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: Paramount Senior Living at Newark **DATE SURVEY COMPLETED:** April 25, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from April 17, 2023 through April 25, 2023. The deficiencies contained in this report are based on interview, record review and review of other facility and partnering services documentation as indicated. The facility census on the first day of the survey was seventy-two (72). The survey sample totaled fifteen (15) residents. Abbreviations/definitions used in this state report are as follows: Acute - An illness that develops quickly, is intense or severe and lasts a relatively short period of time; Comminuted fracture - One in which the broken ends of the bone are shattered into many pieces; Dementia - The loss of cognitive functioning — thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities; Distal - Parts of the body further away from the center; ED - Executive Director; EMR – Electronic Medical Record; Femur – Thigh bone; Fibromyalgia - a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues; Hemiplegia - a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body; MC – Memory Care; MT – Medication Technician; POA – Power of Attorney;		

Provider's Signature Paul Taylor Title Executive Director Date 6.23.23

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	Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; RCA – Resident Care Assistant; RCC – Resident Care Coordinator; RCM – Resident Care Manager; RN – Registered Nurse; 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; TIA - transient ischemic attack is a temporary period of symptoms similar to those of a stroke; Vascular dementia – a condition caused by the lack of blood that carries oxygen and nutrients to a part of the brain; UAI (Uniform Assessment Instrument) - 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.		
3225 **3225.9.0** **3225.9.5**	**Assisted Living Facilities** **Infection Control** **Requirements for tuberculosis and immunizations:**	1) PPOC review of R2, R3, R4 and R9. TB being provided at this time and documented accordingly. 2) All current residents reviewed for current TB results and being provided with TB if not documented.	

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3225.9.5.1	**The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** This requirement was not met as evidenced by: Based on medical record review and review of other facility documentation, it was determined that for four (R2, R3, R4 and R9) out of fifteen residents surveyed, the facility lacked evidence of tuberculin test results on admission. Findings include: 1. 7/24/20 - R2 was admitted to the facility. The facility lacked evidence of tuberculin test results on admission. 2. 12/7/17 – R3 was admitted to the facility. The facility lacked evidence of tuberculin test results on admission. 3. 6/22/22– R4 was admitted to the facility. The facility lacked evidence of tuberculin test results on admission. 4. 5/12/21 – R9 was admitted to the facility. The facility lacked evidence of tuberculin test results on admission. 4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.	3) Root Cause: TB results were not listed on PPOC or skipped by PCP or admitting entity. For all new residents, a letter to the PCP or admitting facility will be provided indicating the requirement for a TB, or equivalent, be provided for admission. **Title: RCM/ARCM/Sales** 4) New Admission and Chart checklist to be reviewed and signed by ED indicating TB results present for new admissions. Process will continue for each new admission moving forward. Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	7.12.23
3225.9.5.2	**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**	1) Review E17 employee file. TB already on file although outside of hiring parameters. Record not able to be changed. 2) All current staff reviewed for current TB results and being provided with TB if not documented.	

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	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 review of facility documentation, it was determined that for one (E17) out of eleven employees surveyed, the facility lacked evidence of a two-step tuberculin test for E17 at hire. Findings include: 11/11/21 - E17 was hired and started employment in the facility. The first step tuberculin testing was performed on 1/27/22, over two months after hire. The second step was administered on 2/7/22. 4/25/23 - Findings were pending the return of additional information at the time of the exit conference with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.	3) With changes in the hiring process, Covid waivers and Management, the TB test process at time of hire had been interrupted. Moving forward, on day of hire, all new employees will be presented to the nursing department to begin the PPD process by the BOM or designee. **Title: BOM/RCM/ARCM** 4) As each New Employee completes orientation, the new employee file checklist will be reviewed and signed by ED indicating TB results present. Monitor deficient practice for each new employee to consistently meet 100% compliance. **Title: ED**	7.12.23
3225.9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, 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 influenza 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.**	1) Record review of R2 and R12, as well as DELVAX database. Influenza/Pneumococcal consent/declination to be reviewed, signed and offered if selected. If desired, Influenza/Pneumococcal will be ordered for administration. 2) All current Resident's Records to be reviewed, as well as DELVAX database. Influenza/Pneumococcal con-	

