DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Peach Tree Health Group **DATE SURVEY COMPLETED:** October 7, 2021

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from October 6, 2021 through October 7, 2021. The facility was found to be out of compliance with the Title 16 Health and Safety Delaware Administrative Code, 3225 Assisted Living Facilities infection control regulations and has not implemented the State and Center for Disease Control and Prevention (CDC) recommended practices for COVID-19. The sample size was ten (10) residents. The facility census on the first day of the survey was 34. Abbreviations/Definitions used in this state report are as follows: ED – Executive Director; DON – Director of Nursing; LPN – Licensed Practical Nurse; SG – Security Guard.	**Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the Statements of Deficiencies. This Plan of Corrections is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.**	
3225	**Regulations for Assisted Living Facilities**		
3225.2.0	**Authority and Applicability**		
3225.8.0	**Medication Management**	Plan of Correction **3225.8.0 Medication Management** 1. No residents were harmed by the deficient practice. 2. Medication Management and Administration policy updated to include the 8 rights of Medication Administration and reflect Lippincott's Nursing Drug guide.	
3225.8.8.2	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered.** This requirement was not met as evidenced by: Based on interview, review of clinical records, review of the facility's policy and procedure, and		

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	review of the facility medication error reports, it was determined that the facility failed to safely administer medications for two (R1 and R9) out of 17 sampled residents based on the standard of practice for medication administration which resulted in a medication error. Findings include: A facility policy entitled Medication Management and Administration, last revised 9/5/19, included: "Those residents who upon admission are incapable of self-administration shall have their medications administered according to the Nurse Practice Act." An additional facility policy entitled Medication Error, included: "The 7 rights of medication administration are to be followed by all persons providing, assisting, or administering medications to residents. Medication errors include: Incorrect medication (administration of the wrong medication)." 1. Review of R9's clinical record and the State Agency's documentation revealed the following: 7/12/21 – A facility medication error report included: E4 (LPN) administered a wrong medication to R9. The description of the error documented: "This nurse was administering medications and picked up the (medication card) and made the mis take of not looking at the name...I handed the card to another nurse to punch out for me, then I administered the med (medication). (It) was (the) wrong medication." E4 did not follow the required medication rights, did not note the name of the resident on the medication card and allowed another	3. Medication Error policy updated to include the 8 rights of Medication Administration and reflect Lippincott's Nursing Drug guide. 4. Education and individual copies provided to nursing staff regarding the updated policies and procedures for Medication Management and Administration along with the Medication Errors policy, to reflect changes. 5. Medication Management and Administration policy and Medication Error policy will be reviewed with Q&A committee for 9 months or until substantial compliance is met. Policy and Procedure Manual will be reviewed annually to ensure compliance with regulations.	

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	nurse to prepare the medication, which resulted in a medication error. 10/7/21 at approximately 1:30 PM – During an interview, E2 (DON) confirmed that the medication error was substantiated, and the standard of practice was not to administer any medication that another nurse prepared. 2. Review of R1's clinical record and the State Agency's documentation revealed the following: 9/9/21 – The Medication Administration Record (MAR) documented that R1 was administered his four (4) medications scheduled for 8 PM by E2 (DON). 9/13/21 – The State Agency's Incident Reporting System documented that on 9/9/21 at approximately 12 AM, R1 stated that he did not get his medications. 10/7/21 10:30 AM – An interview with E2 (DON) revealed that on 9/9/21, a nurse scheduled for the 7 PM to 7 AM shift called out, thus, E2 dispensed the medication into a cup and provided it to E3 (LPN) for E3 to administer to R1. E2 confirmed that she did not observe R1 taking the medication, despite the fact that E2 signed off that she administered the medication on the MAR. 10/7/2021 4:10 PM – Findings were reviewed during the Exit Conference with E1 (ED) and E2 (DON).	**Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the Statements of Deficiencies. This Plan of Corrections is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.**	
3225.9.0	**Infection Control**	Plan of Correction **3225.9.0 Infection Control** **1.2 All rules of the Delaware Division of Public Health are followed so there is minimal danger of transmission to staff and residents.**	

