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

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

STATE SURVEY REPORT

NAME OF FACILITY: Brookdale – Dover Assisted Living **DATE SURVEY COMPLETED: October 30, 2018**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced complaint survey was conducted at this facility beginning on October 25, 2018 and ending on October 30, 2018. The facility census on the entrance day of the survey was 67. The survey sample was composed of 11 residents. The survey process included observations, interviews, review of resident clinical records, and review of other facility documentation as indicated. Abbreviations used in this state report are as follows: ED - Executive Director; HWD – Health and Wellness Director; CG1 – Caregiver DDO – District Director of Operations; DDCS – District Director of Clinical Services; BOM – Business Office Manager; HKR – Housekeeper; HWC – Health and Wellness Coordinator; LLAMS – Limited Lay Administration of Medication Staff; LPN - Licensed Practical Nurse; RCA – Resident Care Associate; Alzheimer's disease – a brain disorder causing loss of memory, thinking and	The following is the Plan of Correction for Brookdale Dover regarding the Statement of Deficiencies dated October 30, 2018. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

Provider's Signature Donna Calley Title Executive Director Date 4/17/19

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	language; Amnesia – memory loss; Dementia – brain disorder with memory loss, poor judgement, personality changes and disorientation or loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; UAI – Uniform Assessment Instrument - an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility. **§ 1127 Resident transfer or discharge.** **16 Del.,C., Chapter 11** **(h)(1) If a resident is transferred out of a long-term care facility to an acute care facility or other specialized treatment facility all of the following apply:** **a. The long-term care facility must accept the resident back when the resident no longer needs acute or specialized care and there is space available in the facility.** **b. If no space is available, the resident must be accepted into the next available bed.** **This requirement is not met as evidenced by:**		

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	Based on record review, interview, and review of facility documentation as indicated, the facility failed to accept a resident back in the facility when the resident no longer needed acute or specialized care and without giving a 30 day notice for one (R1) out of 11 sampled residents: Findings include: The facility policy entitled Admission/Discharge policy last updated July 2016, indicated, "A resident being asked to relocate from the community will be given notice in accordance with the Residency Agreement". The facility admission agreement last updated 2/1/18 in section IV entitled "Term and Termination", indicated "Termination by the facility – we may terminate this agreement upon providing you thirty days written notice for any of the following events as determined by us: - For your welfare or the welfare of others in the community; - Your behavior impairs the well-being or safety of yourself or others creates unsafe conditions... 9/3/218 6:31 AM – A progress note documented "at about 5:20 AM, E8 (LPN) received call from the ER that R1 was about to be discharged to return to the facility. E2 (HWD) wanted to be called before R1's return. A call was placed to E2 and the answerer was no-	This deficiency has an appeal. The community did not refuse to re-admit Resident 1, instead the community accepted Resident 1 back to the community; but, due to aggressive behaviors on the part of the Resident 1, required the family to remain with Resident 1 for the protection of the other residents in the community. The family decided to return to the hospital instead of returning to the community. The family was aware of the aggressive behavior of putting a pillow over another resident face and putting a towel over another resident. The family was aware of the behavior impaired the well-being and safety of other residents. The family was aware the community and caseworker were working on alternate living accommodations and the family was not compliant with the psychiatric recommendations for the treatment of Resident 1.	

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	tified of the call from the ER relating to R1's return. R1 showed up at the front entrance of the facility, in an ambulance along with CG1. The E1 (ED) was notified and advised since it was administration instruction that R1 should not be allowed back into the facility...The family member of the R1 knocked on the exit door, to the facility and was let in. CG1 was told of the directive, and was asked to please wait until further instruction from the administration. A call was placed to E3 (RN) and regional nurse, who was notified of the situation. E8 was told to allow R1 in and let the family members know that they had to stay with R1. After the conservation between E3 and CG 1, CG1decided to take her mother back to the hospital. 9/4/18 An "Official Discharge Notice" from the facility was sent to CG1. During an interview on 11/1/18 at with E3, it was reported that the facility refused to readmit R1 to the facility unless CG1 could remain with R1. The facility failed to accept R1 back into the facility after the resident was transferred out to an acute care facility, and instead discharged R1 effective immediately upon return from the hospital. These findings were reviewed during exit conference on 10/30/18 at 3:35 PM with E1 (ED) and E2 (HWD).	Official discharge notice was delivered to the family after the family decided to return to the hospital.	