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	This requirement was not met as evidenced by: Based on medical record review, interview and review of facility provided documentation, it was determined that for two (R2 and R12) out of fifteen residents sampled for annual vaccination against influenza, the facility lacked evidence the vaccine was given or if the vaccine was offered to the resident and declined. Findings include: 1. 7/24/20 – R2 was admitted to the facility. The facility lacked evidence that the 2022 influenza vaccine was administered or declined by the resident. 2. 2/17/23 – R12 was admitted to the facility. The facility lacked evidence that the 2022 influenza vaccine was administered or declined by the resident. 4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.	sent/declination to be reviewed, signed and offered if selected. If desired, Influenza/Pneumococcal will be ordered for administration. 3) Through change in management and transition from paper to electronic admission records, the vaccine consent/declination form had been held in different locations. Moving forward, for all new residents, the Influenza/Pneumococcal consent/declination will be reviewed with resident and/or Responsible Party by the nursing intake team, not sales. If desired, Influenza/Pneumococcal will be ordered for administration. **Title: RCM/ARCM** 4) New Admission and Chart checklist to be reviewed and signed by ED indicating Influenza/Pneumococcal consent/declination complete and ordered if necessary. Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	7.15.23
3225.9.7	**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.**	1) Record review of R1,R2, R3, R4, R7 R8. R10, R11 and R12, as well as DELVAX database. Influenza/Pneumococcal consent/declination to be reviewed, signed and offered if	

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	This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for nine (R1, R2, R3, R4, R7, R8, R10, R11 and R12) out of fifteen residents sampled, the facility lacked evidence of the vaccination against pneumococcal pneumonia or a vaccination declination. Findings include: 1. 5/25/22 – R1 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 2. 7/24/20 – R2 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 3. 12/7/17 – R3 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 4. 6/22/22– R4 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 5. 3/25/19 – R7 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 6. 3/31/23 – R8 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 7. 5/3/22 – R10 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 8. 8/30/17 – R11 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such.	selected. If desired, Influenza/Pneumococcal will be ordered for administration. 2) All current Resident's Records to be reviewed, as well as DELVAX database. Influenza/Pneumococcal consent/declination to be reviewed, signed and offered if selected. If desired, Influenza/Pneumococcal will be ordered for administration. 3) Through change in management and transition from paper to electronic admission records, the vaccine consent/declination form had been held in different locations. Due to this, for all new residents, the Influenza/Pneumococcal consent/declination will be reviewed with resident and/or Responsible Party. If desired, Influenza/Pneumococcal will be ordered for administration. **Title: RCM/ARCM** **4)** New Admission and Chart checklist to be reviewed and signed by ED indicating Influenza/Pneumococcal consent/declination complete and ordered if necessary. Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	7.15.23

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	9. 2/17/23 – R12 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.		
3225.11.0	**Resident Assessment**		
3225.11.2	**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: Based on record review and review of other facility documentation, it was determined that for one (R2) out of fifteen residents sampled, the facility lacked evidence that the UAI was completed within 30 days prior to admission. Findings include: 7/24/20 – R2 was admitted to the facility. The initial UAI was completed on 7/24/20, the day of admission.	1) R2 initial UAI complete, signed, dated and on file. 2) All current initial resident UAI's on within resident chart signed and dated 3) Due to UAI completed on day of admission for 1 resident without a time stamp of completion, moving forward the Initial UAI is to be completed no greater than 30-days prior to admission. UAI's will be signed, dated and time notated for RN, resident and/or responsible party. **Title: RCM** 4) UAI reviewed for all new admissions by ED as indicated on Resident Chart Checklist and New Admission Checklist. **Title: ED 100%**	7.15.23

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	4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.		
3225.11.3	**Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for two (R1 and R9) out of fifteen residents sampled, the facility lacked evidence that a prospective resident had a medical evaluation completed by a Physician. Findings include: 1. 5/25/22 – R1 was admitted with a diagnosis of hemiplegia. The facility lacked evidence that R1 had a Physician's medical evaluation completed within 30 days prior to admission. 2. 5/12/21 – R9 was admitted with a diagnosis of cognitive impairment. The facility lacked evidence that R9 had a Physician's medical evaluation completed within 30 days prior to admission. 4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.	1) PPOC review of R1 and R9 to assure all information has been carried over from time of admission. 2) All current residents reviewed for appropriate PPOC on their chart. If not, a new PPOC will be obtained from PCP. 3) In review of resident files, original PPOC's had been removed from the resident chart during the thinning process. For all new residents, a letter to the PCP or admitting facility will be provided indicating the requirement for PPOC to be completed in its entirety, to include a signed medication list and orders. Additionally, chart thinning checklist to be updated with what not to remove from a resident chart. **Title: RCM/ARCM/Sales** **4)** New Admission and Chart checklist to be reviewed and signed by ED indicating the current PPOC is in place and on the chart for all new admissions. Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	7.12.23
3225.11.4	**The resident assessment shall be completed in conjunction with the resident.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for nine (R1, R2, R3, R4, R6, R7, R8, R9 and R15)		

