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

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STATE SURVEY REPORT

NAME OF FACILITY: Cadbury of Lewes Assisted Living **DATE SURVEY COMPLETED: August 2, 2017**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning July 31, 2017 and ending August 2, 2017. The facility census on the entrance day of the survey was 31 residents. The survey sample was composed of six residents (four active and two closed records). The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations/definitions used in this state report are as follows:** ED – Executive Director; DON – Director of Nursing; RN – Registered Nurse; CNA – Certified Nurse's Aide; AL – Assisted Living; Anxiety – feeling worried, nervous, restless; Antianxiety – drug used to treat anxiety; AM – morning; LOC (Level of consciousness) – how responsive person is to environment which can decrease with a head injury; PM – evening; Post – after; PRN – as needed; Service Agreement – document describing services provided to the resident (when and how provided and by whom); TB - Tuberculosis; TST – Tuberculosis Skin Testing; UAI (Uniform Assessment Instrument) – assessment form to collect information about the physical condition, medical status and psychosocial needs of an	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.

Provider's Signature [signature] Title Executive Director Date 12/13/2017

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	status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.		
3225.0	**Regulations for Assisted Living Facilities**		
3225.8.0	**Medication Management**	A. Resident R3 has been started on routine Ativan.	08/02/2017
3225.8.1	**As assisted living facility shall establish and adhere to written medication policies and procedures which shall address:**	B. Because all residents who receive PRN antianxiety medications who reside in a specialized medical unit are at risk to be potentially affected by the cited deficiency on 8/2/17, system changes have been implemented as detailed in element C. No other residents were affected.	
3225.8.1.4	**Administration of medication, self-administration of medication, assistance with self-administration of medication, and medication management by an adult family member/support person.**		
3225.8.8.3	**The desired effect of each medication is achieved, and if not, that the appropriate authorized prescriber is so informed.** Based on record review and interview it was determined that for one (R3) out of 4 active sampled residents, the facility failed to provide an adequate indication for repeated use of a PRN antianxiety medication and failed to inform the physician when the medication was not effective. Findings include: May, 2007 - Facility policy entitled Medication Administration included that for all PRN medication, chart the reason for the administration of the medication and to chart resident response to the medication.	C. All licensed staff will be educated by Staff Developer on descriptive documentation to include behavior as evidenced by: (state what resident is doing). Education will also include new process of monitoring PRN anti-anxiety medications. Psychotropic medication review report will be pulled on a daily schedule by the 11-7 nurse to identify residents who receive PRN anti-anxiety medications. The 7-3 nurse will notify MD if multiple doses have been used to inquire whether a routine, scheduled dose is indicated. All nurses will utilize physical monitors put into place to document need of medication and appropriateness. Physical monitors will be added to all anti-anxiety medications at time of transcription	09/27/2017

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	Review of R3's clinical record revealed: 3/7/17 – Physicians' orders included Ativan (an antianxiety medication) to be given up to three times a day PRN for restlessness and agitation. The 'notes' section documented the medication was for agitation, anxiety, insomnia. June – July 2017 MARs / Nursing Notes – R3 received 50 doses of PRN Ativan: - 15 doses lacked an assessment describing resident behavior warranting the need for the PRN medication: June 4, 6 (AM dose), 14, 19, 20, 24, 25 and 28; July 8 (2 doses), 9, 15, 16, 20 and 21. - 7 doses lacked specific resident behavior description but used general terms like agitation, anxious, anxiety, restlessness (June 11, 12, 13 (PM dose), 15, 17, 18 and 22. - 1 dose lacked assessment of behaviors after administration to determine if the medication was effective: July 8. - For 9 doses when behavior continued, there was no evidence in the record that the physician was informed (June 6 (2 doses), 10, 11, 13 and 27; July 3, 17 and 22. During an interview with E2 (DON) and E4 (AL Manager) on 8/1/17 at 3:00 PM to review R3's PRN administrations, E2 stated the expectation would be to document specific resident behaviors and follow-up if not effective. These findings were reviewed with E1 (ED), E2, E3 (ADON) and E4 on 8/2/17 at 3:25 PM during the exit conference	when order is received. Effectiveness will be charted /documented after 1 hour by computerized prompt in EMAR system. If the current dose is not effective the MD will be notified by the nurse. (Attachments 1A and 1B). D. Audits will be conducted by the AL Manager or designee on all residents receiving PRN anti-anxiety medications daily x1 month, and then weekly x4 until 100% compliance is reached. Results will be reviewed by the QA/QI committee. (Attachments 2A and 2B).	09/27/2017

