NAME OF FACILITY: Ingleside Assisted Living

DATE SURVEY COMPLETED: March 1, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
	REVISED REPORT **Deficiency 3225.11.3 Requirements for Resident Assessment. Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician. 3225.11.3 was removed March 14, 2023 as facility provided evidence of compliance.** An unannounced Annual and Complaint Survey was conducted at this facility from February 28, 2023 through March 1, 2023. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was forty-six (46). The survey sample totaled six (6) residents. Abbreviations/definitions used in this report are as follows: DelVAX - Delaware's State immunization registry serving as a database that contains the immunization records of Delaware residents; 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; DON - Director of Nursing; ED - Executive Director; 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	The following is the Plan of Correction for Ingleside Assisted Living regarding the statement of Deficiencies dates March 1, 2023	

Provider's Signature Denise Williams Title Exec. Director Date 3/18/23

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long-Term Care Residents Protection

DHSS - DHCQ
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Newark, Delaware 19702
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STATE SURVEY REPORT

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	resident on both an initial and ongoing basis in accordance with these regulations.		
3225.0	**Assisted Living**		
3225.9.0	**Infection Control**		
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.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for two (R2 and R5) out of six sampled residents, the facility failed to provide evidence that a pneumococcal pneumonia vaccine was administered or that it was offered and declined. Findings include: 1. 2/11/23 – R2 was admitted to the facility. The facility failed to provide evidence that a pneumococcal pneumonia vaccine was administered or that it was offered and declined.	3225.9.7 Residents R2 and R5 medical records have been reviewed by the Director of Nursing. No negative outcomes were identified. The Admissions/Director of Nursing to review the UAI assessment or other documentation for evidence of pneumococcal pneumonia vaccine upon admission for residents older than 65 years of age and 5 years have elapsed. An admission checklist has been revised to add the pneumococcal pneumonia vaccine will be completed by the Executive Director/designee prior to admission audit for compliance of required documents per state guidelines and CDC recommendation as far as immunization is concerned. The Administrative Assistant/designee will audit resident admission files, weekly x 4 weeks, then 2 times per month x 2 months. Audit will be ongoing until 100% compliance of all residents is met, then periodically at the facility discretion.	Completion Date: May 31, 2023

Provider's Signature Venise Williams Title Exec. Director Date 3/18/23

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
	2. 9/28/21 – R5 was admitted to the facility. The facility failed to provide evidence that a pneumococcal pneumonia vaccine was administered or that it was offered and declined. 2/28/23 at 10:40 AM – Per interview with E2 (DON), E2 confirmed the information was not captured in the UAI assessment or other documentation and confirmed he does not have access to the DelVAX site to check immunizations. 3/1/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 2:00 PM.		
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: 3/1/23 at 11:45 AM- The facility's Quality Assurance (QA) policy was reviewed. The facility failed to provide evidence of QA meetings, attendees or minutes. Findings include: 3/1/23 at 1:55 PM – Per interview with E1 (ED) and E2 (DON), it was confirmed that the facility's QA Program was yet to be established. E2 stated that daily meetings are held with staff to review any outstanding issues or resident concerns.	3225.15.0 The Quality Assurance policy has been reviewed by the Executive Director/designee. No negative outcomes were identified. The Quality Assurance program will be established. The Quality Assurance meeting will be held quarterly. The Quality Assurance meeting will be conducted by the Executive Director/designee. An audit will be ongoing quarterly until 100% compliance is met, then at the facility discretion.	Completion Date: May 31, 2023

Provider's Signature Denise Williams Title Exec. Director Date 3/10/23

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	3/1/23 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 2:00 PM.		
3225.19.0	**Records and Reports**		
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	**Reportable incidents include:**		
3225.19.7.7	**Significant injuries.**		
3225.19.7.7.2	**Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic re-assessment of the resident's clinical status by facility professional staff for up to 48 hours.** 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 (R3) out of six sampled residents, the facility failed to report a fall leading to an emergency room (ER) evaluation. Findings include: 3/21/22 – R3 was admitted to the facility with a diagnosis of dementia. Per the medical record, the resident fell on 4/1/22 at 8:20 PM and was sent to the ER for evaluation. Emergency Room documentation revealed that R3 sustained a compression fracture from the fall. 3/1/23 at 1:55 PM – Per interview with E1 (ED) and E2 (DON), it was confirmed that	3225.19.7.7.2 Resident R3 medical records have been reviewed by the Director of Nursing and physician. No negative outcomes were identified. Director of Nursing/designee to re-educate all staff about reportable and non-reportable events and emphasize falls that result to injury and transfer to acute care setting for treatment or require periodic reassessment by a professional staff up to 48 hours will be reported to the state promptly within 8 hours of occurrence. A list of Incident Reports will be bought to daily stand-up meetings to be reviewed by Director of Nursing/designee as per State guideline and Ingleside policy. Director of Nursing/designee will audit Incident reports weekly x 4 weeks, then 2 times per months x 2 months. Audit will be ongoing until 100% compliance is met, then at the facility discretion.	Completion Date: May 31, 2023

Provider's Signature: Nanisa Williams Title: Exec. Director Date: 3/18/23

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	this fall resulted in an ER evaluation with an Injury and it was not reported to the State. 3/1/23 – Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 2:00 PM.		

Provider's Signature [signature] Title Exec. Director Date 3/18/23