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	out of fifteen residents sampled, the facility lacked evidence that the UAIs were completed in conjunction with the resident/POA/family. Findings include: 1. 5/25/22 – R1 was admitted to the facility. The facility lacked evidence that the UAIs dated 5/24/22 and 7/21/22 were completed in conjunction with the resident/POA/family. 2. 7/24/20 – R2 was admitted to the facility. The facility lacked evidence that the UAIs dated 7/24/20, 11/15/21, 2/10/22 and 2/10/23 were completed in conjunction with the resident/POA/family. 3. 12/7/17 – R3 was admitted to the facility. The facility lacked evidence that the UAIs dated 7/18/18, 7/17/19, 7/17/20, 7/17/21 and 7/18/22 were completed in conjunction with the resident/POA/family. 4. 6/22/22– R4 was admitted to the facility. The facility lacked evidence that the UAI dated 6/15/22 was completed in conjunction with the resident/POA/family. 5. 8/3/21 - R6 was admitted to the facility. The facility lacked evidence that the UAIs dated 7/29/21 and 8/1/22 were completed in conjunction with the resident/POA/family. 6. 11/7/16 – R7 was admitted to the facility. The facility lacked evidence that the UAI dated 4/27/22 was completed in conjunction with the resident/POA/family. 7. 3/31/23 – R8 was admitted to the facility. The facility lacked evidence that the UAI dated 3/28/23 was completed in conjunction with the resident/POA/family.	1) Residents R1, R2, R3, R4, R6, R7, R8, R9 and R15 UAI's reviewed for completion and review with resident/POA/Family and signed. 2) Review of all current resident UAI's for review with resident/POA/family. If no signature present, UAI will be reviewed with resident/POA/family. 3) Through management changes the UAI's completed by pervious administration were not being reviewed with the resident/POA/family. Moving forward, all UAI's, to include new, 30-day and annual, to be reviewed with resident/POA/family for signature or notation of review. **Title: RCM/ARCM** 4) New Admission and Chart checklist to be reviewed and signed by ED indicating UAI present with resident/family/POA participation for all new admissions. Annual UAI's will be scheduled in Outlook/PCC and reviewed with resident/POA/family with review during QA process. Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	7.15.23

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	8. 5/12/21 - R9 was admitted to the facility. The facility lacked evidence that the UAIs dated 5/11/21, 6/18/21 and 5/10/22 were completed in conjunction with the resident/POA/family. 9. 2/2/23 – R15 was admitted to the facility. The facility lacked evidence that the UAI dated 2/15/23 was completed in conjunction with the resident/POA/family. 4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.		
3225.11.5	**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 was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for four (R2, R6, R9 and R12) out of fifteen residents sampled, the facility lacked evidence that the 30-day after admission UAI was completed. Findings include: 1. 7/24/20 – R2 was admitted to the facility. The initial UAI was completed on 7/24/20. The facility lacked evidence that a 30 day UAI was completed after admission. 2. 8/3/21 - R6 was admitted to the facility. The initial UAI was completed 7/29/21. The facility lacked evidence that the 30 day UAI was completed.	**1)** Record review for R2, R6, R9 and R12 for up-to-date UAI's. If not present, a new UAI will be developed by the RCM. 2) Review of all current residents to ensure UAI's are current and in line with regulation. 3) Through management changes the 30-day updates had not been completed by pervious administration. All new residents will be scheduled for their 30-day post admission date update utilizing the outlook calendar and Point Click Care. **Title: RCM/ARCM** **4)** New Admission and Chart Checklist to be reviewed and signed by ED indicating 30-day post admit update is complete for all new admissions. 30 day update will be scheduled in Outlook and PCC, as well as reviewed during QA.	7.15.23