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3225.9.0 **3225.9.5** **3225.9.5.1** **3225.9.5.2**	**Infection Control** **Requirements for tuberculosis and immunizations:** **The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** **Minimum requirements for pre-employment require all employees to have a baseline 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.** Based on record review, interview and review of other facility documentation it was determined that the facility failed to maintain an effective infection prevention and control program by not ensuring TB testing was completed for two (R1 and R4) out of 4 active sampled residents. The facility also failed to complete pre-employment TB testing for five (E6, E7, E8, E9 and E10) out of 10 recently-hired employees sampled. Findings include: 2005 – CDC's Guidelines for Preventing the Transmission of *Mycobacterium*	A1. Resident R1 has received and completed 2 step TST with negative findings. B1. All new admissions entering AL facility have the potential to be affected. C1. All licensed staff will be educated by Staff Developer concerning the 2 step process of TST upon admission and the importance of a chest x-ray if resident has had positive results in the past or has allergy. All new admissions will be reviewed by AL Manager for scheduling of TST and completion of series/or chest x-ray. (Attachments 3A, 3B and 3C). D1. Audits will be performed by the AL Manager or designee on all new admissions daily x1 month, then weekly x4 until 100% compliance is reached. Random audits will continue monthly x6 months or until 100% compliant. Results will be reviewed at the QA /QI meeting. (Attachment 4). A2. Resident R4 had chest x-ray on 2/2017, radiology performed a reread to rule out tuberculosis. No tuberculosis identified. AL manager contacted resident's primary care physician for clarification of +PPD history. PCP unable to verify in the records and gave order to start 2 step process. TST completed without adverse skin reaction	08/16/2017 09/27/2017 09/27/2017 08/16/2017

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	tuberculosis in Health-Care Settings recommends that all health care workers receive a two-step TST upon hire. Also a person with an initial positive TST or a history of a positive TST should receive one chest x-ray to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months). https://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf 2014 - Centers for Disease Control and Prevention (CDC) recommends when performing a two-step TST, if the first test result is negative, the TST should be repeated in 1–3 weeks. https://www.cdc.gov/tb/publications/ltbi/diagnosis.htm Resident TB Testing 1. Review of R1's clinical record revealed: 2/15/16 – Admission from the health care center. Immunization Record showed R1 received a TST on 1/31/16 (admission to health care center). There was no evidence a second TST was completed when admitted to AL. During an interview with E2 (DON) on 8/1/17 at 2:50 PM E2 confirmed only one TB test was performed in the health center and additional TST was not done in AL. 2. Review of R4's clinical record revealed:	and resident found to have negative results of 0mm. B2. All new admissions entering AL facility have the potential to be affected. C2. All licensed staff will be educated by Staff Developer concerning the 2 step process of TST upon admission and the importance of a chest x-ray if resident has had positive results in the past or has allergy. All new admissions will be reviewed by AL Manager for scheduling of TST and completion of series/or chest x-ray. (Attachments 3A, 3B and 3C). D2. Audits will be performed by the AL Manager or designee on all new admissions daily x1 month, then weekly x4 until 100% compliance is reached. Random audits will continue monthly x6 months or until 100% compliant. Results will be reviewed at the QA /QI meeting. (Attachment 4).	09/27/2017 09/27/2017

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	7/22/16 – Admission from the community. Immunization Record in R4's chart revealed the resident had a history of a positive TST. The date of the last chest x-ray was 2/4/00. There was no evidence that a chest x-ray to rule out active TB was obtained, potentially exposing staff and residents tuberculosis. During an interview with E2 (DON) and E4 (AL Manager) on 8/1/17 in the afternoon, E2 confirmed that R4 did not have a current chest x-ray on file. <u>Employee TB Testing</u> Facility policy entitled Tuberculosis Screening of Employees (undated) stated: All employees upon hire will be screened for tuberculosis. All newly hired employees, unless they are known to be a positive reactor, shall have a baseline two-step TST completed. Review of TB testing data completed by the facility on a form provided by the surveyor revealed: 3. E6: hired 4/25/16, TST on 4/11/16. 4. E7: hired 9/5/16, TST on 9/17/15 and 8/5/16. 5. E8: hired 9/19/16, TST on 9/9/16 and 9/19/16. 6. E9: hired 11/7/16, TST on 10/31/16 and 11/7/17. 7. E10: hired 3/22/17, step 1 on 3/15/17, step 2 on 3/22/17. During email conversations with E11 (HR) on 8/2/17 it was determined around 9:35 AM that: - E6: did not receive the second TST. - E7: 2015 TST from another employer	A1. E6 two-step process initiated. B1. Because any new employee has the potential to be affected by this deficient practice, all employees have completed 2-step TST with no adverse skin reactions. Negative results of 0mm. C1. All management staff will be educated by the Staff Developer on the new hire process and requirements prior to new hire's first day of employment. No employee will start working until 2 step TST process is completed and/or chest x-ray is on record. (Attachment 5). D1. Audits will be conducted by the HR Manager or designee weekly x4 weeks until 100% compliant, then monthly x6 months to ensure continued compliance. Results will be	08/25/2017 9/27/2017 09/27/2017

