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

DHSS - DLTCRP
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STATE SURVEY REPORT

NAME OF FACILITY: Meadowcrest Assisted Living **DATE SURVEY COMPLETED: November 24, 2021**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Complaint Survey was conducted at this Assisted Living (AL) facility beginning November 18, 2021 and ending November 24, 2021. The facility census on the entrance day of the survey was 33 residents. The survey sample was composed of seven residents, plus two additional subsampled residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. An Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. For the Emergency Preparedness survey, no deficiencies were cited. **Abbreviations/definitions used in this state report are as follows:** Care Partner – direct caregiver in assisted living facilities; Dementia – brain disorder with memory loss, poor judgement, personality changes and disorientation; F (Fahrenheit) – temperature scale; LPN – Licensed Practical Nurse; ED - Executive Director; PCR (Polymerase Chain Reaction) – testing to look for COVID-19 genetic material; POA – Power of Attorney; POC (Point of Care) – testing completed at the facility to detect COVID-19 antigen; Psychiatry –treatment of mental disorders; RN – Registered Nurse; RSD - Resident Service Director;	

Provider's Signature _____ Title EXECUTIVE DIRECTOR Date 1/31/22

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	SS – subsampled resident; SW – Social Worker; UAI (Uniform Assessment Instrument) – assessment form used to collect information about the physical condition, medical 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**	
3225.9.0	**Infection Control**	
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 is not met as evidenced by:** Mask Use 1. Based on random observations it was determined that the facility failed to ensure infection control procedures were followed to prevent the transmission of COVID-19 infection when facility staff members wore facemasks incorrectly (nose and/or mouth exposed). Findings include: According to the Delaware Division of Public Health (DPH) Long Term Care website, face masks are still required of staff, vendors, contractors and visitors. (https://coronavirus.delaware.gov/long-term-care-facilities/) DPH documented Core Principles of COVID-19 Infection Prevention in the COVID-19 Updated	<u>3225.9.1.2</u> 1. A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. ED/designee to communicate to staff the requirement for proper use of face mask coverings by all staff while in the community. D. Designated Dept. Managers will conduct daily audits until 100% compliance is reached over 3 consecutive evaluations. Then the Designated Dept. Managers will conduct audits weekly until 100% compliance is reached over 2 consecutive evaluations. Then the Designated Dept. Managers will conduct audits monthly until 100% compliance is reached over 2 consecutive evaluations. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected and the audit will occur at least quarterly as part of the Infection Control QA monitoring plan.

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	Reopening Plan in Long Term Care Facilities (updated 3/17/21) included "Appropriate use of Personal Protective Equipment" and "Face covering or mask (must cover mouth and nose)." The facility policy entitled Testing for Covid-19 for Residents and Staff (dated 6/1/21) stated that "All staff would follow universal masking while in the facility." 11/18/21 – Random observations revealed the following: - 10:01 AM: E3's (Facilities Director) mask was down off his nose in the first floor hallway. - 10:25 AM: Three kitchen staff (E14, E15 and E16) were in the main dining room physically distanced (standing at least six feet apart) with masks down under their chins, talking. 11/19/21 - Random observations revealed the following: - 11:14 AM: An unidentified housekeeper was cleaning the sink in the second floor common area with her nose exposed. - 11:43 AM: E3 (Facilities Director) walked down the hall in the memory unit with his nose exposed. - 11:59 AM: E4 (Maintenance) was in the first floor hallway with his mask pulled down below his nose and mouth. - 12:08 PM: E5 (Food Service Manager) had his face mask pulled down below his nose in the resident dining room. - 12:09 PM - 12:30 PM: E29 (Housekeeping) was outside of the first floor dining room with her nose and mouth exposed. - 12:10 PM: E4 was observed near the dining room on the first floor without his mask cover-	E. Completion Date : 2/15/22 2. A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Following the survey an audit was completed and identified staff were educated on the risks of declining the vaccine and signed declinations were received. Facility to develop policies and procedures to ensure a process to identify any future staff who have declined the COVID-19 vaccination and provision of required education/documentation. D. The HR Coordinator will conduct an initial audit and subsequent audits monthly until 100% compliance is reached over 2 consecutive evaluations. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected and the audit will occur at least quarterly as part of the QA monitoring plan. E. Completion Date: 3/01/22 3. A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice.

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	ing his nose and mouth. - 12:24 PM: E4 was again observed in the first floor hallway with his nose and mouth exposed. When the Surveyor asked him if he was aware that the mask was supposed to cover both the nose and mouth, he confirmed that he was aware then pulled it mask up into the correct position over his nose and mouth. - 2:28 PM: E29 (Housekeeping) was seen walking in the hall in the Administration area with her mask not covering her nose. - 3:23 PM: E28 (Receptionist) had her nose exposed when speaking with two staff persons at the first floor elevator. - 3:30 PM: E28 was talking on a cell phone at the front desk with her mask pulled down and her nose and mouth exposed. 11/22/21 - Random observations revealed the following: - 2:07 PM: E3 (Facilities Director) delivered a cart of boxed items to the Administration area with his nose exposed. -2:59 PM: E28 (Receptionist) was observed with her nose exposed when Surveyor was signing out at the front desk. 11/23/21 - Random observations revealed the following: 8:29 AM and 3:30 PM: E28 was observed behind the reception desk with her nose and mouth exposed while the Surveyor was signing in and out. 2. Based on interview and review of other facility documentation, it was determined that, for 23 out of 91 facility staff who declined the COVID-19 vaccination, the facility failed to educate on the risks of declining the vaccination	C. Facility conducted a root cause analysis and identified systematic changes that were required in the screening process. The screening tool is being transitioned to an electronic monitoring system with implementation of additional oversight structures. D. Department Managers will conduct daily audits until 100% compliance is reached over 5 consecutive evaluations. Then the Depart Managers will conduct audits weekly until 100% compliance is reached over 3 consecutive evaluations. Then the Department Managers will conduct audits monthly until 100% compliance is reached over 3 consecutive evaluations. Finally the ED /designee will conduct an audit one month later. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected and the audit will occur at least quarterly as part of the Environmental QA monitoring plan. E. Completion Date: 2/15/22

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	and failed to have evidence that records were retained with signed declinations by the 23 employees. Findings include: 11/19/21 11:00 AM – A review of facility policy and procedures found that the facility did not have a process to address employee declination of the COVID-19 vaccination nor for the provision of education for staff who declined as required by DPH. 11/19/21 2:14 PM – During an interview, E2 (RSD) stated that the facility did not keep declination forms or evidence that education was provided to staff when they declined the COVID-19 vaccination. 3. Based on observation and review of other facility documentation, it was determined that, for five (E6, E7, E8, E9 and E10) out of five unvaccinated sampled staff members, the facility failed to screen for symptoms of COVID-19 prior to the start of their shift. Findings include: The Centers for Disease Control and Prevention (CDC) recommended that facilities establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so they can be properly managed: (1) a positive viral test for SARS-CoV-2, (2) symptoms of COVID-19 or (3) who meets criteria for quarantine or exclusion from work. Options included (but were not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-	

