audit system put in place for random medication cart audits to ensure compliance. 4. Weekly medication cart audits will be conducted for 4 weeks to ensure 100% compliance and then will be audited monthly for 3 months to ensure 100% compliance. Random cart audits will occur ongoing.	5/15/24 will be compliance date.

NAME OF FACILITY: AL Peach Tree Health Group, LLC

DATE SURVEY COMPLETED: April 2, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	
	9/21/23 – R12 was admitted to the facility and the service agreement was completed. For mobility the service agreement states that R12 requires a moderate assist with one person while mobilizing in the facility. 11/23/23 2:00 PM – A facility incident report revealed that R12 was found between the first and second floor landing in the stairwell. R12 is legally blind and accidently went into the stairwell. R12 turned around to go back out of the door and lost his balance falling down the stairs in the stairwell. 11/23/23 2:15 PM – An ambulance arrived to take R12 to the hospital for injuries noted to his face, laceration above eyebrow, and pain to the right side. 11/23/23 7:00 PM – A review of the nursing progress notes revealed that R12 sustained fractures to three ribs on the right side, dermabond applied to the right eyebrow for the laceration to close, and multiple x-rays that were negative. Neurological checks were completed and within normal limits. 3/27/24 2:30 PM – An interview with E15 (CNA) revealed that R12 is independent. R12 ambulates independently and uses a cane or walking stick. E15 confirmed that R12 rarely needs help and confirmed that his service agreement was not updated post fall. 3/28/24 10:30 AM – An interview with E1 (ED) revealed that the root cause for the fall was that staff were not watching the resident. E1 revealed that a new policy was implemented that floor staff cannot take a break or chart at the same time so one staff is available to watch residents on the floor.	1. R12 received injuries due to neglect of observation when blind resident mistakenly entered a stairwell and subsequently fell. No additional residents were harmed by this deficient practice. Immediately following this incident, to prevent any further incidents and ensure safety a process for caregivers was put in place that one person had to be monitoring the halls at all times and redirect any residents that are not in the correct area. Only one caregiver can be in the charting area at a time so as not to have the hallway obscure. 2. Two hour checks that are to be documented and signed off by the floor nurse were implemented to ensure every resident's whereabouts are known and they are seen by staff. 3. All staff re-educated on processes to ensure safety of residents that are blind or have vision issues that include the 2 hr rounding, ensuring someone is monitoring the halls at all times and documentation of rounds. 4. To ensure compliance all floors rounding sheets will be audited and monitored weekly for 3 mos and documentation reporting 100% compliance with the POC. Rounding to continue.	5/15/24 will compliance date.

Provider's Signature ______________ Title ______________ Date ______________



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: AL Peach Tree Health Group, LLC **DATE SURVEY COMPLETED:** April 2, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	
	4/2/24 2:05 PM – Findings were reviewed with E1 (ED) and E2 (DON) at the exit conference.		

Provider's Signature __________ Title __________ Date __________