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	3. 5/12/21 - R9 was admitted to the facility. The initial UAI was completed on 5/11/21. The facility lacked evidence that the 30 day UAI was completed. 4. 2/17/23 – R12 was admitted to the facility. The initial UAI was completed on 1/19/23 and the 30-day post-admission UAI was completed on 2/14/23, 3 days prior to admission. The facility lacked evidence that the 30 day post admission UAI was completed. 4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.	Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	
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 and perform their obligations under the agreement.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for fourteen (R1, R2, R3, R4, R6, R7, R8, R9, R10, R11, R12, R13, R14 and R15) out of fifteen sampled residents, the facility failed to provide evidence that the service agreement was completed timely or in conjunction with the resident by obtaining a signature of the resident/POA. Findings include:	1) Residents R1, R2, R3, R4, R6, R7, R8, R9, R10, R11, R12, R13, R14 and R15's Service Agreements reviewed for completion and review with resident/POA/Family and signed. 2) Review of all current resident Service Plans for review with resident/POA/family. If no signature present, UAI will be reviewed with resident/PA/family. 3) Through management changes the 30-day updates had not been completed by pervious administration with signatures not collected. All new residents will be scheduled for their 30-day post admission date service agreement update utilizing the outlook calendar and Point Click Care. Resident/family/POA will be contacted to review/ provide input and sign.	7.15.23

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	1. 5/25/22 – R1 was admitted with a diagnosis of hemiplegia. The facility failed to provide evidence that a service agreement was completed prior to or on admission. 2. 7/24/20 – R2 was admitted with a diagnosis of dementia. The facility failed to provide evidence of R2's signed service agreement. 3. 12/7/17 - R3 was admitted with a diagnosis of TIA. The facility failed to provide evidence of R3's signed service agreement. 4. 6/22/22– R4 was admitted with a diagnosis of hemiplegia. The facility failed to provide evidence of R4's signed service agreement. 5. 8/3/21 - R6 was admitted with a diagnosis of high blood pressure. The facility failed to provide evidence of R6's signed service agreement. 6. 11/7/16 – R7 was admitted with a diagnosis of depression. The facility failed to provide evidence of R7's signed service agreement. 7. 3/31/23 – R8 was admitted with a diagnosis of dementia. The facility failed to provide evidence of R8's signed service agreement. 8. 5/12/21 - R9 was admitted with a diagnosis of cognitive impairment. The facility failed to provide evidence of R9's signed service agreement. 9. 5/3/22 – R10 was admitted with a diagnosis of fibromyalgia. The facility failed to provide evidence of R10's signed service agreement.	**Title: RCM/ARCM** 4) New admission and chart Checklist to be reviewed and signed by ED indicating Service plans present for all new admissions and reviewed with resident/POA/family and signed. 30-day will be scheduled in Outlook and PCC, as well as reviewed in monthly QA. Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	

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	10. 8/30/17 – R11 was admitted with a diagnosis of depression. The facility failed to provide evidence of R11's signed service agreement. 11. 2/17/23 – R12 was admitted with a diagnosis of hemiplegia. The facility failed to provide evidence of R12's signed service agreement. 12. 2/3/23 - R13 was admitted with a diagnosis of high blood pressure. The facility failed to provide evidence of R13's signed service agreement. 13. 12/3/23 - R14 was admitted with a diagnosis of osteoarthritis. The facility failed to provide evidence of R14's signed service agreement. 14. 2/2/23 – R15 was admitted with a diagnosis of vascular dementia. The facility failed to provide evidence of R15's signed service agreement. 4/25/23 – Per interview with E2 (RCM) at approximately 1:10 PM, E2 confirmed service agreement signatures were not obtained and that copies of the signed agreement are not given to the resident unless a copy is requested. 4/25/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 1:15 PM.		
3225.13.3	**The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** This requirement was not met as evidenced by:	**1)** Service agreements for residents R1-R15 updated with physician address. **2)** All current resident service plans reviewed for listing of PCP address **3)** The original DASP did not have an area for PCP address. All	7.12.23

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	Based on record review, interview and review of other facility documentation, it was determined that for fifteen (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14 and R15) out of fifteen sampled residents, the facility failed to provide evidence that the service agreement included the residents' personal Physician's name, address and phone number. Findings include: 1. 5/25/22 – R1 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 2. 7/24/20 – R2 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 3. 12/7/17 – R3 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 4. 6/22/22– R4 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 5. 4/21/22 – R5 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number.	new residents, and existing residents at time of new plan, will utilize a Service Agreement form including a section for the PCP address. **Title: RCM/ARCM: 100%** **4)** New Admission and chart Checklist to be reviewed and signed by ED indicating DASP has PCP address present for new admissions Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: ED**	

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	6. 8/3/21 - R6 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 7. 11/7/16 – R7 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 8. 3/31/23 – R8 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 9. 5/12/21 - R9 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 10. 5/3/22 – R10 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 11. 8/30/17 – R11 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 12. 2/17/23 – R12 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number.		