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	recommendations.html) Review of facility screening records and work schedules revealed the following staff failed to screen themselves for symptoms of COVID-19 prior to work: - 11/13/21: E6 (LPN). - 11/15/21: E6 (LPN) and E9 (CNA). - 11/18/21: E6 (LPN) and E10 (CNA). - 11/19/21: E6 (LPN) and E10 (CNA). - 11/22/21: E6 (LPN), E7 (CNA), and E8 (CNA). 11/22/21 11:10 AM – Findings were reviewed and confirmed with E1 (ED). Findings were reviewed with E1 and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM.	
3225.9.5	**Requirements for tuberculosis and immunizations:**	
3225.9.5.2	**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.** **This requirement is not met as evidenced**	**3225.9.5.2** A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Following the survey an audit was completed and identified staff were provided a schedule to have required TB testing completed within established time frames. Facility developed a tracking system to ensure that pre-employment requirements are met. D. ED/designee will conduct audits on newly hired employees until 100% compliance is reached over 2 consecutive evaluations. Then

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	by: Based on review of other facility documentation and interview, it was determined that, for four (E20, E24, E25 and E26) out of nine sampled staff, the facility failed to ensure that tuberculosis (TB) testing was completed prior to starting employment at the facility. Findings include: The first day of employment in the facility began on the following dates: 1. 9/13/21 - E30 (Maintenance): as of 11/18/21, no TB testing had been performed. 2. 10/6/21 - E24's (Memory Care Staff): chest x-ray result was received on 10/8/21, two days after beginning employment. 3. 10/11/21 - E26 (Housekeeping): first TB testing was 11/9/21, 29 days after beginning employment. 4. 11/2/21 - E25 (AL Resident Staff): as of 11/18/21, no chest x-ray was available. 11/19/21 at approximately 2:10 PM – E1 (ED) confirmed the findings. These findings were reviewed with E1 and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM.	the ED/designee will conduct audits weekly until 100% compliance is reached over 2 consecutive evaluations. Then the ED/designee will conduct audits monthly until 100% compliance is reached over 2 consecutive evaluations. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected and the audit will occur at least quarterly as part of the Pre-Employment QA monitoring plan. E. Completion Date : 2/15/22
3225.9.8	**Specific Requirements for COVID-19:**	
3225.9.8.2	**Staff, vendors, and volunteers**	
3225.9.8.2.3	**All staff, vendors and volunteers who test**	

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	negative must be retested consistent with Division of Public Health guidance for the duration of the public health emergency.	
3225.9.8.2.4	**Facilities must report all staff, vendor and volunteer testing and test results, to the Delaware Division of Public Health.** **This requirement is not met as evidenced by:** Based on review of other facility documentation and interview, it was determined, for two (E6 and E9) out of seven unvaccinated staff sampled, that the facility failed to test and therefore report results as required to the Delaware Division of Public Health (DPH). Findings include: The facility policy Testing for Covid-19 for Residents and Staff (dated 6/1/21) documented that "All staff would be screened prior to entering resident care areas. Reporting requirements were to be followed per state and county health department guidelines." 9/20/21 - DPH guidelines stated that unvaccinated staff in counties in high transmission areas would be tested twice weekly (counties in Delaware had high transmission rates during the time period being reviewed). (https://coronavirus.delaware.gov/wp-content/uploads/sites/177/2021/09/DPH-LTC-COVID-19-Testing-Guidance-09.20.21.pdf) 11/18/21 10:30 AM – During an interview, E2 (RSD) stated that unvaccinated staff were tested twice weekly, on Tuesdays (PCR test sent to the lab) and Thursdays (POC rapid test done in	**3225.9.8.2.4** A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Following the survey the Facility developed a weekly tracking system to ensure that that required testing/reporting of unvaccinated staff is completed in compliance with Division of Public Health (DPH) guidelines. D. ED/designee will conduct weekly audits until 100% compliance is reached over 3 consecutive evaluations. Then the ED/designee will conduct audits monthly until 100% compliance is reached over 2 consecutive evaluations. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected and the audit will occur at least quarterly as part of the QA monitoring plan. E. Completion Date : 2/15/22

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	the facility). Review of testing results provided by E2 showed the following staff were not tested twice each week: 1. E9 (CNA) - PCR test 10/28/21 (Thursday), no other testing the week of 10/23 to 10/30. - PCR test 11/5/21 (Friday), no other testing the week of 10/31 to 11/6 (worked 11/5 and 10/31). - PCR test 11/12/21 (Friday), no other testing the week of 11/7 to 11/13. - No COVID-19 testing the week of 11/14 to 11/20 (worked 11/4, 11/18 and 11/19). 2. E6 (LPN) - No COVID-19 testing the week of 11/7 to 11/13 (worked 11/13 and 11/14). - PCR test 11/17/21 (Wednesday), no other testing the week of 11/14 to 11/20 (worked 11/18 and 11/19). 11/22/21 11:10 AM – In an interview, E1 (ED) confirmed that E6 and E9 lacked twice weekly testing as required for unvaccinated staff. Findings were reviewed with E1 and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM.	
3225.13.0	**Service Agreements**	
3225.13.1	**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**	**3225.13.1** A. Resident R2 service agreement has been reviewed/updated and signed by R2's POA. B. All residents have the potential to be affected.

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	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. **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that, for one (R2) out of three residents investigated on the memory care unit, the facility failed to ensure the service agreement was reviewed with or signed by R2's POA no later than the day of admission to the facility. Findings include: An undated facility policy entitled Service Agreement included a "resident requiring assisted living services shall have a service agreement based on the needs identified in the UAI, physical and psychosocial needs and recognition of his/her capabilities shall be completed prior to or no later than the day of admission to the community. The Resident may include a designated person in making decisions about services." Cross Refer 16.2 and 16.3 Review of R2's clinical record and Service Agreement revealed: 9/14/21 – R2's initial Resident Service Agreement was completed. 10/11/21 – R2 was admitted to the Memory Care unit of the facility with Alzheimer's dementia.	A focused review of service agreements for all current residents was completed in order to identify any which lacked required signatures or dates within required time frames with corrective action taken if necessary. C. The ED reviewed the service agreement completion requirements with the RSD in order to ensure understanding of such requirements. D. The ED/designee will conduct service agreement audits monthly until compliance 100% is achieved over 3 consecutive evaluations. Finally the ED/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur quarterly as part of the QA monitoring plan. Cross Refer 16.2 and 16.3 E. Completion Date : 3/01/22

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	Review of the record revealed R2 had two Resident Service Agreements (dated 9/14/21 and 11/1/21) and both were identified as being the initial Service Agreement. The 11/1/21 Service Agreement should have been identified as a 30-day or significant change Service Agreement and not another initial one. There was no evidence that either Service Agreement was reviewed with or signed by F2 (R2's POA). Copies of the forms the Surveyor obtained on 11/18/21 contained: - 9/14/21: blank signature box for "Responsible Party Signature" next to the pre-printed date of 10/11/21. - 11/1/21: blank signature box for "Responsible Party Signature" next to the pre-printed date of 11/1/21. - E2's (RSD) electronic signature was present on both forms next to a pre-printed date of 11/1/21. The 9/14/21 Service Agreement should have been reviewed and signed by F2 (R2's POA) on 10/11/21, the day of admission to the facility. 11/22/21 at approximately 11:50 AM – During an interview E2 was informed about the missing signatures and offered no comment. Findings were reviewed with E1 (NHA) and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM and with E1 on 11/30/21 by email at 3:57 PM.	
3225.13.2	**The service agreement or contract shall address the physician, medical, and psychosocial services that the resident requires as follows:**	