Provider's Signature Tyler Whitt NHA Title Executive Director Date 11/1/21

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3225.9.1.2	**All rules of the Delaware Division of Public Health are followed so there is minimal danger of transmission to staff and residents.** This requirement was not met as evidenced by: Based on interview, review of the facility policy and procedure, and review of the State of Delaware's Division of Public Health Testing Guidance for Long Term Care Facilities, it was determined that the facility failed to thoroughly screen all visitors in accordance with the State of Delaware's Long Term Care Orders and Guidelines. Findings include: Review of the facility's policy and procedure titled COVID-19 Screening, with an effective date of 3/24/20, stated, the following questions would be asked upon their arrival (Staff and Visitors) "...1. Do you have any respiratory symptom? 2. Have you traveled outside of the state? 3. Have you had contact with any other healthcare facility? 4. Have you knowingly been exposed to COVID-19? 5. Are you suffering from altered taste or smell? 6. Are you experiencing any other COVID-19 symptoms as defined by CDC?" The CDC published on their website, dated 2/22/21, "Symptoms of Coronavirus" that stated, "...People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea ...". Review of the State of Delaware's LTC (Long Term Care) Order and Guidelines, dated 7/2/21, stated, "...Core Principles of COVID-19 Infection	1. No residents were harmed by the deficient practice. 2. COVID-19 screening tool has been updated to include all known "Symptoms of Coronavirus" to reflect CDC's update on 2/22/21. 3. COVID-19 screening tool also updated to include screening question for visitors/staff about close contact with positive COVID-19 recipient (e.g., within 6 feet for more than 15 minutes with confirmed COVID-19 infection). 4. Security staff (or screening party) provided education on new updated screening tool to reflect changes. 5. All logs will be reviewed on a weekly basis for 3 months or until substantial compliance will be met with the Q&A committee.	

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	Prevention...Regardless of vaccination status, active screening of all visitors... who enter the facility for signs and symptoms of COVID-19 (e.g. temperature checks, questions about and observations of signs or symptoms, close contact with COVID positive individual, previous COVID-19 testing), and denial of entry of those with signs, symptoms, or those who had close contact with someone with COVID-19 infection in the prior 14 days... Check-in must include signing a visitor's log (name, address, phone number, date, time, name of the resident, resident room number and resident unit)...Health care workers who are not employees of the facility but provide direct care to the resident...must be permitted to come into the facility as long as they are not subject to the work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened...". 1. Visitor Screening: a. 10/6/21 8:30 AM – Two Surveyors, S1 and S2 arrived at the facility and were screened by E5 (SG) for COVID-19 by being asked the following questions from the facility's paper log, "...Respiratory Symptom?...Traveled internationally/out of state...Contact with any other Healthcare Facility...Any known exposure...Altered Sense of Taste or Smell...". S1 and S2 were not asked about symptoms of chills, headache, fatigue, muscle or body aches, sore throat, nausea, vomiting, or diarrhea. In addition, the Surveyors were not asked if they had been in close contact (e.g. within 6 feet for more than 15 minutes) with a person with a confirmed COVID-		

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	19 infection before being allowed access to the facility. b. 10/6/21 8:43 AM – The third Surveyor (S3) arrived at the facility and was screened by E5 (SG) for COVID-19 by having their temperature taken. No other required screenings were performed prior to S3 being allowed access to the facility. 10/6/21 3:00 PM – An interview with E1 (ED) confirmed that the facility's screening for visitors did not include all the signs and symptoms of COVID-19 and possible exposure to COVID-19. 2. Staff Screening: 10/6/21 6 AM through 8:52 AM – Review of the "Temperature Log", utilized by the facility for COVID-19 screening for staff and visitors revealed that, 23 facility staff were screened. The screening included the following questions, "...Respiratory Symptom?...Traveled internationally/out of state...Contact with any other Healthcare Facility...Any known exposure...Altered Sense of Taste or Smell...". There was lack of evidence that the 23 staff were asked about symptoms of chills, headache, fatigue, muscle or body aches, sore throat, nausea, vomiting, or diarrhea. In addition, staff were not asked whether they had been in close contact (e.g. within 6 feet for more than 15 minutes) with a person with a confirmed COVID-19 infection before being allowed access to the facility.		