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	13. 2/3/23 - R13 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 14. 12/3/23 - R14 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 15. 2/2/23 – R15 was admitted to the facility. The facility failed to provide evidence that the service agreement included the resident's personal Physician's name, address and phone number. 4/25/23 - Per interview with E1 (ED) and E2 (RCM) at approximately 1:10 PM, E2 confirmed the service agreement forms being used do not contain the information providing the personal Physician's name, address and phone number. 4/25/23 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 1:15 PM.		
3225.19.0	**Records and Reports**	1) Resident R10 had no longer been a resident of Paramount as his last billed day was charged as 3.29.23 as he became a resident of another local AL on 3.30.23, which made this a resident to visitor with or without injury. R15 (resident) was in a compromised state and elbowed R10 (visitor). Authorities	
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.**		
3225.19.7.1.1	**Physical abuse.**		
3225.19.7.1.1.1	**Staff to resident with or without injury.**		
3225.19.7.1.1.2	**Resident to resident with or without injury.**		

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: Paramount Senior Living at Newark **DATE SURVEY COMPLETED:** April 25, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.19.7.1.1.3	**Other (e.g., visitor, relative) to resident with or without injury.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R10) out of fifteen sampled residents, the facility failed to provide evidence that a resident-to-resident physical altercation occurred. Findings include: Per interview with E11 (BOM) on 4/24/23 at approximately 9:30 AM, E11 stated she was the Manager on Duty on the day of the altercation. E11 stated she witnessed an incident that occurred on 3/30/23 at approximately 10:00 AM between a female resident (R15) and male resident (R10) while in the facility lobby. R15 appeared upset with R10 while he was waiting for a ride. E11 stated that R15 went over to R10, sat in his lap and leaned on him. R15 then proceeded to keep elbowing R10 while he was sitting in the chair. E11 stated she attempted to separate the residents with other staff. E11 stated 911 and R15's son were both called when R15 persisted in striking both R10 and E11. 4/25/23 - Per interview with E1 (ED), E1 confirmed the incident was not reported to the State per the requirement due to an oversight. 4/25/23 - Findings were reviewed with E1 and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.	contacted. R15 transported to ED and R10 (visitor) exited to his New AL. 2) R15 transported to local ED for evaluation and treatment thus removing contact with all other residents. 3) Due to the incident indicated in this situation, all incidents involving visitors/staff/residents will be treated as state reportable incidents based upon state guidelines and will be submitted by the Executive Director. **Title: ED 100%** 4) All incidents deemed to be state reportable based upon state guidelines will be submitted by the Executive Director. **Title: ED 100%**	6.23.23

Provider's Signature *Paul Taylor* Title Executive Director Date 6.23.23

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
Delaware Code Title 16 Chapter 11 **Subchapter II** **§ 1121** **Subchapter III** **§ 1131**	**Rights of Residents.** **Resident's rights.** **(13) Each resident shall receive care that meets professional standards of care.** **Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents.** **Definitions.** **(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 record review, investigative review, interview and review of other facility and partnering services documentation, it was determined that for one (R1) out of fifteen sampled residents, the facility failed to provide the attention to R1's physical needs and safety needed during wheelchair transport that resulted in physical harm to R1. The facility failed to provide evidence of R1's nursing staff assessment documentation post incident except for the entry on 4/2/23 by E7 (LPN). 5/24/22 – R1 was admitted with a diagnosis of hemiplegia and cognitive deficiency. R1 was not able to walk and had limited verbal inter-	1) In receiving report of the concern with resident R1, records and information reviewed. Employee placed on administrative leave and subsequently terminated. State Reportable Incident submitted. Additionally, family and local authoirities contacted in order to provide information and file a report. State Investigative office contacted to review for any further action to be taken at that time. 2) All residents utilizing wheelchairs: • Footrests present for all WC's • WC transport education provided to nursing staff • Clinical documentation training provided to nurses • Mandatory Reporting training to nurses • Leg rests bag for each chair containing leg rests and numbered to coincide with chair • Color code program indicating self-propel, propel w/some assist or dep. Mobility in WC w/leg rest at all times. • Nursing staff educated on leg rest bags and color code system **Title: RCM/ARCM/HR** 3. In this incident, the aide did not place the legrests on the wheelchair resulting in significant injury. For, each new admission to receive orders for Physical and Occupational therapy evaluation. Existing	