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3225.13.2.3	**Food, nutrition, and hydration services;** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that, for one (R2) out of three residents investigated on the memory care unit, the facility failed to ensure the service agreement included that R2 had a food (lactose) intolerance. Findings include: Review of R2's clinical record revealed that R2 had two Resident Service Agreements (dated 9/14/21 and 11/1/21) that were identified as being the initial Service Agreement. Neither Service Agreement included that R2 had a lactose intolerance (abdominal pain/gas) after having items with lactose like milk, cheese, and ice cream. 11/13/21 9:51 PM – A nursing Progress Note documented that R2 "Was given ice cream before dinner which caused an upset stomach due to his lactose intolerance. Kitchen staff reported that [R2] threatened them and blamed them for the upset stomach." 11/22/21 9:34 AM – During an interview to determine how kitchen staff knew of food allergies or intolerances, E20 (Kitchen Staff) said, "The nurse would tell me." E20 added, "There used to be a paper around here", but was not able to find it. 11/22/21 10:12 AM – During an interview, E19 (LPN) stated that initially F2 (POA) said R2	**3225.13.2.3** A. Resident R2 service agreement has been reviewed/updated to reflect food (lactose) intolerance. B. All residents who have food allergies/intolerances have the potential to be affected. A focused review of service agreements for all current residents was completed in order to identify any which lacked required information related to diet restrictions with corrective action taken if necessary. C. System for communication and documentation for residents diet restrictions were evaluated. As a result of this evaluation systematic changes were implemented to ensure the appropriate documentation is reflected on Resident Service Agreements. A weekly report is generated by nursing and review of resident's who have identified diet restrictions is conducted by the nursing/culinary team to ensure proper documentation. D. The ED/designee will conduct service agreement audits monthly until compliance 100% is achieved over 3 consecutive evaluations. Finally the ED/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur quarterly as part of the QA monitoring plan. E. Completion Date : 3/01/22

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	should not have cheese, but we found out later from F3 (R2's family) that the resident had a lactose intolerance and E19 completed and sent a Diet Notification to the kitchen. Afterward, the Surveyor verified in the computerized documentation system that a Diet Notification was completed on 11/1/21. R2 should not have been given ice cream due to his lactose intolerance. Findings were reviewed with E1 (ED) and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM and with E1 on 11/30/21 by email at 3:57 PM.	
3225.13.3	**The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** **This requirement is not met as evidenced by:** Based on record review, interview and review of facility documentation, it was determined that, for one (R2) out of three residents investigated on the memory care unit, the facility failed to include the name, address and phone number of R2's personal physician and the psychiatrist at the [name] Center for Memory Care and Geriatric Consultation (E21). Findings include: Review of the record revealed that R2 had two Resident Service Agreements (dated 9/14/21 and 11/1/21) and both were identified as being the initial Service Agreement. The Service Agreements did not include the name, address and phone number of R2's physician(s):	**3225.13.3** A. Resident R2 service agreement has been reviewed/updated to include name, address and phone # of R2's personal physician, psychiatrist and signed by R2's POA. B. All residents have the potential to be affected. A focused review of service agreements for all current residents was completed in order to identify any which lacked required physician information with corrective action taken if necessary. C. The ED reviewed the service agreement completion requirements with the RSD in order to ensure understanding of such requirements. D. The ED/designee will conduct service agreement audits monthly until compliance 100% is achieved over 2 consecutive evaluations. Finally the ED/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency

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	- 9/14/21: The Physician box listed Team Health (contracted physician services for the facility) and the address and phone boxes were blank. E21's information for R2's physician from the Memory Center was not included on the form. - 11/1/21: E18 (NP) was pre-printed in the Physician box, the address section was blank, and a telephone number was pre-printed in the Phone section. E21's name was written in the comment box corresponding with the Behavior section without contact information. 11/19/21 6:20 PM – During a telephone interview, F3 (R2's Family Member) informed the Surveyor that the family preference was to keep E21 involved in R2's care. F3 added that no document was presented to the family to turn over R2's care to another physician. 11/22/21 11:46 AM – During an interview with E2 (RSD) to determine the location of the documentation for selection of the resident's physician, E2 stated she would need to check with the Billing Office. 11/22/21 12:54 PM – During a follow-up interview, E2 informed the Surveyor the family did not have to sign or initial anywhere for physician choice. E2 added, "I do explain that outside providers sometimes are hard to reach."	has been corrected and the audit will occur quarterly as part of the QA monitoring plan. E. Completion Date : 3/01/22
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.**	**3225.13.5** A. Upon Resident R2's return to facility on 11/1/21 his service agreement was reviewed/updated to include strategies/approaches for redirection and de-

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	This requirement is not met as evidenced by: Based on record review, interview, observation of facility video, review of hospital records and other family documentation it was determined that, for one (R2) out of three residents investigated on the memory care unit, the facility failed to ensure the service agreement included strategies proven to be effective for redirecting the resident and the family preference of being called to assist with de-escalation (calming) when R2 became agitated. This resulted in an episode of behavior escalation and a hospital admission. Findings include: Review of the record revealed R2 had two Resident Service Agreements (dated 9/14/21 and 11/1/21) and were both identified as being the initial Service Agreement. Neither Service Agreement included strategies proven to be effective for redirecting R2 nor the family's preference to be notified anytime of the day or night to assist with redirecting and de-escalating R2 since the family lived five minutes away from the facility. 10/13/21 – Nursing Progress Notes from evening and night shifts documented that R2 "Came out of room claiming that his room was on fire and that he needed to leave the facility immediately or he would burn up. He started yelling, attempted to open other resident's rooms, became combative and agitated. Many attempts of calming down, redirecting and reassurance did not help or stop his need to leave or beliefs of a fire occurring. The nurse had to be called and it was observed that [R2] only responded	escalation of behaviors. The service agreement was reviewed with R2's POA. Subsequently, an additional review was conducted in order to evaluate any required updates. B. All residents have the potential to be affected. A focused review of service agreements for all current residents was completed in order to identify any which lacked required strategies for required intervention/approaches information with corrective action taken if necessary. C. The ED reviewed the service agreement completion requirements with the RSD in order to ensure understanding of such requirements. D. The ED/designee will conduct service agreement audits monthly until compliance 100% is achieved over 2 consecutive evaluations. Finally the ED/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur quarterly as part of the QA monitoring plan. E. Completion Date : 3/01/22

