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: Oakbridge Terrace at Country House **DATE SURVEY COMPLETED:** June 4, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	
	An unannounced Annual Survey was conducted at this facility from June 3, 2024 through June 4, 2024. The deficiencies contained in this report are based on observations, interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-six (26). The survey sample totaled five (5) residents.		
3225.5.0	**Assisted Living Facilities** Abbreviations/definitions used in this state report are as follows: AL – Assisted Living; DAL - Director of Assisted Living; NHA - Nursing Home Administrator; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a registered nurse; SA (Service Agreement) – allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services; UAI – an assessment and collection of information regarding an assisted living applicant/resident's physical condition, mental status and psychosocial need.	1. Marketing material was updated with an additional form explaining the pre-admission process and criteria for placement, assessment, care planning & implementation process used for assessment, establishing	8/9/24
3225.7.0	**Specialized Care for Memory Impairment**		
3225.7.1	**Any assisted living facility which offers to provide specialized care for residents with**		

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	memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations herein.	and updating the service agreement and its implementation, that staffing plan, orientation, and regular in-service education for specialized care, the physical environment and design features, including security systems appropriate to support the functioning of adults with memory impairment, the frequency and types of resident activities or the family involvement and family support programs.	
3225.7.2	**Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.**	2. Any individual seeking special care for memory impairment at Oakbridge Terrace of Country House could be impacted.	
3225.7.3	**The information disclosed shall explain the additional care that is provided in each of the following areas:**	3. The root cause was determined to be that the community had not compared existing marketing materials to the requirements as outlined in the Assisted Living Regulation. The marketing materials will be updated and the NHA/Designee will educate the Sales Manager, and Director of Assisted Living to utilize the new marketing materials when there is an individual seeking special care for memory impairment.	
3225.7.3.3	**Pre-Admission, Admission & Discharge: the process and criteria for placement, transfer or discharge from this specialized care;**		
3225.7.3.4	**Assessment, Care Planning & Implementation: the process used for assessment and establishing and updating the service agreement and its implementation,**		
3225.7.3.5	**Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care;**		
3225.7.3.6	**Physical Environment: the physical environment and design features, including security systems, appropriate to support the functioning of adults with memory impairment;**	4. The Director of Assisted Living/Designee will audit Marketing Materials to ensure that they include the newly updated Marketing Material for specialized Memory Care. This audit will be conducted once a week x 4 weeks until 100% compliance is achieved, then once every two weeks for one month until 100% compliance is achieved, then once a month for 3 months until 100% compliance is achieved. Outcomes	
3225.7.3.7	**Resident Activities: the frequency and types of resident activities;**		
3225.7.3.8	**Family Role in Care: the family involvement and family support programs:**		
	This requirement was not met as evidenced by:		

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	Based on interview, memory care marketing material review and review of other facility documentation, it was determined that the facility lacked evidence of providing the required policies and procedures to persons seeking specialized care for memory impairment. Facility materials excluded the processes for resident placement, assessment, and care planning, the staffing plan including staff training, the physical environment with security systems, the resident activities available and the family involvement and support programs. 6/4/24 - Per interview with E2 (DAL) at approximately 9:30 AM, E2 confirmed the information provided to persons seeking specialized care for memory impairment was lacking in those areas. 6/4/24 – Findings were reviewed with E1 (NHA) and E2 at the exit conference beginning at approximately 2:00 PM.	of these audits will be reported at the Quarterly QAPI Committee Meeting for review and recommendation as indicated. Medication Management 1. R3 was provided with a locked cabinet and key so that he may store medications in a locked cabinet. Resident was also instructed to be sure that his medications are locked in the cabinet. 2. An audit of existing residents residing in Oakbridge Terrace will be completed to identify any other resident that self-administers medication and will ensure that any residents identified have a locked container to secure their medications. 3. The root cause was determined to be that nursing staff were unaware that R3 did not lock his apartment door when vacating the apartment as this was resident's preference. The Director of Assisted Living / Designee will in-service the Licensed Nurses and C.N.A.s who are LLAM certified to ensure that residents who self-administer medications are	8/9/24
3225.8.0 3225.8.4	**Medication Management** **Residents who self-administer medication shall be provided with a lockable container or cabinet. This requirement does not apply to medications which are kept in the immediate control of the individual resident, such as in a pocket or in a purse. Facility policies must require that medications be secured in a locked container or in a locked room.** This requirement was not met as evidenced by: Based on record review, interview and tour of a resident's room, it was determined that		

