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

DATE SURVEY COMPLETED: July 15, 2020

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 at this facility from July 2, 2020 through July 15, 2020. The deficiencies contained in this report are based on interviews, review of resident's clinical records and review of other facility documentation as indicated. The facility's census the first day of the survey was one hundred (100). The survey sample size was three (3).	Cross Reference CMS 2567-L F tag 660 completed July 15th, 2020	7/31/20
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 met as evidenced by the following:**		

Provider's Signature [signature] Title C.E.D Date 8/3/20

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 07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER LAKE CENTER	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	F 000		

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The abbreviations/definitions used in this report are as follows:

BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 -15.
13-15: Cognitively Intact
08-12 Moderately Impaired
00-07 Severe Impairment;
CDC - Center for Disease Control and Prevention;
CHF - Congestive heart failure;
COVID-19/Coronavirus - 'CO' stands for 'corona,' 'VI' for 'virus', and 'D' for disease. Formerly this disease was referred to as "2019 novel coronavirus" or "2019-nCoV". There are many types of human coronaviruses, including some that commonly cause mild to severe upper respiratory tract illness;
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 persons daily functioning, may or may not be Alzheimers related;
DON - Director of Nursing;
EMS - Emergency Medical Services;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 07/27/2020

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 000	Continued From page 1 ER - Emergency Room; MD - Medical Director; MDS (Minimum Data Set) assessment - standardized assessment form used in nursing homes; NHA- Nursing Home Administrator; RN- Registered Nurse; SW - Social worker; Transmission based precautions - additional infection control measures in a healthcare setting used to help the spread of germs from one person to another.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support	F 660		7/31/20

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F 660	Continued From page 2 person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.	F 660		

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F 660	Continued From page 3 (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R1) out of three residents reviewed for discharge the facility failed to involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. Findings include: The facility policy entitled Discharge and Transfer (last revised 2/1/19) included that "A Center must immediately inform the patient/resident representative, consult with the patient's physician, and notify, consistent with below, when there is a decision to transfer or discharge the patient from the Center. The patient and resident representative must be notified in writing and in a language and manner they understand ...For unplanned, acute transfers where the Center does not plan to take the patient back from the hospital, the patient and/or resident representative will be notified verbally followed by written notification using the NOID (notice of involuntary discharge form) or state specific transfer form." The following was reviewed in R1's clinical record:	F 660	F-Tag 660 1. Resident R1 was discharged from the facility on April 16, 2020. On May 28, 2020 a letter was sent to Family member 1. 2. All residents have the potential to be affected. An audit was conducted on July 20, 2020. It was determined that no other residents should have received the NOID (notice of involuntary discharge form) or state specific transfer form. 3. A Root Cause Analysis (RCA) was completed. As a result, it was determined that education will be given to Administration on the policy entitled Discharge and Transfer by the NPE. The CED or designee will complete a weekly audit on 100% of the residents for compliance with the facility policy entitled Discharge and Transfer. 4. The CED will report on results of audits at QAPI (Quality Assurance/	

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F 660	Continued From page 4 6/26/19 - An Admission MDS assessment documented that on 6/19/19 R1 was admitted to the facility for rehabilitation post hospitalization. 4/16/2020 8:35 PM - A nursing note by E2 (DON) documented: "Called ER about resident to give them (E3 Medical Director's) number about getting resident possible committed due to endangering other residents with COVID and I was told by (name of nurse) the ER nurse for (R1) that he was being admitted due to CHF and that the social worker there could help with his discharge to the correct facility." 4/16/2020 5:50 PM - A nursing note by E2 (DON) documented: "Resident continues to go in and out of his room multiple times endangering other residents. He did not go into any other room but would not stay in his room. Per MD (E3 Medical Director) to send to ER and when EMS arrived he refused to go and SW had to give a copy of the report where resident was deemed in able (unable) to make decisions. They called supervisor who arrived and convinced resident to go to ER. Resident went via ambulance to ER." 5/19/2020 - An Admission MDS assessment (from the new long-term care facility) documented that on 5/13/2020 R1 was admitted from the hospital and that his BIMS (Brief Interview for Mental Status) score was 7 (severe cognitive impairment). 5/28/2020 - A letter was sent from E1 (NHA) to family member 1 (first contact for R1) that stated: "(R1) was discharged to (the new long-term care facility) from (the hospital) on 5/13/2020. (R1) was transferred to (the new long-term care	F 660	Performance Improvement) meeting for review and recommendations weekly X 1 month for 100% compliant and then monthly x 3 months for 100% compliance and will report it to the monthly QAPI committee.	