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	to a male rather than the female (staff). " There was no evidence that nursing utilized the family to help de-escalate R2's behaviors. 10/14/21 4:06 PM – A Progress Note included that R2 "Was refusing care and was increasingly agitated towards CNA. She asked if he needs assistance down to breakfast and he had his fist balled up and very angry. There were multiple attempts by the nurse and the Care Partners to redirect resident, but he was not cooperative. Other residents were anxious and scared. Called [F2] POA made him aware, and he came to assist with his dad. Son able to calm him down and redirected him." 10/14/21 10:32 PM – A Progress Note included that F3 was "In the facility, informed this nurse to Hold the Seroquel order until [E18] NP speaks with [E21 Psychiatrist at the Memory Center]." E18 was given the information this morning by E2 (RSD). 10/18/21 3:31 PM – A Progress Note documented that "NP [E18] reached out to the [E21] and left message. The Doctor has not returned her call to discuss care plan and tx (treatment) for resident." 10/19/21 5:07 PM – E2's (RSD) note included, "Spoke to Psych doctor [E21] who recommended Lexapro (antidepressant)... Consulted with [NP] received ok to start Lexapro [dose] in am (morning). Also, ab (sic lab – blood test) for b12 (vitamin B12) and vit d (vitamin D) to be drawn on Thursday 10/21/21." 10/20/21 6:00 AM – E6's (LPN) progress note	

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	documented, "Resident at around 0545 (5:45 AM) came out his room and started getting aggressive, become combative and started wandering into other resident's rooms. Staff attempted to redirect resident however he started becoming even more agitated and aggressive with staff. Resident did confront other residents in the process he was only agitated and aggressive towards staff ... staff were not able to redirect. 911 was called ... [E18] was notified and [F2] POA. Resident was physically aggressive with paramedics ... and barricaded the apartment door [of the room belonging to another resident] with a small nightstand. The son arrived after the paramedic team attempted to engage the resident, but the resident started punching him as he attempted to restraint (sic) his hands. [F3] arrived (and) was present to witness the aggression. Resident was medicated with injectable medications by paramedics... was finally able to settle down and was assisted to the stretcher, buckled in an (sic) transported to [name of hospital emergency department] for further evaluation and treatment." 10/20/21 2:59 PM – A Psychiatry Consult Note completed in the Emergency Department included, "Since going to the care unit, his behaviors were reported as agitated. Curiously, he had a (very) comprehensive consultation at [name] Memory Center with E18 (NP) I reviewed the consultation, including the recommendations." 10/20/21 3:13 PM – The hospital History and Physical documented that R2 required thorough encouraging and instructions, however, usually responds well to them. [R2] reportedly was aggressive and screaming that "This is my	

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	room. Staff felt threatened to the patient's severe agitation and he required [name of two sedating medications]. Patient subsequently became lethargic (extremely sleepy) ... had to initiate [name of manual equipment to get air into the lungs]." 10/29/21 6:50 AM – A hospital Nursing Note included that R2 stated he did not know where he was or how he got there. Talking about being "tied down, beat up, gagged. [R2] is not violet (sic), but confused and restless...willing to take [medication] to help calm him." 11/22/21 10:12 AM – During an interview, E19 (LPN) stated that the resident (SS2) where R2 had been barricaded, slept and did not awaken. The facility failed to contact F2 (R2's POA) to assist with redirection and de-escalation prior to calling 911 on 10/20/21. 11/19/21 6:20 PM – During a telephone interview and review of family documentation of the events, F3 (R2's Family) stated the family repeatedly told nursing staff, including the Nursing Supervisor, that the family lived within five minutes of the facility and were willing to help with grooming or redirection while R2 adjusted to the new living arrangement. F3 said the family informed staff on more than one occasion of ways that had been effective for redirecting R2 which included not asking questions like, "Do you want to eat?" as R2 did not understand and it could lead to frustration. R2 did well with providing reminders and demonstrating what it was that he should be doing. F3 added that the family requested a care plan meeting with E2 (RSD) to review how the facili-	

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	ty could support R2's adjustment to the facility. F3 said the meeting to develop an individualized care plan was rejected since that type of meeting was "not done until after 30 days." F3 stated the family confirmed with E21 (Psychiatrist at the Memory Center) on 10/18/21 that he nor his team received a call or message from the facility. F3 explained that the family facilitated a telephone conversation between E21 and E2 (RSD) on 10/19/21 (prior to the 911 incident on 10/20/21). F3 informed the Surveyor that E21 let the family know that the facility was fearful of R2's aggressive behavior and that E21 discussed behavioral interventions that would be helpful for the facility with E2. F3 added that the day before 911 was called, E2 informed the family that R2 "may need to be admitted to [name of a psychiatric hospital] for stabilization" although R2 was calm at the time and redirectable. F2 expressed that the family thought the 911 call and subsequent hospitalization could have been avoided if the facility had called the family to help deescalate R2 or contacted E21 when initially requested on 10/14/21 so the medication E21 wanted to be ordered could be started. The approaches stated by the family were not included in the Service Agreement. 11/22/21 9:40 AM – During an interview, E11 (Memory Care Director) identified how residents with dementia best respond to redirection. E11 stated the interactions should include positive statements, like "Let's go over here, instead of get out of there." E11 added that these concepts are reviewed in a special class and E11 reinforced it daily with staff on the unit.	

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	11/22/21 11:38 AM – The Surveyor called E18 (NP) to determine which phone number was used to contact E21 and when the contact(s) were made. The Surveyor left a message with a return telephone number. E18 never returned the phone call as of 12/1/21. 11/22/21 1:48 PM - 214 PM – During an observational interview to review the 10/20/21 video with E1 (ED) at his computer, R2 was seen entering SS2's room (Room 155). Several staff looked like they were verbally encouraging R2 to leave the room. Due to no sound on the video, it was not possible to hear what the staff said. R2 would briefly walk out of the room, then return inside the room and close the door. At one point, R2 exited the room while swatting with his hands and chasing staff. E1 stated that "Entering other rooms is commonplace in memory care." The Surveyor explained that R2's Service Agreement was not individualized to include strategies that worked and what didn't work for R2's redirection and de-escalation. 11/23/21 9:40 AM – During an interview with E1 (ED), the Surveyor reviewed and showed E1 the Progress Notes where E18 (NP) was given E21's (Psychiatrist at the Memory Care Center) number on 10/14/21, however, there was no evidence of calling E21 until 10/18/21. The Surveyor advised E1 that she paged E18 the day before on 11/22/21 and got no response. 11/24/21 8:51 AM – During an interview, E27 (Care Partner) described a 10/16/21 incident when "Female staff were trying to redirect [R2] ... He was becoming hostile to the female staff,	

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	so they called [E6 LPN] ... when their redirection techniques were not working. E6 was able to get R2 out of the room and [R2] seemed calmer ... R2 was in a female's room ... and that's where he became more aggressive." 11/24/21 9:45 AM – During an interview, E7 (Care Partner) reported she was working upstairs and went to the Memory Care unit when called to help. E7 said that R2 would not leave the other resident's room (Room 155). They were unsuccessful in de-escalating R2, so they called E6 (LPN) who was also unsuccessful. R2 became more agitated and aggressive towards E6, so the police were called. These findings were reviewed with E1 (ED) and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM and with E1 on 11/30/21 by email at 3:57 PM.	
3225.16.0	**Staffing**	
3225.16.2	**A staff of persons sufficient in number and adequately trained, certified, or licensed to meet the requirements of residents shall be employed and shall comply with applicable state laws and regulations.** **This requirement is not met as evidenced by:** Based on record review, interview, and review of other facility documentation it was determined that the facility failed to ensure that staff were adequately trained to meet the needs of residents with dementia, specifically in the areas of re-direction and de-escalation. Findings include:	**3225.16.2** A. Staff was provided focused education re: strategies/approaches for redirection and de-escalation of behaviors for R2. B. All residents have the potential to be affected. C. A review of dementia training policies and procedures was conducted. There were no required changes/modifications based on the review. Processes and schedules for required training have been established with attendance tracking implemented. D. The HR Coordinator/designee will oversight

