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.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Rockland Place **DATE SURVEY COMPLETED: March 21, 2023**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE-TION DATE
	REVISED REPORT **Deficiency 3225.10.1 The assisted living facility shall supply a written contract that is precise, easily understood and readable by a resident, and in compliance with all applicable laws. This deficiency was removed on the State report as the Facility submitted the evidence of the signed contracts on May 17, 2023.**		
3225	**Assisted Living Facilities** **Rockland Place Assisted Living** An unannounced Annual and Complaint Survey was conducted at this facility from March 16, 2023 through March 21, 2023. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was sixty-six (66). The survey sample totaled nine (9) residents. Abbreviations/definitions used in this state report are as follows: Alzheimer's - a gradually progressive brain disorder that causes problems with memory, thinking and behavior; Cerebellar Stroke Syndrome – a type of stroke that occurs in the cerebellum which is responsible for coordination and balance; 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; DRC - Director of Resident Care; ED - Executive Director;		

Provider's Signature Jessica A. Gray Title Executive Director Date May 19, 2023

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	EMR – Electronic medical record; Hemiplegia - a condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body; MC – Memory Care; Per Diem - an employment arrangement whereby workers such as nurses are paid a day rate for temporary or on-call work; POA – Power of Attorney; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; RN – Registered Nurse; 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 resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.		
3225.5.0 **3225.5.12**	**General Requirements** **An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or**	**GENERAL REQUIREMENTS**	5/20/2023

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	other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for two (E6 and E7) out of four sampled employee files, the facility lacked evidence of annual training pursuant to the Memory Impaired resident. Findings include: 1. 12/20/18 – E6 was hired and dementia training was completed 12/21/18. The facility lacked evidence of annual training after 12/21/18. 2. 4/17/13 – E7 was hired and the latest dementia training was completed 5/15/19. The facility lacked evidence of annual training after 5/15/19. 3/21/23 at 2:00 PM - Per interview with E1 (ED), E1 stated these employees are per diem and not available for trainings. The Surveyor stated that the two employees	A. **Individual/Resident Impacted** Two individuals were impacted by this deficient practice. The 2 Identified employees (E6) and (E7), have received and completed their mandatory Memory Impaired Training "Managing Behavioral and Psychological Symptoms of Dementia (BPSD), received on May 1, 2023, conducted by the Memory Care Program Director. B. **Identification of other residents/employees with the potential to be affected** The Memory Care Program Director will conduct an audit on all employees, to ensure mandatory annual Dementia training is completed. All staff were educated on "Managing Behavioral and Psychological Symptoms of Dementia (BSPD) on May 1, 2023, conducted by the Memory Care Program Director. C. **System Changes** The facility lacked evidence to ensure all PRN employees completed their annual Dementia Training. The Memory Care Program Director will conduct a quarterly audit to identify any newly hired employees who have not completed their training, in addition to annual training for all employees All new and recently hired employees will be required to attend the	

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	both received other trainings (Abuse, Emergency Preparedness) in late 2022. 3/21/23 - Findings were reviewed with E1, E2 (DRC), E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM.	Watermark specific "NAYA" traiing, conducted by the Regional Program Director or designee. This training will focus on various topics related to the psychological, social, physical and communicative needs of our residents, while understanding the safety aspects associated with resi dents diagnosed with Alzheimers' Disease or other forms of dementia, to include behavioral deficits. This training will provide guidance on knowing when the need for placement in a secured environment becomes necessary. D. **Success Evaluation** The Memory Care Program Director will monitor staff training, weekly, times four weeks, then monthly, until 100% compliance and then re viewed during Quality Assurance meetings.	
3225.7.0 3225.7.1 3225.7.2 3225.7.3 3225.7.3.4 3225.7.3.5 3225.7.3.6	**Specialized Care for Memory Impairment** **Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations herein.** **Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.** **The information disclosed shall explain the additional care that is provided in each of the following areas:** **Assessment, Care Planning & Implementation: the process used for assessment and establishing and updating the service agreement and its implementation,** **Staffing Pl7.35an & Training Policies: staffing plan, orientation, and regular in-service education for specialized care;** **Physical Environment: the physical environment and design features, including security systems, appropriate to support the**	3225.7.0 **Specialized Care/Memory** A. **Individual/Resident Impacted** No residents/individuals were impacted by this deficient practice. The facility has taken immediate corrective action to ensure each category outlined in the deficient practice is in substantial compliance with the state required rules and regulations.	5/20/2023