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	for one (R3) out of two residents sampled for self-administration of medications, the facility failed to provide a locked container or to ensure the resident locked the apartment door on exit. 11/22/22 – R3 was admitted to the AL residence. Per visit and interview to R3's room on 6/4/24 at approximately 11:45 AM, the Surveyor noted R3's medication out on his desk in the bedroom. R3 stated he had just refilled his medi-planner and had not yet put the medications back in a black canvas bag and into his closet. There was no locked container noted in the room. R3 stated he has never locked his door when he leaves his apartment. 6/4/24 – Findings were reviewed with E1 (NHA) and E2 (DAL) at the exit conference beginning at approximately 2:00 PM.	storing medication in a locked cabinet or container. Additionally they will be in-serviced that any newly admitted resident who self-administers medications will have a locked cabinet/container to store medications. 4. The Director of Assisted Living / Designee will audit residents who self administers medications to ensure that medications are locked in a cabinet/container. This audit will be conducted once a week x 4 weeks until 100% compliance is achieved, then once a month for 3 months until 100% compliance is achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee Meeting for review and recommendation as indicated.	
3225.11.0 3225.11.2	**Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.** This requirement was not met as evidenced by:	**Resident Assessment** 1. Residents R1, R2, R3, R4 and R5 admission UAI's have already been completed and cannot be corrected. 2. Any new resident scheduled to admit to Oakbridge Terrace at Country House could be impacted. 3. The root cause was determined to be that Director of Assisted Living did not complete the UAIs timely. The NHA / Designee will educate the Director of Assisted Living that the UAI-based resident assessment is completed by a registered nurse (RN) no more than 30 days prior to admission. 4. The Director of Assisted Living / Designee will audit newly admitted residents to ensure that UAI-based	8/9/24

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	Based on record review, interview and review of other facility documentation, it was determined that for five (R1, R2, R3, R4 and R5) out of five residents sampled for resident assessments, the facility lacked evidence of timely completion of the required UAI assessments. Findings include: 1. 4/22/24 – R1 was admitted to the AL. The initial UAI showed a date of completion discrepancy. Page 3 date entry was 4/11/24, however the completion date by the RN was dated 4/22/24, the day of admission. 2. 6/1/23 – R2 was admitted to the AL. The initial UAI was completed on 6/2/23, the day after admission. The 30-day UAI was not in evidence. 3. 11/22/22 – R3 was admitted to the AL. The initial UAI was completed on 11/22/22, the day of admission. 4. 11/1/23 – R4 was admitted to the AL. The initial UAI showed a date of completion discrepancy. Page 3 date entry was 11/2/23, however the completion date by the RN was dated 11/1/23, the day of admission. 5. 7/27/23 – R5 was admitted to the AL. The initial UAI was completed on 7/27/23, the day of admission. 6/4/24 – Per interview with E2 (DAL) at approximately 1:55 PM, E2 confirmed the date discrepancies, the assessments done the day of admission and the missing 30-day assessment on R2. 6/4/24 – Findings were reviewed with E1 (NHA) and E2 at the exit conference beginning at approximately 2:00 PM.	resident assessment is completed no more than 30 days prior to admission. This audit will be conducted once a week x 4 weeks until 100% compliance is achieved, then once every two weeks until 100% compliance is achieved, then once a month for 3 months until 100% compliance is achieved. Outcomes of these audits will be reported to the Quarterly QAPI Committee Meeting for review and recommendation.	