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	Review of training documents provided to the Surveyor by E1 (ED) revealed that less than 30% of direct care staff attended the facility's 5-hour training on dementia, re-direction, and de-escalation: - 7 out of 25 Memory Care employees, 28%. - 10 out of 39 All direct care staff, 25%. Review of the staffing sheet from the night of 10/19/21 through the morning of 10/20/21 when 911 was called after staff were unable to redirect R2 and those who received dementia training found the following staff did not receive this specialized dementia training: - E6 (LPN) hired 8/31/21, not trained. - E31 (LPN) hired 8/31/21, not trained. - E8 (Care Partner) hired 9/7/21, trained on 11/5/21 after the incident. - E31 (Care Partner) hire date unknown, not trained. - E7 (Care Partner) hired 9/7/21 trained 11/5/21, after the incident. - E33 (Care Partner) hired 10/19/21, not trained. 11/19/21 at 6:20 PM - During an interview, F3 (R2's family) expressed concern over the staff's ability to deal with residents with dementia who were agitated and felt that staff were inconsistent. Review of documentation by F3 revealed that on 10/18/21 the family discovered that R2 did not have dinner and staff told family he "declined" dinner. The family reinforced with staff to NOT ask R2 if he wants to eat, but instead prompt him to eat and drink. For example, "Let's go have dinner now." F3 stated that R2 often did not understand questions be-	training attendance and conduct audits monthly until compliance 100% is achieved over 2 consecutive evaluations. Finally the HR Coordinator/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur quarterly as part of the QA monitoring plan. E. Completion Date : 3/01/22

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	ing asked which could lead to frustration and agitation. 11/22/21 9:40 AM – During an interview, E11 (Memory Care Director) identified how residents with dementia best respond to redirection. E11 stated the interactions should include positive statements, like "Let's go over here, instead of get out of there." E11 explained that "A brief review is covered during orientation class, but these concepts got reviewed more in depth during a special 5-hour class." E11 stated she reinforced the need to use positive statements on the unit daily. These findings were reviewed with E1 (ED) and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM and with E1 on 11/30/21 by email at 3:57 PM.	
3225.16.3	**All direct care staff shall be familiar with the service agreement for each resident for whom they provide care.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that, for two (R2 and SS1) out of three residents reviewed on the Memory Care unit, the facility failed to ensure that staff followed the service agreement when the Resident Care Card was inaccurate. Findings include: 1. Review of R2's clinical record revealed: 10/11/21 – R2's Resident Care Card (guide for the Care Partners/aides to know how to care	**3225.16.3** A. Resident R2 and SS1's service agreements and care cards have been reviewed/updated to accurately reflect resident needs and degree of assistance required. B. All residents have the potential to be affected. C. A review of resident service agreements and associated care cards will be completed for all current residents in order to identify any which do not accurately reflect resident needs and degree of assistance required. D. The RSD/designee will conduct service agreement/care card audits monthly until compliance 100% is achieved over 2 consecutive evaluations. Finally the ED/designee will conduct an audit 1 month later. If 100% compli-

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	for the resident) included that R2 needed reminders/cues for dressing and eating; was independent with bathing, toileting, and needed set-up assistance for mouth care. 11/1/21 – The latest Service Agreement included that R2 needed cueing/reminders for bathing, dressing (lay out clothes), eating, dining, oral care, shaving and toileting. The Resident Care Card did not accurately report that R2 needed reminders/cues for bathing, toileting and dressing by laying out clothes. The information for the aides also did not include shaving and that R2 had a lactose intolerance and should not have dairy products like cheese, milk, and ice cream. There was no explanation as to how much help R2 needed for mouth care. 11/19/21 6:20 PM – During a telephone interview, F3 (R2's family) stated that R2 had a lactose intolerance and had informed the facility soon after admission. 11/22/21 9:40 AM – During an interview to review the discrepancy between R2's Service Agreement and the Resident Care Card, E11 (Memory Care Director) was asked how would staff know about food allergies or intolerances. E11 said she thought there was a "Sheet in the kitchen." E11 walked to the kitchen area in the Memory Care unit's dining room and informed the Surveyor she "Could not locate anything." E11 stated, "I understand that the card is not reflecting the resident needs and the degree of assistance needed." E11 added that she would review with E2 (RSD).	ance is achieved, the community will conclude the deficiency has been corrected and the audit will occur quarterly as part of the QA monitoring plan. E. Completion Date : 3/01/22

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	2. Review of SS1's clinical record revealed: 9/23/21 – SS1's Resident Service Agreement completed prior to the 10/3/21 admission included that SS1 needed cues/reminders for bathing, dressing, eating, toileting, oral care, nail care and hair. SS1 needed to be escorted to and from the dining room too. 10/4/21 – SS1 was admitted to the facility to the assisted living section. 10/4/21 – The Resident Care Card did not include that SS1 needed reminders / cues for bathing, nutrition, oral care, and toileting. 11/22/21 9:40 AM – During an interview to review the discrepancy between the Service Agreement and the Resident Care Card for SS2, E11 (Memory Care Director) stated, "I understand that the card is not reflecting the resident needs and the degree of assistance needed." E11 added that she would review with E2 (RSD). Findings were reviewed with E1 (NHA) and E2 on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM.	
3225.17.0 **3225.17.8**	**Environment and Physical Plant** **Hot water at resident bathing and hand-washing facilities shall not exceed 120 degrees Fahrenheit.** **This requirement is not met as evidenced by:** Based on observation and interview it was	**3225.17.8** A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected. C. At the time of survey adjustments were made to the hot water heating system settings in order to maintain hot water temperatures at,

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	determined the facility failed to ensure the water temperature did not exceed 120 degrees Fahrenheit (F) on three out of three floors in the facility, including the Memory Care unit. Findings include: 11/18/21 - During random observations of water temperatures the following temperatures (in degrees Fahrenheit) were discovered in the following sinks: - 9:55 AM: 130.3 - common bathroom on the Memory Care unit. This was confirmed by E11 (Memory Care Director) who said she would contact maintenance. - 10:04 AM: 127.6 - third floor common area. - 10:13 AM: 130.6 - second floor common area sink. - 10:27 AM: 127.9 - Cantwell Pub on the first floor. 11/18/21 11:00 AM – During an interview, E1 (ED) stated he had already been informed about the hot water. E1 said an electrician worked to rewire the water circulator the night before or early this morning. E1 added that the water heater was left off and the water temperature was 80 degrees Fahrenheit this morning. Facility maintenance staff turned the water temperature up for fast heating and then it was turned down. 11/18/21 1:30 PM – During a random observation of the common bathroom the water temperature in the Memory Care unit's bathroom the temperature was down to 121.3 degrees Fahrenheit from 130.3 degrees Fahrenheit earlier. These findings were reviewed with E1 and E2	or below, 120 degrees Fahrenheit. Temperatures were monitored daily during the remainder of the survey in order to ensure compliance with maximum temperatures with weekly checks being conducted/logged on an ongoing basis. D. The ED/designee will conduct hot water log audits weekly until compliance 100% is achieved over 3 consecutive evaluations. Finally the ED/designee will conduct an audit 1 week later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur quarterly as part of the QA monitoring plan. E. Completion Date : 2/15/22