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	did not include two-step TST. [E7 should have had two-step TST performed prior to employment]. - E8, E9 and E10: received their second step on their first day of employment. [Result would not be available until 48-72 hours after employment.] These findings were reviewed with E1 (ED), E2 (DON), E3 (ADON) and E4 (AL Manager) on 8/2/17 at 3:25 PM during the exit conference.	reviewed at the QA/QI meeting. (Attachment 6). A2. E7 is no longer employed. B2. Because any new employee has the potential to be affected by this deficient practice, all employees have completed 2-step TST with no adverse skin reactions. Negative results of 0mm. C2. All management staff will be educated by the Staff Developer on the new hire process and requirements prior to new hire's first day of employment. No employee will start working until 2 step TST process is completed and/or chest x-ray is on record. (Attachment 5). D2. Audits will be conducted by the HR Manager or designee weekly x4 weeks until 100% compliant, then monthly x6 months to ensure continued compliance. Results will be reviewed at the QA/QI meeting. (Attachment 6). A3. E8 received two-step TST and results were negative at 0mm. B3. Because any new employee has the potential to be affected by this deficient practice, all employees have completed 2-step TST with no adverse skin reactions. Negative results of	08/27/2017 09/27/2017 09/27/2017 09/27/2017

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		0mm.	
		C3. All management staff will be educated by the Staff Developer on the new hire process and requirements prior to new hire's first day of employment. No employee will start working until 2 step TST process is completed and/or chest x-ray is on record. (Attachment 5).	09/27/2017
		D3. Audits will be conducted by the HR Manager or designee weekly x4 weeks until 100% compliant, then monthly x6 months to ensure continued compliance. Results will be reviewed at the QA/QI meeting. (Attachment 6).	09/27/2017
		A4. E9 received two-step TST and results were negative at 0mm.	09/27/2017
		B4. Because any new employee has the potential to be affected by this deficient practice, all employees have completed 2-step TST with no adverse skin reactions. Negative results of 0mm.	
		C4. All management staff will be educated by the Staff Developer on the new hire process and requirements prior to new hire's first day of employment. No employee will start working until 2 step TST process is completed and/or chest x-ray is on record.	09/27/2017

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		(Attachment 5). D4. Audits will be conducted by the HR Manager or designee weekly x4 weeks until 100% compliant, then monthly x6 months to ensure continued compliance. Results will be reviewed at the QA/QI meeting. (Attachment 6).	09/27/2017
		A5. E10 received two-step TST and results were negative at 0mm. B5. Because any new employee has the potential to be affected by this deficient practice, all employees have completed 2-step TST with no adverse skin reactions. Negative results of 0mm. C5. All management staff will be educated by the Staff Developer on the new hire process and requirements prior to new hire's first day of employment. No employee will start working until 2 step TST process is completed and/or chest x-ray is on record. (Attachment 5). D5. Audits will be conducted by the HR Manager or designee weekly x4 weeks until 100% compliant, then monthly x6 months to ensure continued compliance. Results will be reviewed at the QA/QI meeting. (Attachment 6).	09/27/2017 09/27/2017 09/27/2017