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	action. The wheelchair transport incident occurred on 3/30/23 during the 3:00 PM-11:00 PM shift. 4/2/23 – Per statement from E3 (CNA) to E2 (RCM) and E12 (RCC), E3 stated, "I don't think I was going fast. I do remember her yelling for me to stop, but I had to stop anyway because her leg fell off the footrest and you know it makes you stop. I put her foot back on and took her to her room." Later that evening E3 stated R1 was "fine." 4/2/23 – Per statement from E5 (MT), E5 reported to Nursing on 4/1/23 on the 11:00 PM-7:00 AM shift that R1 "seemed to be in pain on her left side" and that R1's "left leg was swollen." There was no documentation in R1's record that an assessment by a Nurse was completed. E5 again reported to the Nurse on 4/2/23 on the 7:00 AM-3:00 PM shift that R1 "needed to be assessed on her left side from her thigh to her foot." There was no documentation in R1's record that an assessment by a Nurse was completed. 4/2/23 – Per statement from E8 (receptionist), E8 stated, "the aide was pregnant. R1 was saying 'stop this thing' as her legs and feet were motioning up and down. The aide flew past my desk at a high rate of speed. I reported the incident to the Charge Nurse on duty." There was no documentation in R1's record that an incident occurred or that an assessment was completed by a Nurse. 4/2/23 – Per statement from E20 (RCA), E20 stated R1 was "fine laying down and talking to me around 7:30 AM. I got her dressed and successfully in her chair. She was complaining about her right knee hurting. The remainder of the day, R1 stated her knee was bothering her	residents will be discussed in weekly risk meeting. • If the resident requires a Wheelchair they will be evaluated by therapy for safe use • Verified that the wheelchair has the appropriate footrests available if • Footrest leg bag installed w/# and color code • Proper wheelchair use by resident will be provided on the service agreement • Each resident with a wheelchair will be discussed in weekly risk meeting with therapy • Wheelchair transport training provided to new staff and annually • Mandatory reporting training provided to all new staff and annually4) 4. Review and Sign: 100% • Nursing Admission Checklist for all new residents • Open Chart Checklist for all new residents • Attendance at weekly Risk Meeting with Therapy • Review of all new employee file checklist • Review of all staff annual training checklist Monitor deficient practice for each new admission to consistently meet 100% compliance. **Title: Executive Director**	7.15.23

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	and I asked E13 (RN) to check it out." There was no documentation in R1's record that an assessment by a Nurse was completed. E20 continued saying "on 4/2/23 I came in and her pain was a lot worse. I couldn't put her sock on without her being in pain. Her left knee is visibly swollen as well. I let E7 (LPN) know." E7 documented on 4/2/23 at 11:11 AM in R1's EMR by an "alert charting note" entry that identified R1 had "left knee swollen red and hot to touch, small bruises noted under left knee," and that Hospice was notified. 4/3/23 - Per statement from R16 (anonymous Resident) to E2 (DRC), R16 stated he "witnessed the CNA rushing off of the elevator and could hear R1 saying 'ouch, stop' as her foot was dragging under the wheelchair." R16 stated he did not see E3 stop to check R1. 4/4/23 – Per statement by E9 (RN, Charge Nurse), E9 stated the incident wasn't reported regarding the fast transport or E3's actions. "I was told that R1's foot fell off the footrest while being taken to her room, but I did check her and to see if she was okay" on 3/30/23. There was no documentation of this assessment in R1's record. 4/19/23 – Per interview with E7 (LPN) at approximately 9:30 AM, E7 stated she was called to R1's room on 4/2/23 to assess R1 after the Aide reported "Something going on-she isn't right." E7's documentation on 4/2/23 at 11:11 AM in R1's EMR by an "alert charting note" entry identified that R1 had "left knee swollen red and hot to touch, small bruises noted under left knee," and that "Hospice was notified." E7 stated H2 (Hospice Nurse) was notified and came to evaluate R1 at approximately 12:30 AM. H2 then notified H4 (Hospice Physician) who ordered stat x-rays. When results		