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	functioning of adults with memory impairment; This requirement was not met as evidenced by: Based on policy review, interview and review of other facility documentation, it was determined that the facility lacked some specific MC policy and procedures pursuant to the Memory Impaired resident. Findings include: 3/21/23 – Facility Policy and Procedure manuals and Resident Agreement packets were reviewed. There was evidence of some specific MC Information, however the above referenced regulations 7.3.4 assessment, care planning and implementation, 7.3.5 staffing plan and training policies of the staff and 7.3.6 the physical environment referencing the security systems were not in evidence. 3/21/23 at 2:00 PM - Per interview with E1 (ED), E10 (Sales Director) and E11 (MC Program Director), E1 and E11 stated these elements of memory care were not included in the preadmission or admission packets. E10 stated she discusses this information when interviewing families prior to admission. E1 also stated they were working on a handbook that would be given to resident families at admission that is specific to the Memory Program information. 3/21/23 - Findings were reviewed with E1, E2 (DRC), E9 (Maintenance Director), E10, E11 and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM.	**B. Identification of other Residents/Family Member(s) with the potential to be affected** The Sales Director/designee, will ensure the "Pathways and Our Place Scope of Services Program" is reviewed with the POA/family at the time of admission. The POA/family will sign the signature page, acknowledging receipt of the Program review. The Sales Director/designee, will conduct a weekly audit on admission records for all current memory care residents (until completed) to ensure the POA/family has signed the signature page, acknowledging their receipt of the Program review. **C. System Changes** The facility did not review the overall program of Memory Care services with the family during the time of admission. The Sales Director will review the community's Pathways and Our Place Scope of Services Program with the POA/family at the time of admission. (Exhibit #1) The POA/family member will sign the acknowledgement page, indicating they have reviewed the Program. (Exhibit #2) **D. Success Evaluation** The Sales Director/designee, will	

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3225.8.0 3225.8.6 3225.8.7	**Medication Management** **Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication.** **The assisted living facility shall ensure that the review required by section 8.6 is documented in the resident's records, including any recommendations given by the reviewer.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for two (R1 and R7) out of two residents sampled, the facility failed to provide evidence of completed resident evaluations for self-administered medications in a timely manner. Findings include: 1. 8/9/21 - R1 was admitted to the facility with a Physician's order written on 8/9/21 and again on 7/5/22 for R1 to self-administer her own medications. R1's record indicated that the RN's onsite assessment to determine the resident's cognitive and physical ability to self-administer medication was only evident on the following dates: 3/22/22, 6/13/22 and 8/22/22. The facility lacked evidence that an assessment for self-administration of medications was	monitor the review of our Pathways and Our Place Scope of Services Program, with a signed acknowledgement of receipt, weekly, times 4 weeks, then monthly, until 100% compliance and then reviewed during Quality Assurance meetings. **3225.8.0 MEDICATION MANAGEMENT** **A. Individual/Resident impacted** Two residents (R1) and (R7) were impacted by this deficient practice (R1) was corrected by the Resident Care Director on 5/1/2023 (R7) is no longer self-administering medications. **B. Identification of other Residents/Family Member(s) with the potential to be affected** All residents have the potential to be impacted by this deficient practice. The Resident Care Director/RN has re-assessed all remaining residents who self-administer medication. The Resident Care Director has obtained physician's orders on 4/27/23 and 5/1/2023, for all residents who self-administer medications.	5/20/2023