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3225.0	**Regulations for Assisted Living Facilities** **8.0 Medication Management** **8.1 An assisted living facility shall establish and adhere to written medication policies and procedures shall address:** **8.1.1 Obtaining and refilling medication;** **8.8.2 Each resident receives the medications that have been specifically prescribed in the manner that has been ordered.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that the facility failed to ensure that each resident received the medications that had been specifically prescribed in the manner that had been ordered for three, (R1, R5, and R8) out of 11 sampled residents. Findings include: 1. 4/4/18 R1 was given an order for Ativan (anti-anxiety) medication to be given once a day. 5/31/18 6:43 AM - A progress note documented "at about 5:10 AM E8 (LPN) was notified of R1 having a seizure. E8 rushed to R1's room and found R1 sitting on the toilet and an	3225.0 R1 was seen in the hospital, stabilized, and returned to the community. The physician and families of R5 and R8 were notified of missed medication, blood glucose monitoring. Scheduling of medication administration staff was reviewed for adequate staffing per Brookdale policy and state regulation. The Health and Wellness Director audited resident medications for adequate supply and administration per physician orders. The Health and Wellness Director audited resident MAR and TAR for missed medication and treatments. Nursing staff were re-educated on the process of ordering controlled medications,	

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	aide holding the back of her head to keep it up and prevent R1 from hitting her head. Small bleeding observed from R1's mouth and R1 was held in an upright position by E8 until seizure episode stopped. R1 walked with guidance back to her bed and the mattress was placed on the floor and R1's head elevated. 911 called and R1 was sent to ER for further evaluation. 5/31/18 – A hospital d/c summary documented R1's diagnosis as seizure. May 2018 – Review of R1's EMAR revealed that R1 was not given her prescribed dose of Ativan (anti-anxiety medication) daily on 5/28/18, 5/29/18, 5/30/18 and 5/31/18. 6/12/18 – A facility reported incident submitted to the State Agency documented R1 "did not receive medication (Ativan) for 3 days causing R1 to be sent to the hospital. R1 suffered seizures." During an interview on 6/14/18 at 10:54 AM, E9 (RN) former (HWD) reported that R1's refill for Ativan "was placed on the paper MD order and fax form, but the pharmacy did not notify the facility that they did not accept fax's for controlled substances. Nursing staff was educated on the process of getting medication refilled and reviewing charts for missed orders before allowing residents to miss medications." The facility failed to refill R1's prescrip-	and following physician orders for treatments and medication administration. The Executive Director or designee will audit medication carts monthly for adequate supply of resident medications. Responsible party: Executive Director. Completion Date: 11/30/18 and on-going.	

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	tion for Ativan, as a result R1 was not given her medication for 4 days, then required a visit to the ER. 2. Review of R5's EMAR for July 2018 revealed the following missed medication administrations: -Novolog (insulin) inject 10 units twice a day not administered on 7/14/18 and 7/22/18. - Monitor blood glucose at bedtime, not administered on 7/20/18, 7/24/18. - Insulin Pen needle inject t unit in the afternoon missed on 7/24/18 and 7/28/18. 3. Review of R8's EMAR for July 2018 revealed the following missed medication administration: - Lantus (insulin) inject 47 units before bedtime for DM missed on 7/9/18 and 7/26/18. - Monitor blood glucose three times a day missed on 7/14/18 12:00 noon. During an Interview on October 3018 at 10:17 AM with E6 (LLAMS) it was confirmed that she had worked 3 consecutive shifts in the past "a couple of times" due to staffing shortages. E6 reported the printed schedules are not always accurate because they are not always revised to reflect call outs. When asked if there were incidents in which residents did not receive medi-		

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	cations related to staffing shortages E1 stated "on at least one occasion our regular nurse was on vacation and they had someone filling in and that's why I was coming in at 4:00 AM. One day I couldn't come in and I had heard that the people on front hall didn't get there medications." E6 confirmed that she has worked as an LLAMS without a licensed nurse "because it was a staffing issue" but she did not administer medications outside her scope of practice and as a result, "there were 2 or 3 people that needed fingersticks and one of them should have gotten coverage, but they didn't. One was R5, R8 and I believe and R9. E6 could not recall exactly when this occurred but stated "it would have been lunch time, longer than a month it was during the summer maybe July." During an interview on 10/30/18 at12:22 PM with E1 (ED) she reported that in July when former HWD E9 was no longer employed ,E1 came in to assist when staffing was low and worked as an aide. E1 denied knowledge of any dates in which LLAMS worked independent of a licensed nurse. E6 reported there may have been one incident in which the overnight nurse did not administer insulin but that nurse was disciplined. E1 did not provide any documentation of that incident. During an interview on 11/1/18 at 2:44		

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	PM with E3 (RN) regional nurse, it was confirmed that on at least one occasion LLAMS worked without a licensed nurse present. E3 stated "there was one weekend day, I can't tell you when, ...I got a call in the middle of the day from the LLAMS that the day shift nurse did not show and as a result some insulins were missed. The facility failed to administer medications as ordered for R1, R5 and R8. Staff interview with E3 confirmed that R5 and R8's medications were not administered related to licensed staff not being available. These findings were reviewed during exit conference on 10/30/18 at 3:35 PM with E1 (ED) and E2 (HWD). **19.0 Records and Reports** **19.7 Reportable incidents include:** **19.7.1.1.2 Resident to resident with or without injury.** **19.7.5.2 Any circumstance in which a cognitively impaired resident, whose whereabouts are unknown to staff exits the facility.** **This requirement is not met as evidenced by:** Based on record review, interview, and review of other facility documentation as indicated, it was determined that the facility failed to record and report, reportable incidents for 4 (R10, R1, R6	The staff were re-educated on reportable events and how to report event per Brookdale Policy and state regulations.	

