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: Silver Lake Center Nursing Home **DATE SURVEY COMPLETED: February 11, 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 COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from February 5, 2021 through February 11, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of survey was 92. The survey sample totaled nine (9).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 11, 2021: F868 and F880.		

Provider's Signature Vickie K. Cao Title NHA, RED Date 2-26-2021

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Provider's Signature Nicki K. Cox Title NHA, RED Date 2-26-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. BUILDING _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from February 5, 2021 through February 11, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 92. The survey sample totaled nine (9). Abbreviations and definitions used in the report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; COVID-19 (Coronavirus) - a respiratory illness that can be spread person to person; QAA -Quality Assessment and Assurance team of interdisciplinary professionals that meet quarterly to discuss plans to improve identified weakness in the facility.	F 000		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's	F 868		3/5/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/26/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 868	Continued From page 1 staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the quality assessment and assurance committee (QAA) consisting of a minimum of the Director of Nursing (DON), Medical Director or designee, and at least three other members of the facility's staff (at least one of whom must be the administrator, owner, a board member or other individual in a leadership role) failed to meet at least quarterly to identify issues with respect to which quality assessment and assurance activities were necessary. Findings include: Review of the facility's quarterly QAA committee meeting sign in sheets revealed that for three out of four quarterly meetings reviewed, required members were not in attendance: March 2020 - the facility NHA was not in attendance, June 2020 - the facility NHA was not in attendance, and December 2020 - the Medical Director or designee was not in attendance. During an interview on 2/10/21 at 3:31 PM, E1 (NHA) confirmed that required committee members were not consistently present at the facility's quarterly QAA committee meetings. E1 stated, "I reviewed them myself and attendance	F 868	F 868 1. There were no residents directly affected by the deficient practice of the required members of the QAA failing to be in attendance for 3 out of 4 quarterly meetings. 2. Current residents could be affected by the deficient practice if the Medical Director, Director of Nursing, and Administrator do not have the opportunity to contribute to the development of clinical policy and practice guidelines. 3. Center Executive Director (CED) communicated with the Medical Director regarding the assignment of a physician designee to attend the meeting in her absence. The CED communicated with the Director of Nursing on her responsibility to attend the quarterly QAA meeting. The CED will educate facility managers on policy OPS103 Center Quality Assurance and Performance Improvement (QAPI) process.	

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F 868	Continued From page 2 was inconsistent, I only joined the facility in the new year [2021]." Findings were reviewed during the exit conference on 2/11/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 868	4. The Center Executive Director/Asst. Center Executive Director/Designee will be responsible for monitoring attendance and assuring a Director of Nursing, Administrator, Medical Director, or designee are present at the quarterly QAA meeting. (attachment A)The Administrator will monitor that the required members are present quarterly and report it to the QAA committee.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		3/5/21

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F 880	Continued From page 3 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to thoroughly screen employees prior to their entrance into the facility. Findings include: Review of the CDC's Infection Control Guidance, dated 7/15/2020, indicated, "...Screen everyone (patients, health care personnel, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with SARS-CoV-2 infection and ensure they are practicing source control. Actively take their temperature and document absence of symptoms consistent with COVID-19...." (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control recommendation/html). Review of the facility policy for infection control practices related to COVID-19, last updated 12/21/2020, indicated, "active screening of all persons entering the Center (such as employees, visitors, medically necessary personnel, contracted staff/vendors and volunteers) will be done upon entry into the Center." Review of the facility screening logs for January 2021 revealed that on 1/4, 1/8,1/9,1/10,1/11, 1/13, 1/15, 1/16, 1/22, 1/23, 1/24, and 1/26 employees entered the facility without completing the review of symptoms related to COVID-19 portion of the entrance screening. During an interview on 2/5/21 at 3:31 PM with E2 (DON) it was confirmed that screening logs for the aforementioned dates were incomplete.	F 880	F 880 1. There were no residents or staff directly affected by the deficient practice of the facility failing to thoroughly screen employees prior to their entrance into the facility. 2. Current residents and staff could be affected by this deficient practice if a thorough screening process is not completed for employees prior to their entrance into the facility. 3. A root cause analsyis was completed and findings will be submitted with the directed plan of correction. The Nurse Practice Educator/Unit Manager will educate all of the screeners on the importance of a "thorough screening process" to include the following: Anyone entering the center must immediately stop at the designated screening area to be screened for an elevated temperature and presence or absence of COVID-19 symptoms as well as an acceptable proof of COVID-19 testing from non-employed staff performed within the Center's Testing Frequency, and answering the Center's required COVID-19 screening questions. Answers to the screening questions will indicate whether individuals are cleared to enter the center or not cleared to enter the center. Answers to screening questions will be recorded. Persons who have a temperature of 100 degrees Fahrenheit or higher or have indicated that they have	

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F 880	Continued From page 5 Findings were reviewed during the exit conference on 2/11/21 at 10:30 AM with E1 (NHA) and E2 (DON).	F 880	symptoms of COVID-19 will not be allowed to leave the designated screening area. 4. CED/Assistant CED/designee will complete audits of employee screening to verify all required documentation is complete (see attachment B). Audits will occur daily until 100% compliance is achieved on 30 consecutive days, then weekly until 100% compliance is achieved on 4 consecutive audits, and then monthly until 100% compliance is achieved on 3 consecutive audits. Results of audits will be presented to the Quality Assurance and Performance Improvement Committee for further evaluation, recommendations, and sustainability of plan.	