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3225.9.0	completed within 30 days of her admission or for one congruent to the UAI completed on 9/9/22. 2. 11/11/22 – R7 was admitted to the facility with a diagnosis of dementia. The Physician's assessment, dated 11/7/22, indicated that R7 was not capable of administering his/her own meds and was not able to determine the right medications. There was no evidence of a Physician's order for R7 to self-administer medications. The UAI, dated 11/10/22, indicated R7 needs set-up and assistance in managing medications. A medical record note on 11/15/22 indicated that the daughter-in-law fills the med-planner every week and R7 needs reminders to take her medication. The UAI, dated 12/11/22, indicated R7 required reminders to take her medication. The facility lacked evidence that an assessment for self-administration of medications was completed within 30 days of R7's admission or of Physician notification. 3/21/23 at 2:00 PM - Per interview with E2 (DRC), E2 confirmed the assessments for R1 and R7's ability to self-administer medications were not in evidence. E2 stated that some records are not current and she plans to review all residents who self-administer medications to ensure compliance. 3/21/23 - Findings were reviewed with E1 (ED), E2, E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM.	The Resident Care Director/RN will assess all residents who self - administer upon admission, 30 days after admission, every 6 months and when there is a significant change in condition. The Resident Care Director/RN will ensure all physician orders are obtained, prior to approval of resident's request to self-administer medication. **C. System Changes** The facility did not ensure that all residents who self-administer received an assessment within 30 days of their UAI and did not obtain a physician's order. The Resident Care Director/RN will audit all new admissions monthly, until 100% compliance is achieved. The Resident Care Director/RN will conduct random quarterly audits to ensure 100% compliance with all residents who self-administer. **D. Success Evaluation** The facility will review all residents who self-administer medications weekly, times 4 weeks, then monthly, until 100% compliance and then reviewed during Quality Assurance meetings.	

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3225.9.5 3225.9.5.2	**Infection Control** **Requirements for tuberculosis and immunizations:** **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 Quanti-Feron. 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 was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for three (E7, E8 and E9) out of five employees surveyed, the facility lacked evidence of a two-step tuberculin test for E7, E8 and E9. Findings include: 1. 7/28/22 – E7 was hired. The first step Tuberculin test was done 7/27/22. The facility lacked evidence of a second step Tuberculin test being administered. 2. 6/2/22 – E8 was hired. The first step Tuberculin test was done 6/7/22. The facility lacked evidence of a second step Tuberculin test being administered.	**3225.9.0 INFECTION CONTROL** **A. Individual/Resident Impacted** Three (3) individuals were impacted by this deficient practice. **B. Identification of other Residents with the potential to be affected** All residents have the potential to be affected by this deficient practice. The Human Resource Director/ designee, will ensure all two-step Tuberculin tests are administered for all new hires. **C. System Changes** The facility did not ensure all new hires received their second step of the Tuberculin test screening. The Human Resource Director will implement a new hire TB checklist. (Exhibit #3) The Human Resource Director will audit all new hires, weekly, or until 100% compliance is achieved. **D. Success Evaluation** The Human Resource Director/de signee, will monitor the Tuberculin two-step checklist, weekly, times 4 weeks, then monthly, until 100% compliance, and then reviewed during Quality Assurance meetings.	5/20/2023

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	3. 7/18/22 – E9 was hired. The first step Tuberculin test was done 7/18/22. The facility lacked evidence of a second step Tuberculin test being administered. 3/21/23 at 2:00 PM – Per discussion with E2 (DRC), two-step testing was waived by the State due to serum shortages and these employees may have fallen within that timeframe. On Surveyor review, these three employees were not within the waived timeframe of the 2-step testing, The memorandum by Order of the Department of Health and Social Services dated 1/18/22 was for 45 days duration. 3/21/23 - Findings were reviewed with E1 (ED), E2, E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM.		
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** This requirement was not met as evidenced by:	**3225.9.7 INFECTION CONTROL** **A. Individual/Resident Impacted** Five residents were impacted by this deficient practice. R1 – Current Resident R2 – Discharged 6/27/22 R5 – Current Resident R6 – Discharged 3/5/23 R7 – Current Resident Ri, R2, R5, R6 and R7 will be offered the Pneumococcal vaccination by May 25, 2023. **B. Identification of other Resident with the potential to be affected** All residents have the potential to be	5/20/2023