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	and R11) out of 11 sampled residents. R10 was involved in an incident in which an impaired resident's location became unknown to staff. R1, R6 and R11 were involved in unreported resident-to-resident incidents of abuse on 8/9/18 and 9/2/18.. Findings include: The facility policy entitled Abuse, Neglect and Exploitation last updated July 2017 indicated that: -Upon receipt of an allegation of abuse, neglect or exploitation, the ED, or their designee, should conduct a confidential internal investigation of the incident. - The ED should notify the Division of Healthcare Quality within 8 hours of the occurrence. 1. The facility policy entitled "Missing Resident Policy" last updated July 2015 indicated "within 24 hours of the missing resident/elopement, the ED or designee will notify the appropriate State Agency. 12/21/17 – A UAI assessment completed for R10 documented had dementia/Alzheimer's and short term memory problems. 12/29/17 -R10 was admitted to the facility with multiple diagnoses including, dementia, amnesia (memory loss), restlessness and agitation. 9/12/18 - A UAI assessment completed for R10 documented had demen-	The Executive Director audited reported events for record and report per Brookdale policy and state regulation. The Executive Director or designee will audit community events monthly for recording and reporting compliance per Brookdale policy and state regulation. Responsible person: Executive Director. Completion date: 11/30/18 and on-going.	

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	tia/Alzheimer's, anxiety disorders and amnesia. 9/12/18 – The personal service plan for R10 documented that R10 was not always oriented to time and place. 9/17/18 – A facility incident report documented that at 7:45 AM "the writer (E2) was informed that R10 was found walking unassisted down the road from the facility...R10 appeared anxious and agitated as evidenced by slamming his walker into the ground and stating "I need to help my wife", R10 was placed on the locked unit." The incident was documented as an "elopement". UAI 9/12/18 During an interview on 10/30/18 at 2:38 PM with E2 (HWD) it was reported that R10's elopement was not reported to the state agency under the direction by E3 (RN) and the facility's regional corporate nurse. During an interview on 10/30/18 at 2:45 PM with E7, housekeeper it was confirmed that on September 17, 2018 "around 7:45 AM" E7saw R10 walking outside of the facility, several feet away by a nearby development and E7 drove to the facility and alerted the staff. During an interview 11/1/18 2:44 PM E3 confirmed that she directed E2 not to report R10's elopement to the state		

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	agency. 2. 7/9/18 A facility incident report documented that R1 engaged in resident-to-resident alleged aggressive behavior towards R6 when R1 was found "with a pillow over R6's face." This incident was reported to the S.A. the same day as resident-to-resident abuse. 8/9/18 10:57 PM a progress note documented "staff saw R1 in the hall and went down to check on her, when she went into R1's bedroom and saw a pillow on her roommates, R11's face. The pillow was taken off R11's face. R11 was asleep. The nurse was mad aware. The nurse assessed the roommate. No acute distress was noted. No injuries was noted....Nurse removed R1 out of the room and put her in the common area, were staff could watch her overnight, and her R11 could be safe. Nurse continue to monitor." 8/9/18 A physician notification form to E10 (MD) documented "Resident put a pillow over another residents face, please be aware and advise". The facility failed to provide an incident report related to investigation of this incident. 9/2/18 A physician notification form sent to E10 (MD) documented "R1 was seen placing a towel over another residents face." 9/2/18 A facility incident report documented R1 engaged in alleged aggres-		

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	sive resident-to-resident behavior. A statement documented "R1 was observed holding a towel over R11's face. Both residents were assessed by the nurse." The facility failed to provide evidence this incident was reported to the S.A. During an interview on 10/30/18, 12:23 PM with E1 (ED) it was confirmed that the resident-to-resident incidents involving allegations of abuse between R1 and R11 on 8/9/18 and 9/2/18 were not reported to the S.A. by the facility. E1 confirmed that the August 9, 2018 incident was not investigated because R1 was not actually observed engaging in the act. E1 stated following the incident R11 was removed from sharing a room with R1 and R1 remained in a private room. The facility failed to report incidents involving resident-to-resident abuse on 8/9/18 and 9/2/18. These findings were reviewed during the exit conference on 10/30/18 at 3:35 PM with E1 (ED) and E2 (HWD).		