DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
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STATE SURVEY REPORT

NAME OF FACILITY: Paramount Senior Living at Newark

DATE SURVEY COMPLETED: September 20, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Complaint Survey was conducted at this facility from September 13, 2023, through September 20, 2023. The deficiencies contained in this report are based on interview, record review, observation, and review of other facility documentation, as indicated. The survey sample totaled nine reviewed residents. Abbreviations/definitions used in this state report are as follows: ADON – Assistant Director of Nursing; Basaglar – long-acting basal insulin used to control high blood sugar; CNA – Certified Nursing Assistant; Dementia - the loss of cognitive functioning – thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities; DON – Director of Nursing; ED – Executive Director; Lantus – long-acting insulin used to treat high blood sugar; Levemir – long-acting insulin used to treat high blood sugar; MD – Medical Doctor; Medication Administration Record (MAR) – list of daily medications to be administered; Novolog Insulin – a rapid-acting insulin used to lower blood sugar/ glucose; RCA – Resident Care Assistant; Service Agreement – allows both parties involved (the resident and the assisted living facility to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care and supervision services; UAI (Uniform Assessment Instrument) – a document setting forth standardized criteria developed by the Division to assess each		

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	resident's functional, cognitive, physical, medical, and psychosocial needs and status.		
3225.0	**Assisted Living Facilities**	1) All 5 residents on insulin have been assessed with no current ill effects with historical blood sugars in line with their past experiences. 2) No other residents were potentially impacted. 3) Moving forward, we are implementing a plan to have a Med Tech on each wing of the building with the nurse(s) functioning as wellness nurses. a. The nurse on shift will review the blood sugar results for each Insulin dependent resident taken by the Med Tech b. If insulin is to be given the nurse will provide the injection. i. The Med Tech will log out of the medication pass ii. The nurse willing into the medication pass iii. The nurse will follow the proper process for medication administration, administer the insulin injection and sign off on the administration iv. The nurse will log out of the medication pass	11.17.23
3225.8.8	**Medication Management**		
3225.8.8.2	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;** Based on record review and review of other facility documentation, it was determined that for five (R1, R2, R3, R4 and R5) out of five residents reviewed, the facility failed to administer insulin as ordered by the physician causing a significant medication error. Findings include: 1. R1's July 2023 MAR lacked evidence that the following two doses of insulin were administered by a licensed nurse: - Novolog insulin flex pen 12 units on 7/10/23 at 5:00 PM (at dinner); and - Basaglar (insulin) 30 units on 7/10/23 at 9:00 PM (bedtime). 2. R2's July 2023 MAR lacked evidence that Levemir (insulin) flex pen was administered on 7/10/23 at 8:00 PM by a licensed nurse. 3. R3's July 2023 MAR lacked evidence that Basaglar insulin 24 units was administered on 7/10/23 at 8:00 PM by a licensed nurse. 4. R4's July 2023 MAR lacked evidence that Lantus insulin pen was administered on 7/10/23 at 8:00 PM by a licensed nurse.		

Provider's Signature Paul Taylor MBA, NHA Title Executive Director Date 10.31.23

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	Additionally, R4's August 2023 MAR indicated an unqualified staff person, E4 (Med Tech), administered Lantus (insulin). 5. R5's July 2023 MAR lacked evidence that Lantus insulin 15 units was administered on 7/10/23 at 8:00 PM (bedtime) by a licensed nurse. Additionally, R5's August 2023 MAR revealed that the 8/14/23 8:00 PM (bedtime) dose of Lantus insulin 15 units was administered by an unqualified staff person, E6 (Med Tech). 9/14/23 at 3:16 PM – During an interview, E2 (DON) confirmed a licensed nurse was scheduled for 3:00 PM to 11:00 PM on 7/10/23 and that nurse called off. E2 confirmed there was no licensed nurse in the facility to administer the residents' insulin. E2 also confirmed that Med Techs are not permitted to administer insulin. 9/20/23 at 1:55PM – Findings were reviewed with E1 (ED), E2 (DON), and E3 (ADON) during exit conference.	v. The med tech will log back into the medication pass in order to complete the remaining medications **Title(s): DON and ADON** 4) Blood sugar and insulin injections will be reviewed each morning during morning meeting in order to assure all insulin dependent resident injections and blood sugar results have been recorded accurately until 100% compliance is met. **Title: ED**	
3225.11.0 **3225.11.5**	**Resident Assessments** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** This requirement was not met as evidenced by:	1) R2, R3, R6 and R8 appropriate UAI's complete, signed, dated and on file. 2) All current resident UAI's on file within resident chart signed and dated 3) UAI's continue to be completed and documented by the DON or RN Designee for	11.17.23