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	(RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM.	
3225.19.0	**Records and Reports**	
3225.19.1	**The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service agreement for each resident.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that the facility failed to ensure that resident records were accurate and complete for four (R2, R7, R8 and SS1) out of nine sampled residents. Findings include: Review of R2's clinical record revealed: 10/11/21 – R2 was admitted to the Memory Care unit. The following required documents were not in R2's electronic record or were incomplete: a. Pneumonia vaccination status. b. COVID-19 vaccination status (although dates were on a separate list provided by the facility). c. Influenza vaccination status. d. History and Physical (H&P) completed prior to admission. 11/19/21 2:14 PM – During an interview with E2 (RSD), E2 provided a copy of the immuniza-	**3225.19.1** A. Resident R2, R6, R7, and SS1 clinical record has been reviewed to ensure accuracy and completeness. B. All residents have the potential to be affected. A focused review of clinical records for all current residents has been initiated in order to identify any were incomplete or had inaccuracies with corrective action taken if necessary. C. The ED reviewed resident record completion documentation requirements with the RSD and Memory Care Director in order to ensure understanding of such requirements. Processes, to include completion/review of resident records were evaluated and modified to ensure compliance. D. The RSD/designee will conduct resident record audits monthly until compliance 100% is achieved over 3 consecutive evaluations. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will be randomly conducted annually to assess continued compliance with review time frames. The results of the audits will be reviewed and reported to the community QA committee. E. Completion Date : 3/01/22

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	tions, but not the H&P. E2 asked if she could email the H&P to the Surveyor. 11/22/21 9:10 AM – During an interview, E2 provided a copy of the H&P. The Surveyor informed E2 that the Influenza Vaccine Consent Form was undated. E2 offered no comment. 11/22/21 after lunch - The Surveyor verified the H&P was scanned into the record on 11/22/21 at 9:16 AM and the immunization documents were scanned on 11/19/21. e. R2's Leveling Tool (dated 11/1/21) was incomplete and the second page was blank. 11/23/21 11:30 AM – During an interview with E2 (RSD) the Surveyor explained that R2's Leveling Tool was incomplete and showed the blank second page. E2 replied with "uh huh" and offered no additional information. f. R2's Elopement Risk Assessment did not include his diagnosis of dementia. g. R2's Resident History and Personal Preferences Survey was undated and failed to include the move in date, name of staff completing the survey, and multiple questions were unanswered. 11/22/21 9:40 AM – During an interview, E11 (Memory Care Director) said, "I have been talking to [F2] (R2's POA) and [F3] (Family) and have to add more information." 2. Review of SS1's clinical record revealed inaccurate documents:	

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	a. 9/23/21 - SS1's Leveling Tool for Wandering or Elopement Risk was inaccurate and was updated after the resident's move to the Memory Care unit. 11/23/21 11:30AM - During an interview, E2 (DON) confirmed this finding. b. SS1's Resident History and Personal Preferences Survey was undated and failed to include the move in date, name of staff completing the survey, and at least ten questions were unanswered. 3. Review of R6's clinical record revealed: 10/19/21 - R6 was admitted to the facility with dementia. 10/19/21 - R6's physician orders were signed as reviewed by E19 (LPN). 10/20/21, 11/11/21, 11/12/21 and 11/15/21- The Physician Order Sheet (POS) for R6's medications were signed by E18 (NP), but were undated. 11/23/21 8:53 AM – During an interview, E1 (ED) confirmed the POS was signed, but not dated. 4. Review of R7's clinical record revealed: 10/11/21 - R7 was admitted to the facility with diabetes and kidney failure. a. 10/11/21- R7's Self-Administration of Medications Assessment (administering your own medications rather than the nurse or medica-	

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	tion technician) was not signed or dated by the Wellness Nurse. 11/23/21 11:29 AM - E2 confirmed R7's Self-Administration of Medications Assessment was not signed or dated. b. 10/11/21 – R7's original medication orders signed by R7's outside physician were not in the electronic record nor was the Physician Order Sheet (POS) from admission to the facility. 11/23/21 10:53 AM – During an interview, E2 (RSD) provided the Surveyor with R7's original medication orders signed 10/5/21 by the outside provider. When first asked, E2 could not find R7's initial POS from admission. E2 said that she would call the pharmacy for them to sendt and added, "It (the orders) must have been shredded." Review of the 10/11/21 POS provided by the pharmacy revealed that E18 (NP) had signed but did not date the orders. 11/23/21 11:29 AM - E2 confirmed that E7's 10/11/21 POS was not signed and dated by nursing until 11/20/21 (41 days after admission) during the current survey. c. 10/4/21 and 11/11/21 – R7's admission (10/4/21) and 30-day Service Agreement documented that R7 was both independent and required assistance for medication administration and that the LLAM (Medication Technician) or the Nurse were to provide R7's medications. This documentation contradicted R7's Self-Administration Form and R7's UAI. 11/22/21 1:30 PM - During an interview, E19	

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	(LPN) stated that the facility used binders to retain documents that needed to be scanned into the resident's records, but she had been too busy to do it most days, so scanning documents had gotten behind. 11/23/21 12:38 PM – During a follow-up interview, E19 commented that the scanning book had gotten so big that the facility was trying to divide it up to get it done. These findings were reviewed with E1 (ED) and E2 on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM.	
3225.19.4	**In cases in which facilities have created the option for an individual's record to be maintained by computer, rather than hard copy, electronic signatures shall be acceptable. In cases when such attestation is done on computer records, safeguards to prevent unauthorized access and reconstruction of information must be in place. The following is an example of how such a system may be set up:**	**3225.19.4** A. Resident SS2, SS1 and R2 clinical record have been reviewed. It was determined that no corrective actions could be made. B. All residents have the potential to be affected. C. A focused review of clinical records for all current residents has been initiated in order to identify any issues related to documentation structure with corrective action as warranted. ED RSD have met with EMR provider to review findings related to electronic documentation, modification capabilities/safeguards and update tracking to ensure accuracy and completeness. EMR provider to provide additional training for ED, RSD and identified staff. Policies and Procedures to be reviewed and modified if warranted. D. The RSD/designee will conduct resident record audits weekly until compliance 100% is achieved over 3 consecutive evaluations. Fi-
3225.19.4.1	**There is a written policy, at the assisted living facility, describing the attestation policy(ies) force at the facility;**	
3225.19.4.2	**The computer has built-in safeguards to minimize the possibility of fraud;**	
3225.19.4.3	**Each person responsible for an attestation has an individualized identifier;**	
3225.19.4.4	**The date and time is recorded from the computer's internal clock at the time of entry;**	