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	10/6/21 3:00 PM – An interview with E1 (ED) confirmed that the facility's screening for visitors and staff did not include all of the signs and symptoms of COVID-19 and possible exposure to COVID-19. 10/6/21 4:10 PM - Findings were reviewed during the Exit Conference with E1 (ED) and E2 (DON).	**Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the Statements of Deficiencies. This Plan of Corrections is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.**	
3225.9.5.2 **3225.9.5.2.4**	**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 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.** **A report of all test results shall be kept on file at the facility of employment.** This requirement was not met as evidenced by: Based on interview and review of facility documents it was determined that for one (E3) LPN out of eight employees reviewed for TB screening, the facility failed to screen an employee upon hire. Findings include: 4/27/21 - Date of hire for (E3) LPN.	Plan of Correction **3225.9.5 Tuberculin Testing** **5.2.4 A report of all test results shall be kept on file at the facility of employment.** 1. No residents were harmed by this deficient practice. 2. All current employees were audited to ensure that PPD/QuantiFERON are present and clear. New hire preboarding checklist was created to ensure that PPD/QuantiFERON are completed prior to orientation. 3. HR staff was educated regarding PPD/QuantiFERON requirements. 4. PPD/QuantiFERON will be audited on a biweekly basis for 3 months or until substantial compliance is met and reviewed in the Q&A committee.	

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	10/7/21 - Review of facility new Employee PPD documents lacked evidence of TB screening upon hire for E3. 10/7/21 1:20 PM – An interview with E1 (ED) confirmed that E3 had not received a TB test either prior or on the date of hire. 10/7/21 4:10 PM – Findings were reviewed during the Exit Conference with E1 (ED) and E2 (DON).	**Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the Statements of Deficiencies. This Plan of Corrections is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.**	
3225.15.0	**Quality Assurance** **The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction.** This requirement was not met as evidenced by: Based on interview, record review, review of the facility's policy and procedure, and review of the facility medication error reports, it was determined that the facility failed to have a QA program that identified quality issues, specifically, a nurse with reoccurring medication errors. Findings include: A facility policy entitled Quality Assurance, last revised 9/7/19, included: - Policy Overview: The facility will perform quality assurance to maintain accepted standards of care as designated by DE REG, Title 16, Chapter 3225, 15.0. - Policy Purpose: To identify opportunities to improve our services; study any	Plan of Correction **3225.15.0 Quality Assurance** 1. Q&A program will review any med error/omission incidents from the past 90 days to ensure no further services are compromised. 2. Nursing staff will be educated accordingly based off these findings. 3. Med errors/omissions from the MAR's will be reviewed on a bi-weekly basis for the next 3 months or until substantial compliance is met and reviewed in the Q&A committee.	

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	problems or root causes to the services we provide; and implement plans of correction or change and continue to monitor our progress. 4/27/21 – E3 was hired by the facility as an (LPN). The following facility medication error reports document E3's trending medication error administration performance: 1. 5/14/21 – E3 failed to administer R6's herbal sleep medication at bedtime as prescribed by the physician. 2. 7/24/21 - E3 failed to administer R6's vitamin supplement and two seizure medications as prescribed by the physician. 3. 7/24/21 – E3 failed to administer R3's antipsychotic medications at 8:00 AM and 5:00 PM. 4. 7/24/21 – E3 failed to administer R5's seven medications including: a blood pressure medication, a dementia medication, a blood sugar medication, two blood thinner medications, a fluid reducing medication, and a nasal spray as prescribed by the physician. 5. 8/21/21 – E3 failed to administer R2 and R3's pain medications as prescribed by the physician. 6. 9/8/21 - E3 failed to administer R10's blood pressure medication.		

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	7. 9/16/21 - E3 failed to administer R4's allergy medication as prescribed by the physician. 8. 9/16/21 - E3 failed to administer eleven of R2's medications including: a blood thinner medication, a muscle relaxer, vitamin supplement, a seizure medication, a vitamin that reduces the risk of contracting bladder infections, a multivitamin, a blood pressure medication, an acid reducing medication for the stomach, a pain medication, and a steroid medication as prescribed by the physician. Despite all of the serious medication omissions from E3's date of hire on 4/27/21, the facility lacked evidence that a quality issue was identified and addressed related to E3's repetitive medication errors, until the 9/16/21 medication error that resulted in termination. 10/7/21 at approximately 1:45 PM - During an interview, E2 (DON) confirmed that all of the medication errors by E3 (LPN) were substantiated. The facility failed to monitor E3 with poor performance in the area of medication administration. 10/7/2021 4:10 PM – Findings were reviewed during the Exit Conference with E1 (ED) and E2 (DON).		

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