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	Based on record review and review of other facility documentation, it was determined that for five (R2, R3, R6, R8 and R9) out of six residents reviewed for resident assessments, the facility failed to complete the initial and annual UAI(s). Findings include: 1. 4/20/22 - R2 was admitted to the facility. As of 9/20/23, the facility lacked evidence that an annual UAI was completed for 2023. 2. 6/28/19 – R3 was admitted to the facility. As of 9/20/23, the facility lacked evidence that an annual UAI was completed for 2022 and 2023. 3. 7/25/23 – R6 was admitted to the facility. The facility lacked evidence of an initial UAI assessment for R6. 4. 7/2/18 – R8 was admitted to the facility. The facility lacked evidence of a completed annual UAI assessment for R8 for 2023. 5. 8/31/22 – R9 admitted to the facility. Record review revealed that R9 was transferred to the hospital on 4/2/23 via EMS. The facility lacked evidence of a completed Significant Change UAI for R9. As of 9/13/23, it was still classified as "in progress." 9/20/23 1:55 PM - Findings were reviewed with E1 (ED), E2 (DON), and E3 (ADON) during exit conference.	Initial, 30-day, annual and/or significant change. **Title: RCM** 4) UAI reviewed for residents utilizing due date tracker until 100% compliance is reached. **Title: ED**	
3225.13.0 **3225.13.1**	**Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed to**	1) Residents R2, R3, and R8 Service Agreements reviewed for completion and review	11.17.23

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3225.13.6	**or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and facility shall sign the agreement, and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.** **The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction wit each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** This requirement was not met as evidenced by: Based on interview and record review, it was determined that for three (R2, R3 and R8) out of seven residents reviewed for timely completion of a Service Agreement, the facility failed to update these residents' Service Agreement in conjunction with the annual UAI. Findings include: 1. 3/30/2011 - R2 was admitted to the facility. The facility lacked evidence that an annual Service Plan was completed for 2023. 2. 6/28/19 – R3 was admitted to the facility. The facility lacked evidence that an annual Service Plan was completed for 2022 and 2023. 3. 7/2/18 – R8 was admitted to the facility.	with resident/POA/Family and signed. 2) Review of all current resident Service Plans for review with resident/POA/family. If no signature present, UAI will be reviewed with resident/PA/family w/service agreement. 3) All residents will be scheduled for their annual service agreement update utilizing the outlook calendar and Point Click Care. Resident/family/POA will be contacted to review/ provide input and sign. **Title: RCM/ARCM** 4) New admission and chart Checklist to be reviewed and signed by ED indicating Service plans present residents and reviewed with resident/POA/family and signed until 100% compliance is achieved. **Title: ED**	

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	7/18/22 – R8's Service Plan was finalized, along with R8's annual UAI. 8/16/23 – R8's UAI was classified as being "in progress." 9/15/23 untimed – The surveyor requested and received R8's most current Service Plan, which was dated 7/22/22. The facility failed to update R8's Service Plan. 9/20/23 1:55 PM - Findings were reviewed with E1 (ED), E2 (DON), and E3 (ADON) during exit conference. **Resident Rights** **Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein.** **Resident's rights.** **(a) It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the residents in long-term care facilities.** **(b) It is declared to be the public policy of this State that the interests of the resident shall be protected by a declaration of a resident's rights, and by requiring that all facilities treat their residents in accordance with such rights, which shall include the following:** **(10) Each resident shall be free from chemical and physical restraints imposed for**		
3225.14.0 **3225.14.1** **§ 1121**		1) In receiving report of the concern with resident R5, records and information reviewed. Employee E4 placed on administrative leave and subsequently terminated. State Reportable Incident submitted. Additionally, family and local authoirities contacted in order to provide information and file a report. State Investigative office contacted to review for any further action to be taken at that time. Additionally, due to a delay in reporting, E5	11.17.23

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	purposes of discipline and convenience, and not necessary to treat the resident's medical condition. Based on interview, observation, and record review, it was determined for one (R5) out of one resident reviewed for resident rights, the facility failed to ensure the resident was free from physical restraints imposed for purposes of convenience. In addition, the facility failed to keep R5 out of involuntary seclusion. Findings include: 10/26/22 – R5 was admitted to the facility. 10/22/22 – R5's initial service plan was completed and revealed that he has dementia and requires moderate supervision. "Provide supervision, cueing, coaching, reminders. Notify MD of changes in mental status, behaviors and wandering." R5 is listed as being alert and oriented only to self. "Reorient due to dementia with confusion." The service plan also revealed that R5 wanders, and this was a "minimal problem" ... "Staff to redirect when wandering, offer support and activity." 9/18/23 approximately 9:20 AM – An interview with E2 (DON), who stated she had a screen shot from the text E4 (RCA) sent to E5 (med tech) on 8/24/23 at 4:17 AM asking E5 to remove the belt from R5's door. E5 responded, "Okay." E2 stated that E4 was being terminated. E5 told E2 of this incident on 9/15/23 and E2 stated she believed E5 was afraid to come forward with a report, resulting in the delay in reporting.	was also placed on administrative leave and subsequently terminated. 2) Staff to be educated on resident rights, specifically #10, and the reporting of abuse/neglect 3) Utilized education will be made part of new employee orientation with special focus on resident rights and the need to report. **Title: BOM/HR** 4) Existing staff roster and new employee records to be reviewed for compliance with training and documented understanding until 100% compliance is met. **Title: ED**	