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3225.12.0 3225.12.1 3225.12.1.3	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **2-102.12 Certified Food Protection Manager (A) At least one employee, the PERSON IN CHARGE at the time of inspection, shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM.** 6/4/24 –During the survey of the facility at 11:00 AM, the Surveyor observed that no employee in the kitchen at the time of food service had a Food protection manager certification. **3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5ºC	<u>Services</u> 1. The Director of Culinary and the Executive Chef will be certified in a Food Protection Manager certification. The missing temperature records were not located. The puddle by the dish washer was cleaned and the leak in the dish washer was repaired. 2. Any current resident has the potential to be impacted. 3. The root cause was determined to be a Food Protection Manager certification had expired and was in process of renewal. A supervisor had accidentally discarded food temperature logs because the file was not properly labeled. The dish washer leak had not been reported for repaired. The NHA/Designee will in-service the Culinary Director to ensure appropriate certification is maintained for persons in charge at the time of food production, temperature records are maintained per policy, and to ensure equipment is maintained per manufacturer's specifications. 5. The NHA/Designee will audit the following: Food Protection Certification is current and maintained for appropriate staff, temperature logs are maintained per protocols, and equipment in the kitchen is maintained in a state of repair. These audits will be conducted once a week x 4 weeks until 100% compliance is achieved, then once every two weeks until 100% compliance is achieved, then once a month for 3	8/9/24

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	(41ºF) or less. P (B) EGGS that have not been treated to destroy all viable Salmonellae shall be stored in refrigerated EQUIPMENT that maintains an ambient air temperature of 7°C (45°F) or less. 6/4/24 –During the survey of the facility at 11:30 AM, the Surveyor observed temperature records for January first through the twenty-eighth, 2024 for the breakfast, lunch, and dinner timeframes were missing. **4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.** 6/4/24 –During the survey of the facility at 12:45 PM, the Surveyor observed a large puddle of water in the dish room and E11 (Person in Charge of Kitchen) stated the dishwasher had a leak. 6/4/24 –Findings were reviewed with E1 (NHA), E9 (Nutrition Services Manager) and E11 at 1:30 PM.	months until 100% compliance is achieved. Outcomes of these audits will be reported to the Quarterly QAPI Committee Meeting for review and recommendation. Service Agreements 1. R1's Service agreement was completed and unable to take corrective action 2. Any potential newly admitted resident may be impacted. Existing residents Service agreements are completed. 3. The root cause was determined to be that the Director of Assisted Living missed completing the service agreement prior to or the day of the admission in error. The NHA/Designee will in-service the Director of Assisted Living to ensure that future residents admitted to	
3225.13.0 **3225.13.1**	**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 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**		8/9/24

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	and perform their obligations under the agreement. This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of five residents sampled, the facility failed to complete the service agreement prior to or no later than the day of admission. The facility failed to provide a copy of the signed agreement to the resident. Findings include: 4/22/24 – R1 was admitted to the AL. The SA was completed on 4/29/24, a week after admission. 6/4/24 – Per interview with E2 (DAL) at approximately 1:55 PM, E2 confirmed the completion date was after R1's admission. E2 stated that the residents do not receive a copy of the SA unless they request it. 6/4/24 – Findings were reviewed with E1 (NHA) and E2 at the exit conference beginning at approximately 2:00 PM.	Oakbridge Terrace at Country House will have a service agreement completed prior to or no later than the day of admission. 4. The Director of Assisted Living / Designee will audit Service Agreements for newly admitted residents to ensure that the service agreement was completed prior to or on the day of admission. This audit will be conducted once a week x 4 weeks until 100% compliance is achieved, then once every two weeks until 100% compliance is achieved, then once a month for 3 months until 100% compliance is achieved. Outcomes of these audits will be reported to the Quarterly QAPI Committee Meeting for review and recommendation.	

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