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	Based on record review and review of other facility documentation, it was determined that for five (R1, R2, R5, R6 and R7) out of seven residents sampled, the facility failed to provide evidence of the vaccination against pneumococcal pneumonia or a vaccination declination. Findings include: 1. 8/9/21 – R1 was admitted with a diagnosis of hemiplegia. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 2. 12/19/19 – R2 was admitted with a diagnosis of dementia. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 3. 12/30/22 – R5 was admitted with a diagnosis of alcohol dependence with induced dementia. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 4. 1/18/23 - R6 was admitted with a diagnosis of cerebellar stroke syndrome. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 5. 11/11/22 – R7 was admitted with a diagnosis of dementia. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 3/21/23 - Findings were reviewed with E1 (ED), E2 (DRC), E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM. **Contracts**	affected by this deficient practice. All residents will be offered the Pneumococcal Vaccination by May 15, 2023. **C. System Changes** The facility did not ensure that evidence for pneumococcal vaccinations were being offered or declined prior to or upon admission/ re-admission. The Resident Care Director/designee will conduct a monthly audit of all resident admissions and re-admissions for Pneumococcal vaccinations until 100% compliance is achieved. The Resident Care Director/designee will utilize the DELVAX website to verify resident status of pneumococcal vaccination. The Resident Care Director/designee will ensure that the pneumococcal vaccination will be offered to all residents during the facility's annual Flu Vaccine Clinic. **D. Success Evaluation** The facility will review all resident pneumococcal vaccination audits weekly, times 4 weeks, then monthly, until 100% compliance, and then reviewed during Quality Assurance meetings.	
3225.10.0 3225.10.10		**3225.10.1 Contracts** **A. Individual/Resident Impacted**	5/20/2023

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3225.11.0 3225.11.2	**No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for one (R3) out of five residents sampled, the facility obtained a signed contract prior to the service agreement being executed. Findings include: 5/23/17 - R3 was admitted with a diagnosis of Alzheimer's. The initial UAI was not in evidence and the service agreement was signed on 5/25/17. The contract was signed on 5/23/17 prior to the assessment or service agreement being executed. 3/21/23 - Findings were reviewed with E1 (ED), E2 (DRC), E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM. **Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30**	Two residents/individuals were impacted by this deficient practice. R2 – Discharged on 6/27/2022 R5 – Currently resides in assisted Living R6 – Discharged on 3/5/2023 R7 – Currently resides in assisted living **B. Identification of other Residents/Family Member(s) with the potential to be affected** All residents have the potential to be affected by this deficient practice. The facility has taken immediate corrective action to ensure each category outlined in the deficient practice is in substantial compliance with the state required rules and regulations. The Memory Care Program Director will ensure the POA/family member of all current Memory Care residents, will be provided with the facility's Memory Care Scope of Services Contract, that is precise, easily understood and readable by each resident/family member and signed, acknowledging their receipt. **C. System Changes** The facility failed to ensure that a full assessment was completed prior to signing a residency agreement/contract.	

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	days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for four (R1, R2, R3 and R4) out of seven residents sampled, the facility lacked evidence that the pre-admission UAIs were completed or done timely. Findings include: 1. 8/9/21 – R1 was admitted with a diagnosis of hemiplegia. The initial UAI was completed on 8/10/21, one day after the admission date. 2. 12/19/19 – R2 was admitted with a diagnosis of dementia. The initial UAI was completed on 12/20/19, one day after the admission date. 3. 5/23/17 - R3 was admitted with a diagnosis of Alzheimer's. The facility lacked evidence that an initial UAI was completed. 4. 8/10/20 – R4 was admitted with a diagnosis of Alzheimer's. The initial UAI was completed on 8/11/20 which was one day after the admission date. This initial UAI was listed as a significant change in condition assessment. 3/21/23 at 2:00 PM - E2 (DRC) stated that going forward, she plans to use paper UAI forms for the initial UAI collection within 30	The Sales Director/designee, will review the community's Memory Care Scope of Services Contract at the time of admission. (Exhibit #1) The Sales Director/designee, will ensure each POA/family member signs the "Contract" acknowledgement page, indicating their receipt and review of the Memory Care Program Contract. The Sales Director/designee, will conduct a weekly audit on admission records for all current memory care residents (until completed), to ensure the POA/family has signed the signature page, acknowledging their receipt of the Program review. **D. Success Evaluation** The Sales Director/designee, will monitor the review of our Pathways and Our Place Scope of Services Contract with a signed acknowledgement of receipt, weekly, times 4 weeks, until 100% compliance, then monthly, until 100% compliance and then re viewed during Quality Assurance meetings. **3225.11.0 RESIDENT ASSESSMENT/UAI** **A. Individual/Resident Impacted** Four residents (R1, R2, R3 & R4) were impacted by this deficient practice. R2 – Discharged on 6/27/2022	5/20/2023