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3225.12.0 **3225.12.1** **3225.12.1.3** **3-302.11 (A) (4)**	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code;** Based on observation and interview it was determined that the facility failed to comply with the Delaware Food Code Findings include: The initial kitchen tour was conducted 7/31/17 between 8:40 AM – 9:00 AM. **Packaged and Unpackaged Food - Separation, Packaging, and Segregation** **(A) FOOD shall be protected from cross contamination by:** **(4) Except as specified under Subparagraph 3-501.15(B)(2) and in ¶ (B) of this section, storing the FOOD in packages, covered containers, or wrappings;** 1. An upright refrigerator contained an open package of breaded meat product. The plastic bag containing the food was missing a section approximately 5 inches across which exposed the food. Food shall be protected from cross contamination by being in a covered container.	A. All food items which were identified as out of compliance were immediately destroyed. B. A review of all food storage areas was conducted to identify any further food items which were not labeled/dated. C. Dining staff were in-serviced by Dining Director on proper storage of food. (Attachment 7). D. Audits of food storage areas by Closing Shift Dining Manager & Cook and will be conducted daily x2 weeks then weekly x4 weeks until 100% compliance is reached. Results will be reported and reviewed at QA/QI meeting. (Attachment 8).	09/02/2017 09/02/2017 09/27/2017 09/27/2017

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3-501.17 (B)	**Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.** **(B) Except as specified in ¶¶ (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and:** 2. The refrigerator identified in example 1 contained a bag of french fries which had been opened and resealed, but lacked the "use by" date. 3. The walk-in refrigerator contained three packages of cheese (shredded cheddar cheese, cheddar cubes and feta cheese) which had been opened and resealed, but lacked the "use by" date. Food is to be clearly marked with the date by which it must be consumed or discarded.	A. All food items which were identified as out of compliance were immediately destroyed. B. A review of all food storage areas was conducted to identify any further food items which were not labeled/dated. C. Dining staff were in-serviced by the Dining Director on proper labeling & dating of food. (Attachment 7). D. Audits of food storage areas by Closing Shift Dining Manager & Cook and will be conducted daily x2 weeks then weekly x4 weeks until 100% compliance is reached. Results will be reported and reviewed at QA/QI meeting. (Attachment 8).	09/02/2017 09/02/2017 09/27/2017 09/27/2017
3-501.18 (A)(3)	**Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition.** **(A) A FOOD specified in ¶ 3-501.17(A) or (B) shall be discarded if it:** **(1) Exceeds the temperature and**	A. All food items which were identified as out of compliance were immediately destroyed B. A review of all food storage areas was conducted to identify any	09/02/2017 09/02/2017

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	time combination specified in ¶ 3-501.17(A), except time that the product is frozen; **(3) Is appropriately marked with a date or day that exceeds a temperature and time combination as specified in ¶ 3-501.17(A).** 4. The walk-in refrigerator identified in example 3 contained four small cartons of Lactaid milk with an expiration date of 7/20/17. Food shall be discarded if the date marked on its label has exceeded. These findings were immediately confirmed during the initial kitchen tour with E5 (DFS) and the food items were discarded. These findings were reviewed with E1 (ED), E2 (DON), E3 (ADON) and E4 (AL Manager) on 8/2/17 at 3:25 PM during the exit conference.	further food items which were out of date. C. Dining staff were in-serviced by the Dining Director on proper rotation and discarding of food items. (Attachment 7). D. Audits of food storage areas by Closing Shift Dining Manager & Cook and will be conducted daily x2 weeks then weekly x4 weeks until 100% compliance is reached. Results will be reported and reviewed at QA/QI meeting. (Attachment 8).	09/27/2017 09/27/2017
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.**	A1. Resident R1 continued to receive contracted care and services as specified in service agreement. Service agreement has been signed and reviewed with resident and family. B1. All residents who reside in AL have the potential to be affected by this deficient practice. C1. AL Manager will be educated by the Staff Developer concerning importance of obtaining POA written or verbal consent for the	09/02/2017 09/27/2017

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3225.13.6	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** Based on record review and interview it was determined that the facility failed to obtain appropriate signatures on updated service plans reflecting an increased need for services for two (R1 and R3) out 4 active sampled residents. Findings include: 1. Review of R1's clinical record revealed: 2/13/17- Significant Change UAI assessment showed R1 needed supervision / occasional assistance with bathing, dressing and transferring when the resident was Independent in these areas on the 2/11/16 UAI. 2/13/17 – E4 (AL Manager) updated and signed the Service Agreement (SA) to reflect R1's increased needs in the areas identified in the UAI. There was no evidence that the revised SA was reviewed by the resident on 2/13/17 since the only dated signature was from 2/17/16. 2. Review of R3's clinical record revealed: a, 10/21/15- 30-day UAI showed that R3 needed supervision with dressing and assistance with hygiene after toileting	service agreement. Attempts will be made to have scheduled family meetings with each scheduled UAI to review plan of care in service agreement. Resident to be included. (Attachments 9A and 9B). D1. Audits will be conducted weekly x4 weeks, then monthly x6 months by the DON or designee until 100% compliant. Sample size will be 100% of AL census. Results will be reviewed at the QA/QI meeting. (Attachment 10). A2. Resident R3 has continued to receive care and services as specified in service agreement. Current AL Manager has reviewed service agreement with POA, and verbal consent has been verified. B1. All residents who reside in AL have the potential to be affected by this deficient practice. C1. AL Manager will be educated by the Staff Developer concerning importance of obtaining POA written or verbal consent for the service agreement. Attempts will be made to have scheduled family meetings with each scheduled UAI to review plan of care in service agreement.	09/27/2017 09/02/2017 09/27/2017