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F 660	Continued From page 5	F 660		

facility), rather than (the facility being cited), due to his non-compliance with CDC, State and facility guidelines concerning isolation during the pandemic. (R1's) transfer was approved by the (State Agency). Once the pandemic is over, (R1) will have the option to return to (the facility being cited)."

7/2/2020 4:00 PM - During an interview, E1 (NHA) explained that R1 was sent to the hospital on 4/16/2020 because he was positive for COVID-19 and noncompliant with COVID-19 transmission-based precautions; therefore, putting the facility's staff and other residents at risk. Because the facility did not have other COVID-19 residents, E1 requested a waiver from the State Agency, which was approved on 5/12/2020, to have R1 sent from the hospital to a sister facility that had multiple COVID-19 positive residents.

7/13/2020 12:30 PM - During an interview, Family Member 2 (second contact for R1) stated that the facility did not communicate with R1's family until after he was already at the new long-term care facility that has multiple COVID-19 positive residents. Family Member 2 stated that R1 has been at the facility for over a year and was recently diagnosed with dementia. When R1 contracted COVID-19, the facility sent him to the hospital. The hospital tried to send him back to the facility, but they refused to take him back on 5/11/2020. Because he has COVID-19, the facility told the hospital that they would have to send him to (the new long-term care facility). While R1 was still at the hospital, he told his family someone from the facility called him and said he was going back to the facility. It was not until after the family contacted the Ombudsman that the family

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F 660	Continued From page 6 received anything in writing about R1 having to go to the new facility. 7/14/2020 1:06 PM - During email communications, E1 (NHA) was asked to provide documentation that the facility communicated with R1's family that he could not return to the facility prior to R1 being sent from the hospital to the new long-term care facility. E1 wrote: "(R1) is not able to make his own decisions. There is no POA for R1. R1 was non compliant with transmission based precautions on 4/16/20 and that is why he was transferred to the hospital. The waiver for R1 to be admitted to the (the new facility) was approved after discussions with (our) corporate, Epidemiology and the (State Agency). I called and spoke with (R1) to make him aware of the group's decision to transfer him to (the new facility) on 5/12/20. I called and spoke with (Family Member 1) the RP (responsible party) for R1 and explained the group decision. He agreed and respected the decision for his transfer to the (the new facility)." When asked if there was any documentation of these conversations, E1 provided a message from Family Member 1 requesting a call back about where R1 is being discharged from the hospital to dated 5/12/2020 at 3:18 PM, and two handwritten notes dated 5/12/2020 that he spoke to R1 and Family Member 1 about the transfer to the new facility. 7/14/2020 2:30 PM - During an interview, Family Member 1 (first contact for R1) stated, "I know (E1 NHA) did not do everything he was supposed to do. He did not call me to explain that (R1) would have to go from the hospital to the new long-term care facility until after he was already there. I was very upset. I would have never wanted my child to go there (to the new long-term	F 660		

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F 660	Continued From page 7 care facility); lots of people were dying there." Review of R1's electronic medical record did not reveal any evidence that the facility communicated with the responsible party about his transfer from the hospital to the new facility. 7/15/2020 11:00 AM - These findings were reviewed during a telephone exit conference with E1 (NHA) and E2 (DON).	F 660		