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3225.11.5	days prior to admission, and once signed by the resident, will upload into the EMR. 3/21/23 - Findings were reviewed with E1 (ED), E2, E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM. **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: Based on record review, interview and review of other facility documentation, it was determined that for four (R2, R3, R4 and R5) out of seven residents sampled, the facility lacked evidence that the 30-day post-admission UAIs were completed. Findings include: 1. 12/19/19 – R2 was admitted with a diagnosis of dementia. The initial UAI was completed on 12/20/19. The facility lacked evidence of the 30-day post admission UAI being completed. 2. 5/23/17 - R3 was admitted with a diagnosis of Alzheimer's. The facility lacked evidence of a 30-day post admission UAI being completed. 3. 8/10/20 – R4 was admitted with a diagnosis of Alzheimer's. The initial UAI was completed on 8/11/20 which was after the	**B. Identification of Other Residents** All residents have the potential to be impacted by this deficient practice. The Resident Care Director/designee, will ensure that all new admissions will receive their UAI prior to admission. **C. System Changes** The facility lacked evidence to ensure the pre-admission UAI was completed or done timely. The Resident Care Director/designee, will audit potential new admis sions, within 48 hours prior to new admission, to ensure UAI is com pleted. **D. Success Evaluation** All new admissions will be audited by the Executive Director monthly, times 4 weeks until 100% compliance, then monthly, until 100% compliance, and then reviewed during Quality Assurance meetings. **3225.11.5 UAI ASSESSMENT** **A. Individual/Resident Impacted** Four residents R1, R2, R3, R4 were impacted by this deficient practice. R2 – Discharged on 6/27/2022	5/20/2023

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3225.13.0 3225.13.1	admission date. The facility lacked evidence of the 30-day post admission UAI being completed. 4. 12/30/22 – R5 was admitted with a diagnosis of alcohol dependence with induced dementia. The initial UAI was completed on 12/16/22. The facility lacked evidence of the 30-day post admission UAI being completed. 3/21/23 at 2:00 PM - Per interview with E2 (DRC), E2 confirmed the assessments were not located. E2 stated that some records are not current or not filed and she plans to review all residents' assessments to ensure compliance. 3/21/23 - Findings were reviewed with E1 (ED), E2, E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM. **Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.** This requirement was not met as evidenced by:	**B. Identification of Other Residents with the potential to be affected** All residents have the potential to be affected by this deficient practice. The Resident Care Director/designee has completed all new admissions and UAIs within the past 30 days. All status post, new admissions have been updated with the 30-day assessment. **C. System Changes** The facility lacked evidence to ensure that the 30-day post UAI was completed. All admissions/UAIs 30-day assessments will be audited by the Resident Care Director/designee, monthly, until 100% compliance is achieved. **D. Success Evaluation** The Executive Director will review the audits for compliance weekly, times 4 weeks, until 100% compliance, then monthly, until 100% compliance, and then reviewed during Quality Assurance meetings. **3225.13.0 SERVICE AGREEMENT** **A. Individual/Resident Impacted** Residents (R1, R3, R4, R5 & R7) were impacted.	5/20/2023