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3225.19.4.5 **3225.19.4.6**	**An entry is not to be changed after it has been recorded; and** **The computer program controls what sections/ areas any individual can access / enter data based on the individual's personal identifier.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that the facility's documentation software did not contain the safeguards necessary to prevent the reconstruction of information and fraud. Findings include: 1. Review of SS2's clinical record revealed: 10/20/21 - Review of printed Progress Notes found the description of the incident when R2 barricaded himself in SS2's room. The Surveyor, by chance, hovered the mouse cursor on the 10/20/21 date and a black box popped up showing that the note was actually written on 11/3/21 at 2:04 PM. The actual date/time the note was written was not visible on the printed notes. 11/23/21 9:23 AM – During an interview, E1 (ED) confirmed that E2's (RSD) note in SS1's record about the 10/20/21 incident was not written until 11/3/21. The Surveyor stated that this did not meet the regulation of not being able to reconstruct information since it should show tracking of the electronic documentation. E1 said he would check with the software	nally the RSD/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will occur quarterly as part of the QA monitoring plan. E. Completion Date : 2/15/22

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	company. 2. Review of R2's clinical record revealed: Cross Refer 19.1, Example 1e. a. 11/18/21 - R2's Leveling Tool for Wandering or Elopement Risk was blank on the second page when reviewed by the Surveyor. The documentation software showed that E2 completed the document on 11/20/21. However, the 11/1/21 completion date on the form remained unchanged on the printed copy without the ability to see the date, time and who made edits. b. Review of printed Progress Notes revealed the 10/20/21 note about the incident was created by E6 (LPN) and updated by someone else. 10/20/21 6:00 AM – When hovering the mouse cursor over the date of the incident tracker Progress Note it showed the note was created on 10/20/21 at 9:42 AM and was updated 11/8/21 at 10:52 AM. 11/22/21 9:50 AM - During an interview with E11 (Memory Care Director), when asked if she wrote notes in the chart, E11 said "No." The Surveyor explained about wanting to check to see if the original 10/20/21 note was still available. E11 stated, "I heard about that." 11/22/21 10:12 AM – During an interview with E19 (LPN) to review how to edit notes, E19 said she would delete the original and cut and paste it into a new document in order to change. E19 was not sure about editing words. 11/23/21 9:23 AM – During an interview with	

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	E1 (ED) to review why his name was listed under the update column, E1 thought it was that he was signing to acknowledge the note since it was an "Incident Tracking" note. E1 denied editing the note. 11/23/21 10:54 AM - During an interview, E2 (RSD) showed the Surveyor how to see revised notes on her computer using the 10/20/21 note as an example. E2 gave the Surveyor a printout of the 10/20/21 note that showed E6 initially wrote "...and started getting really aggressive, become... "Review of the edits found on 11/8/21 at 10:52 AM revealed that E1 changed the beginning of E6's note to "... and started yelling showing aggression, become ...". The revision written by E1 was what was visible in the record and when printing notes. c. 12/1/21 - Review of documents faxed by E1 to the Surveyor revealed the 11/1/21 Service Agreement now had the POA's electronic signature in the signature box next to the 10/11/12 reviewed date. There was no evidence on the document as to when and who added the electronic signature as the copy saved by the Surveyor on 11/18/21 did not include any signature in that box on the form. These findings were reviewed with E1 (ED) and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM and with E1 on 12/5/21.	
3102	**Long Term Care Transfer, Discharge and Readmission Procedures**	

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3.3	Notice before transfer. Before a facility transfers or discharges a resident, the facility must—	
3.3.1	Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.	
3.3.2	Provide a copy of the notice to the Division; the State LTC ombudsman; the resident's Delaware Medicaid managed care organization (MCO), if any; any DHSS agency involved in the resident's placement in the facility, including APS; and the protection and advocacy agency as defined in Title 16 Del.C. §1102 if the resident is an individual with a developmental disability or mental illness.	
3.3.3	Record the reasons in the resident's clinical record; and	
3.3.4	Include in the notice the items described in paragraph 3.5 of this section.	
3.4	Timing of the notice.	3102.3.4.1
3.4.1	Except as specified in paragraphs 3.4.2 and 3.8 of this section, the notice of transfer or discharge required under paragraph 3.3 of this section must be made by the facility at least 30 days before the resident is transferred or discharged. This requirement is not met as evidenced by:	A. Resident R2 returned to the community on 11/1/21 where he continues to reside. B. All residents who may be discharged have the potential to be affected. C. A review of clinical records for all current residents who have been hospitalized and/or discharged has been conducted. There were no findings based on the review. A review of applicable policies and procedures was conduct-

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	Based on record review, interview, review of hospital records and review of the State Agency complaint system, it was determined that, for one (R2) out of three residents reviewed on the Memory Care unit, the facility failed to provide a discharge notice when the facility refused to accept R2's return when cleared by the hospital for discharge. Findings include: 6/1/21 – The facility document entitled Alzheimer's Disease or Related Disorders Special Care Unit or Program Disclosure Form included, "A Resident may be discharged from (the facility) if his/her needs have exceeded the amount of care to be provided by or managed by this community. Residents with acute medical conditions which require more than intermittent nursing care will be re-assessed for the suitability of their continued residency at this community. The staff providing direct resident care and their family members are often the first resource for input on the resident's adjustment into the community. We welcome all concerns and provide prompt response where possible. Family members are invited to call the nursing department on a regular basis to follow up on the resident's condition and any new changes in care or medication administration." Cross Refer 13.5, 16.2 and 19.4, Example 2. Review of R2's clinical record revealed: 10/11/21 – R2 was admitted to the Memory Care unit in the AL (Assisted Living) facility with a diagnosis of Alzheimer's Disease, a type of dementia. 10/20/21 6:00 AM – A facility Nursing Progress	ed with no required changes identified. A system has been implemented ensure proper decision making and communication processes are in place in order to meet the notice of transfer or discharge requirement. D. The ED/designee will conduct audits monthly until compliance 100% is achieved over 3 consecutive evaluations. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and the audit will be randomly conducted annually to assess continued compliance with transfer and discharge notice requirements. The results of the audits will be reviewed and reported to the community QA committee. Cross Refer 13.5, 16.2, and 19.4 Example 2. E. Completion Date : 3/01/22

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	Note documented, "At around 0545 (5:45 AM) [R2] came out his room and started yelling showing aggression, become (sic) combative and started wandering into other resident's rooms. Staff attempted to redirect resident however he started becoming even more agitated and aggressive with staff and barricaded himself in SS2's room. Staff called 911. E18 (NP) and F2 (POA) were notified. The paramedics entered the room and gave R2 two sedating injectable medications. After the drugs took effect, R2 was assisted onto the stretcher, buckled in, and transported to the emergency department." 10/22/21 1:12 PM - The Hospital Psychiatry Progress Note included that R2 "Is responding well to initial pharmacological (medication) management of agitation. I think the current regimen is very appropriate for him to go back to the memory care unit with, exactly as written. We have no further recommendations. He is cleared from a psychiatric standpoint to go back to the facility. He does not need inpatient psychiatric care." Hospital Discharge Planning notes documented multiple attempts to discharge R2 back to Meadowcrest: - 10/20/21 10:20 AM: Initial discharge plan "... within 48 hours...". - 10/20/21 10:25 AM: "The case manager spoke with F3 (R2's family) at bedside and [R2] from Meadowcrest in [Town] but is unable to return to facility per their (facility) request due to behavioral issues."	