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	9/18/23 approximately 9:45 AM – An interview conducted with R5, who said he only remembers one time that he could not exit his apartment. He stated this was probably four or five years ago. 9/18/23 approximately 9:50 AM – The surveyor observed what appeared to be damage to the doorway with paint appearing to be rubbed off, along with paint being rubbed off on the handrail next to the door. 9/18/23 approximately 10:15 AM – An interview with E4 (RCA), who stated, "I can't even tell you what happened. No one will tell me anything. I got a call yesterday about what it was, and it broke my heart." E4 further stated that she did not know anything about a belt being tied to R5's door and that the first she heard anything about it was on 9/17/23. E4 confirmed that R5 wanders on the unit. E4 stated that R5 likes to go into the kitchen and get sugar packets, creamers, or things out of the refrigerator although R5 is diabetic. E4 explained that when R5's sugar levels increase, staff "gets yelled at." E4 stated that when R5 heads for the dining room, he needs to be redirected. E4 has asked for door to the dining room to be installed because R5 wanders "every single day." 9/19/23 at 9:45 AM – A telephonic interview conducted with E5 (med tech), who stated she did not just get off work, but that, "They fired me." E5 stated that if R5 tried to leave the room, E4 (RCA) would "force him" to go back. To get R5 to stay in the room, E4 would put a belt around the doorknob and the handrail on the wall. R5's		

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	door would then not open. E5 stated she had "witnessed enough to the point she had to say something." E5 stated that this occurred over five times, but probably not over ten times. E5 stated that E4 is bigger and older than she is, and she was concerned for her safety. E4 stated that E5 was recently removed from the memory care unit due to "aggression with residents." 9/19/23 at 10:13 AM – E1 (ED) confirmed in an email that R5 did not have a psychological evaluation for assessment of behaviors. 9/20/23 at approximately 9:30 AM – E1 (ED) confirmed that both E4 (RCA) and E5 (med tech) were terminated. 9/20/23 1:55 PM - Findings were reviewed with E1 (ED), E2 (DON), and E3 (ADON) during exit conference. **Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients.** **Definitions** **(11) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **c. Failure to carry out a prescribed treatment plan for a patient or resident.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was		
16 Delaware Code, Chapter 11, Sub-Chapter, III **1131**		1) All 5 residents on insulin have been assessed with no current ill effects with historical blood sugars in line with their past experiences. 2) No other residents were potentially impacted. 3) Moving forward, we are implementing a plan to have a Med Tech on each wing of the building with the nurse(s) functioning as wellness nurses. a. The nurse on shift will review the blood sugar results for each Insulin dependent resident taken by the Med Tech b. If insulin is to be given the nurse will provide the injection.	11.17.23

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	determined that the facility failed to have a Registered Nurse (RN) to deliver care from 3:00 PM to 11:00 PM on 7/10/23. Findings include: Cross refer 8.8.2 examples 1, 2, 3, 4, 5 7/10/23 – A facility schedule documented the RN scheduled for 3:00 PM to 11:00 PM called off. 9/14/23 3:16 PM – E2 (DON) confirmed that a nurse was scheduled for 3:00 PM to 11:00 PM on 7/10/23, but that nurse was a call off and there were no qualified personnel at the facility to administer insulin. E2 stated that on 7/10/23, she was out of town and the facility did not have an ADON. E2 also confirmed that med techs are not permitted to administer insulin. 9/20/23 at 1:55PM – Findings were reviewed with E1 (ED), E2 (DON), and E3 (ADON) during exit conference.	1. The Med Tech will log out of the medication pass 2. The nurse willing into the medication pass 3. The nurse will follow the proper process for medication administration, administer the insulin injection and sign off on the administration 4. The nurse will log out of the medication pass 5. The med tech will log back into the medication pass in order to complete the remaining medications **Title(s) DON/ADON** 4) Blood sugar and insulin injections will be reviewed each morning during morning meeting in order to assure all insulin dependent resident injections and blood sugar results have been recorded accurately until 100% compliance has been met. **Title: ED**	

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