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	Based on record review, interview and review of other facility documentation, it was determined that for five (R1, R3, R4, R5 and R7) out of seven sampled residents, the facility failed to provide evidence that the service agreement was completed in conjunction with the resident/POA. Findings include: 1. 8/9/21 – R1 was admitted with a diagnosis of hemiplegia. The facility lacked evidence that a service plan was completed prior to or on admission. 2. 5/23/17 - R3 was admitted with a diagnosis of Alzheimer's. The initial service agreement was executed on 5/25/17, two days after admission. 6/20/22 - The facility lacked evidence that R3's service agreement was completed in conjunction with the resident or the POA. 3. 8/10/20 – R4 was admitted with a diagnosis of Alzheimer's. The initial service agreement was executed on 8/14/20, four days after admission. 4. 12/30/22 – R5 was admitted with a diagnosis of alcohol dependence with induced dementia. The facility lacked evidence that R5's initial service agreement, dated 1/7/23, eight days after admission was completed or done in conjunction with R5 or the POA. 5. 11/11/22 – R7 was admitted with a diagnosis of dementia. The facility lacked evidence that a completed initial service agreement, dated 11/14/22, three days after admission was completed or done in conjunction with R7 or the POA.	**B. Identification of other residents with the potential to be affected.** All residents have the potential to be affected by this deficient practice. The Resident Care Director/designee will complete all initial service plans and UAIs, prior to admission, in conjunction with the resident/POA. **C. System Changes** The facility lacked additional evidence to ensure that a service plan was completed prior to, or upon admission. The Resident Care Director/designee, will audit all pre-admission UAIs and service plans up to 48 hours or less, prior to admission, monthly, until 100% compliance is achieved. **D. Success Evaluation** 1. The Executive Director will review the audits for compliance weekly, times 4 weeks, until 100% compliance, then monthly, until 100% compliance, then monthly, until 100% compliance, and then reviewed during Quality Assurance meetings.	

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3225.13.3	3/21/23 at 2:00 PM - Per interview with E2 (DRC), E2 confirmed the service agreements were not located. E2 stated that some records are not current or not filed, and she plans to review all residents' assessments to ensure compliance. E2 stated that going forward, she plans to use paper service agreement forms within 30 days prior to admission and once signed by the resident, will upload into the EMR. 3/21/23 - Findings were reviewed with E1 (ED), E2, E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM. **The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for seven (R1, R2, R3, R4, R5, R6 and R7) out of seven sampled residents, the facility failed to provide evidence that the service agreement included the residents' personal Physician's name, address and phone number. Findings include: 3/21/23 at 2:00 PM - Per interview with E2 (DRC), E2 confirmed the service agreement forms being used in the EMR do not contain the Physicians name, address and phone number. E2 stated that going forward, she plans to use paper service agreements to include this information and once	**3225.13.3 SERVICE AGREEMENT** **A. Individual/Resident Impacted** Residents R2 and R6 were impacted by this deficient practice. R2 – Discharged 6/27/2022 R6 – Discharged 3/5/2023 **B. Identification of other residents with the potential to be affected.** All residents have the potential to be affected by this deficient prac tice. The Resident Care Director/designee has updated all service plans with the PCC's name, address and telephone number. **C. System Changes** The facility failed to provide evidence reflecting the service agreement included the resident's physician's name, address and telphone number. The Resident Care Director/designee, will conduct monthly audits to ensure all new admissions and random audits of current residents' service plans include the physician's name, address and telephone number. **D. Success Evaluation** The Executive Director will re-	5/20/2023

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3225.15.0	signed by the resident, will upload into the EMR. 3/21/23 - Findings were reviewed with E1 (ED), E2, E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM. **Quality Assurance** **The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction.** **13 DE Reg. 1328 (04/01/10)** This requirement was not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility lacked evidence of ongoing QA reviews. Findings include: 3/21/23 at 2:00 PM - Per interview with E1 (ED), E1 confirmed the Quality Assurance monitoring was not in evidence. Only one meeting was documented for October 2022 that included a signature page. The facility failed to provide evidence of any other QA meetings held. 3/21/23 - Findings were reviewed with E1, E2 (DRC), E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Director) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM.	view 10% random audits for compliance, weekly, times 4 weeks, until 100% compliance, then monthly, until 100% compliance and then reviewed during Quality Assurance meetings. **3225.15.0 QUALITY ASSURANCE** **A. Individual/Resident Impacted** No residents/individuals were directly impacted by this deficient practice. **B. Identification of other residents with the potential to be affected.** All residents have the potential to be impacted by this deficient practice. A Quality Assurance Meeting was held on April 28, 2023. **C. System Changes** The facility lacked evidence of ongoing Quality Assurance reviews. The Executive Director/Resident Care Director will ensure Quarterly Quality Assurance meetings are conducted consistently. **D. Success Evaluation** The Executive Director/Resident Care Director will conduct QA reviews weekly, times 4 weeks, until 100% compliance, then monthly, until 100% compliance, and then reviewed during Quality Assurance	5/20/2023

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		meetings.	

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