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	came back late in the day, x-rays showed a left distal fracture of the left femur. R1 was then transported to the hospital emergency room by ambulance. 4/20/23 – The Surveyor found that all other accounts of the incident and per interview with E1 (ED) at approximately 12:00 PM, the wheelchair footrests were not in place during transport, they were discovered in R1's room. 4/20/23 – Per interview with E13 (RN) at approximately 11:00 AM, E13 stated she and E20 (RCA) assisted R1 to transfer to the wheelchair on 3/31/23. R1 exhibited no pain, but was unable to bear much weight on legs. On assessment, E13 stated there was no leg swelling or bruising observed. E13 also stated that R1's son visited R1 on 3/31/23 and did not express any concerns to Nursing. There was no documentation in R1's record that an assessment by a Nurse was completed. 4/20/23 - Per interview with E13 (RN) at approximately 9:00 AM, E13 stated that R1 was able to stand with two person assist and pivot into a wheelchair complete with footrests for transport and never saw R1 being transported without the footrests in place. R1 was not able to put her feet on the wheelchair footrests, but R1 could take them off. 4/24/23 – Per R1's medical record review, the Surveyor was unable to locate Nursing notes for the period of 1/26/23-4/1/23. The Surveyor requested these nursing progress notes on R1 to verify assessments and findings, but received only the entries for medication or skin tear care orders. E2 (RCM) acknowledged there were no Nursing progress notes in the EMR for that period.		

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	4/24/23 - Per interviews and statements provided by facility staff (E1, E2, E3, E5, E7, E8, E9 and E13), R1 was not eating and aides reported the change to the Nurses on 4/1/23. It was stated that Nursing staff did assessments periodically on 3/31/23 and 4/1/23, however, the EMR contained no Nursing notes or assessment documentation from 1/26/23 through 4/1/23. 4/24/23 - Per interviews with E1 (ED), E2 (RSD), E7 (RN), E10 (Activities Manager) and E13 (RN), R1's previous transports were always with footrests on the wheelchair. 4/24/23 – Per telephone call from the Surveyor at approximately 9:00 AM, F1 (R1's daughter) stated that brother visited on 3/31/23 and found their mom was "totally out of it and slumped in a chair." F1 stated that "no family visited on 4/1/23 but received a call on 4/2/23 from the facility Nurse that there was a change in R1's condition." 4/24/23 - Per interview with H1 (Hospice RN) at approximately 11:40 AM, H1 stated H3 (Hospice CNA) provided care on 3/31/23 (day after incident) and found "nothing out of the ordinary." Review of Hospice assessments and visit notes indicated that R1 needed footrests on the wheelchair and that R1 frequently took her foot off of the rests where staff had to correct for transport. She was non-ambulatory and nonverbal except for a few words. 4/24/23 - Per R1's medical record, Hospice was notified by E7 (RN) on 4/2/23 at approximately 11:10 AM when E7's assessment revealed R1 with pain, swelling and redness of the left knee and hip with some bruising noted under R1's knee. H2 (Hospice RN) evaluated R1 on 4/2/23 at approximately 12:46 PM and notified H4		

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	(Hospice Physician) who ordered x-rays. X-rays were completed at 3:00 PM and results were obtained at approximately 9:00 PM which indicated a moderately acute fracture of the distal shaft of the left femur. R1 was transferred to the hospital emergency room. The Surveyor reviewed H2's (Hospice Nurse) assessment note from 4/2/23. Per H2's assessment, R1 had swelling, pain and decreased strength in both legs. H2 documented the Hospice Physician was notified. Hospital records indicated that R1 suffered from mildly displaced fractures of both femurs that appear comminuted. 4/25/23 - Findings were reviewed with E1 (ED) and E2 (RCM) at the exit conference, beginning at approximately 1:15 PM.		

Provider's Signature *Paul Taylor* Title Executive Director Date 6.23.23

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STATE SURVEY REPORT

NAME OF FACILITY: Paramount Senior Living at Newark **DATE SURVEY COMPLETED:** April 25, 2023

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Provider's Signature *Paul Taylor* Title Executive Director Date 6.23.23