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	- 10/21/21 10:24 AM: "Family waiting on final determination from Meadowcrest if patient will be allowed to return, otherwise family consented to referral to [Another AL Facility]." - 10/22/21 4:10 PM: "Received call back from [E23 Facility Nurse] who reported that they are not planning for pt (patient) to return and they will not accept d/c (discharge) at this time." - 10/25/21 3:09 PM (three days after R2's hospital clearance for discharge): F2 (R2's POA) "Requesting follow up with [E1 ED] at MeadowCrest assisted living (to see if the AL changed their mind and would accept R2 back to the facility) ... [E1] was not available ... left call back info (information)." - 10/26/21 9:54 AM (four days after R2's hospital clearance for discharge): "Received voicemail from [E1] ... called back, staff stated he was in a meeting ... left message requesting call back and fax number for clinicals (clinical documents)." - 10/26/21 12:58 PM: "Received call back from [E1] ... would like to review clinical documents to determine if it was safe for patient to return ... documents faxed." - 10/27/21 10:25 AM (five days after R2's hospital clearance for discharge): "Placed call to Meadowcrest to discuss plan with [E1] ... was in morning meetings ... voicemail message left requesting call back." - 10/27/21 1:50 PM: "Spoke with [E1] and faxed additional nursing notes as requested and also provided the rationale for 1:1 sitter is for elopement purposes since patient has dementia and likes to walk ... [E1] stated he will meet	

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	with DON this afternoon to discuss further." - 10/28/21 2:01 PM (six days after R2's hospital clearance for discharge): "Called MeadowCrest and spoke with [E1]. They are requesting to speak with primary RN to discuss behaviors and sitter ... will provide RN with contact info for Meadowcrest. [E1] is also requesting nursing notes from yesterday and today ... faxed Progress Notes from 10/26 & (and) 10/27...DC (discharge) plan pending acceptance." - 10/28/21 3:35 PM: "Faxed most recent Psych (Psychiatric) note to MeadowCrest." - 10/29/21 11:22 AM (six days after R2's hospital clearance for discharge): "Spoke with [E1] to request a family meeting. He is agreeable and will speak with his DON (E2 RSD) to determine when they are available...left voice mail for [F3] to discuss." - 10/29/21 4:18 PM: "Family meeting held ... it was decided that [R2] is able to return on Monday as the facility currently has a covid outbreak. The facility is requesting that the pt's family be at the facility when the pt returns and they are not cleared for visitors until monday 11/1. The family is agreeable. They (facility) also requested that there be a meeting to discuss pt needs and transition when they arrive. All are in agreement. Facility requesting a 1:30 (PM) pick up on monday 11/1/21. All are in agreement." - 11/1/21 10:15 AM: "Attempted to call Meadowcrest ... told to call back at 12:30 PM when their management is available."	

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	- 11/1/21 10:27 AM: "Spoke with [F3 Family and F2 POA] ... both confirmed that the plan as discussed with Meadowcrest was for [R2] to be discharged back to Meadowcrest today ... [F2] reports he will provide transport to Meadowcrest. - 11/1/21 12:40 PM: "Spoke with [E2] ... confirming pt is discharging to their facility ... requested progress notes, copies of hard scripts (Prescriptions) and D/C summary be faxed ... Nurse to nurse (report given by hospital nurse to facility nurse) can be called to [phone number] Review of faxes sent by the hospital to E1 (ED) revealed: - 10/26/21 1:14 PM: 27 pages including the current medication list and MAR (Medication Administration Record), History and Physical and Psychiatry Consultation from 10/20, Rehab assessment from 10/21, Provider Note and Nursing Note from 10/25. The MAR showed R2 received an oral medication on 10/22/21 at 1:29 PM for severe agitation and a different oral medication on 10/26/21 at 11:17 AM for mild agitation. - 10/27/21 1:57 PM: 3 pages with three Nursing Notes from October 20, 22 and 27. - 10/28/21 2:16 PM: 5 pages with one Nursing Note and two Provider Notes from October 27. 10/27/21 2:25 PM – A hospital Provider Note included to "Continue sitter for now as he is high elopement risk and attempted to leave the floor multiple times this admission without sit-	

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	ter present." 10/28/21 10:00 AM – The State Agency received a complaint that R2 had been ready for discharge since 10/21/21 and the facility was not accepting him back. 11/1/21 – R2 returned to the facility 12 days after he was cleared for discharge from the hospital. 11/3/21 11:11 AM – A State Agency investigator emailed E2 (RSD), after speaking to both E1 (ED) and E2 on the phone and requested documents. 11/3/21 – A certified letter was sent to R2's family giving them a 30-day Discharge Notice and that R2 would be discharged on 12/3/21 at 1:00 PM. The reason for the discharge was R2's behavior was "Detrimental to the physical, mental or economic safety of self, other residents or staff." R2's "Care and service needs exceeded what the community can provide." The 30-day Discharge Notice should have been provided when R2 was cleared for discharge on 10/21/21 and the facility was not planning for R2 to return. 11/18/21 2:06 PM – During an interview, E1 (ED) explained that the "Incident that occurred over the weekend was not as bad as staff made it out to be.... [E1] got the info third hand." E1 stated that the family thought that the facility was trying to get R2 out when staff informed them of the behavior. "We were not trying to get him out." R2 was in SS1's room (Room 163) and SS1 was walking around naked.	

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	11/19/21 6:20 PM – During a telephone interview and review of notes kept by R2's family member, F3 indicated when R2 was being taken out of the facility by the ambulance medics and police, E2 (RSD) told the family that R2 "Cannot come back today." F3 added that the day before (10/19/21), E2 informed the family that R2 might have to "be sent out to [Name of Acute Psychiatric Hospital] for stabilization." F3 added that E2 did not have a response when F3 pointed out that R2 appeared calm, was redirectable and was not committable. F3 added that after R2 was cleared for discharge, E11 (Memory Care Director) called the family on 10/21/21 and stated she was waiting on a decision by the clinical team to decide if R2 could return. F3 stated that she felt like the facility was not going to take him back. 11/23/21 9:23 AM – During an interview, E1 (ED) explained that when he informed F2 (POA) that R2 was found in SS1's room again this past weekend (11/21/21) it was "Just so he [F2] was aware." E1 added that F2 told him that R2 did not like to be alone. E1 stated he was offsite on October 27 and was on vacation October 28-29, but was in town and available. E1 said that E2 (RSD) was off October 29 - November 1. E1 added that "It was hard to get information from the hospital" which delayed R2's return. 11/24/21 11:00 – During an interview, E22 (Hospital SW) said R2 was ready to return to the facility on 10/21/21 and she left multiple messages with E1 and E2 and "They were not responding" to her calls. She said she was playing phone tag with them. E22 added that R2 was not appropriate to stay in acute care be-	

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	yond 10/21/21 and felt the facility was dumping the resident there and didn't want to take him back. The only calls from the facility to the hospital were in response to the hospital initiating the contact Findings were reviewed with E1 (NHA) and E2 (RSD) on 11/23/21 at the initial Exit Conference, beginning at 2:30 PM and with E1 on 11/30/21 by email at 3:57 PM.	

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

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