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	when previously the resident was identified as being Independent in these areas on the 9/4/15 Initial UAI. 10/21/15 – E12 (former AL Manager) did not sign/date the SA when updated to reflect the increased needs identified in the UAI. There was no evidence that the revised SA was reviewed by R3's responsible party on 10/21/15 since the only dated signature was 9/21/15. b. 10/21/16 – Annual UAI documented that R3 needed complete assistance with grooming and bathing. 10/21/16 – E4 (AL Manager) updated and signed the SA to reflect R3's increased needs in the areas of dressing/undressing and grooming. There was no evidence that the revised SA was reviewed by the responsible party since the only dated signature was from 9/21/15. During an interview with E4 on 8/1/17 around 9:50 AM, E4 acknowledged that the R1 and R3's SAs should have been signed and dated by the resident and responsible party, respectively. These findings were reviewed with E1 (ED), E2 (DON), E3 (ADON) and E4 on 8/2/17 at 3:25 PM during the exit conference.	Resident to be included. (Attachments 9A and 9B). D1. Audits will be conducted weekly x4 weeks, then monthly x6 months by the DON or designee until 100% compliant. Sample size will be 100% of AL census. Results will be reviewed at the QA/QI meeting. (Attachment 10).	09/27/2017
3225.19.0 **3225.19.1**	**Records and Reports** **The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service**	A. Resident R3 received a complete fall assessment. Neurological status remained unchanged. R3 was able to continue in plan of care without medical intervention.	08/02/2017

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	agreement for each resident. Based on record review and interview it was determined that the facility failed to complete all documentation related to post fall assessments for one (R3) out of 4 active sampled residents. Findings include: 2010 - Facility policy entitled Fall Prevention Program included that each fall will be properly documented in the resident chart. If the fall results in a suspected head injury, the neurological check list is to be completed. Review of R3's clinical record revealed: 2/4/17 – Computerized service plan in the included the problem At Risk for Falls. 24 hour Post Fall Assessment (PFA) and Neurological (Neuro) Checklist both indicated completion at set intervals after a fall (initially with fall, 8 hours, 16 hours and 24 hours post fall. Post Fall Assessment included LOC and checking pupils if head involved which were also included on the Neuro Checklist, which also contained speech and arm/leg movement. January 2017 – June 2017 – Review of PFA and Neuro Checklists discovered three falls involving a suspected head injury where the PFAs were completed in entirely but the Neuro Checklist had missing entries: - 2/1/17: 24 hours post fall - 3/7/17: 24 hours post fall - 4/4/17: 16 and 24 hours post fall During an interview with E4 (AL Manager)	B. All residents who reside in AL who have a fall, have the potential to be affected by this deficient practice. C. All licensed AL staff will be educated by the Staff Developer on the completion of the newly devised 24 hour post fall/neurologic assessment form. (Attachments 11A, 11B and 11C). D. Audits will be performed daily by AL Manager or designee on all falls in AL x30 days until 100% compliance is reached, then weekly x4. Audits will be reviewed at the QA/QI meeting. (Attachment 12).	09/27/2017 09/27/2017

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	on 8/1/17 at 9:50 AM to review R3's falls E4 stated that when R3 was not sleeping at night the resident would nod off and roll off of chairs/sofas in the living room. E4 added that, after medication adjustment, R3 is sleeping more at night and falls decreased with none in July. E4 stated she would check the computerized record for additional assessment information. During a follow-up interview with E4 on 8/1/17 in the afternoon, E4 confirmed that PFA was done every 8 hours after the three previously identified falls, but that the Neuro Checklist (on a separate paper) was not filled out completely. During an interview with E2 (DON) on 8/1/17 at 3:00 PM to discuss the aforementioned issue, E2 acknowledged that combining the forms would reduce this occurrence in the future. These findings were reviewed with E1 (ED), E2 (DON), E3 (ADON) and E4 on 8/2/17 at 3:25 PM during the exit conference.		