

### STATE SURVEY REPORT

Page 1 of 18

NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: March 21, 2023

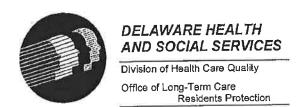
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	REVISED REPORT  Deficiency 3225.10.1 The assisted living facility shall supply a written contract that is precise, easily understood and readable by a resident, and in compliance with all applicable laws. This deficiency was removed on the State report as the Facility submit-		17/
	ted the evidence of the signed contracts on May 17, 2023.	g.	
3225	Assisted Living Facilities		
	Rockland Place Assisted Living	9	
æ	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 per- son's daily life and activities;		
	DRC - Director of Resident Care;		
	ED - Executive Director;		

Provider's Signature

1. Skry

Title Executive Due ct os

Date May 19, 2023



# STATE SURVEY REPORT

Page **2** of **18** 

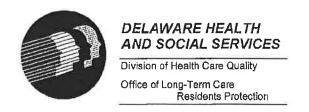
NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: March 21, 2023

Date \_

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	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;	e e	
	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;	9	
	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	General Requirements	GENERAL REQUIREMENTS	5/20/2023
3225.5.1	An assisted living facility that provides di- rect healthcare services to persons diag- nosed as having Alzheimer's disease or		

Provider's Signature \_\_\_\_\_ Title \_\_\_\_



### STATE SURVEY REPORT

DATE SURVEY COMPLETED:

Page 3 of 18

NAME OF FACILITY: Rockland Place

SECTION

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES

COMPLE-TION DATE

March 21, 2023

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.

STATEMENT OF DEFICIENCIES

SPECIFIC DEFICIENCIES

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

Provider's Signature	Title	Date
FIOVIDE 5 DIGITARIA 6	1140	Du(0



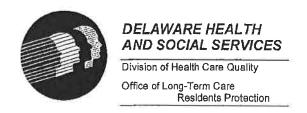
## STATE SURVEY REPORT

Page 4 of 18

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
	both received other trainings (Abuse, Emer-	Watermark specific "NAYA" traiing,	
	gency Preparedness) in late 2022.	conducted by the Regional Program	
	3/21/23 - Findings were reviewed with E1,	Director or designee. This training will focus on various topics related	
	E2 (DRC), E9 (Maintenance Director), E10	to the psychological, social, physical	
	(Sales Director), E11 (Memory Care Direc-	and communicative needs of our	
	tor) and E12 (Director of Community Life)	residents, while understanding the	
	at the exit conference, beginning at approx-	safety aspects associated with resi	
	imately 2:00 PM.	dents diagnosed with Alzheimers'	
	·	Disease or other forms of dementia,	
3225.7.0	Specialized Care for Memory Impairment	to include behavioral deficits. This	
3225.7.1	Any assisted living facility which offers to	training will provide guidance on	
	provide specialized care for residents with	knowing when the need for placement in a secured environ-	
	memory impairment shall be required to	ment becomes necessary.	
	disclose its policies and procedures which	ment becomes necessary.	
	describe the form of care or treatment	D. Success Evaluation	
	provided, in addition to that care and		
	treatment required by the rules and regu-	The Memory Care Program Director	
	lations herein.	will monitor staff training, weekly,	
		times four weeks, then monthly,	
7.2	Said disclosure shall be made to the De-	until 100% compliance and then re	
3225.7.2	partment and to any person seeking spe-	viewed during Quality Assurance	
	cialized care for memory impairment in an	meetings.	
	assisted living facility.		
	The information disclosed shall explain the	3225.7.0 Specialized Care/Memory	5/20/2023
3225.7.3	additional care that is provided in each of	3223.7.0 Specialized Care/Memory	
	the following areas:		
		A. Individual/Resident Impacted	
	Assessment, Care Planning & Implementa-		
3225.7.3.4	tion: the process used for assessment and	No residents/individuals were im-	
	establishing and updating the service	pacted by this deficient practice.	
	agreement and its implementation,		
	Staffing Pl7.35an & Training Policies: staff-	The facility has taken immediate	
3225.7.3.5	ing plan, orientation, and regular in-ser-	corrective action to ensure each cat-	
	vice education for specialized care;	egory outlined in the deficient prac-	
		tice is in substantial compliance	
	Physical Environment: the physical envi-	with the state required rules and	
3225.7.3.6	ronment and design features, including se-	regulations.	n:
	curity systems, appropriate to support the		



### STATE SURVEY REPORT

Page 5 of 18

NAME OF FACILITY: Rockland Place DATE SURVEY COMPLETED: March 21, 2023 SECTION STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR COMPLE-SPECIFIC DEFICIENCIES CORRECTION OF DEFICIENCIES TION DATE functioning of adults with memory impair-B. Identification of other Resiment; dents/Family Member(s) with the potential to be affected This requirement was not met as evidenced by: The Sales Director/designee, will ensure the "Pathways and Our Place Based on policy review, interview and re-Scope of Services Program" is re view of other facility documentation, it was viewed with the POA/family at the determined that the facility lacked some time of admission. The POA/family specific MC policy and procedures pursuant will sign the signature page, to the Memory Impaired resident. Findings acknowledging receipt of the include: Program review. 3/21/23 - Facility Policy and Procedure The Sales Director/designee, will conmanuals and Resident Agreement packets duct a weekly audit on admission recwere reviewed. There was evidence of ords for all current memory care resisome specific MC Information, however the

dents (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 com munity'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

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.

above referenced regulations 7.3.4 assess-

ment, care planning and implementation,

7.3.5 staffing plan and training policies of

the staff and 7.3.6 the physical environ-

ment referencing the security systems

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.



## STATE SURVEY REPORT

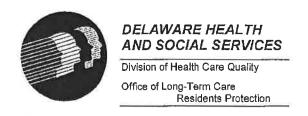
Page 6 of 18

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
3225.8.0	Medication Management	monitor the review of our Pathways	
3225.8.6	Within 30 days after a resident's admis-	and Our Place Scope of Services  Program, with a signed	
5223.6.0	sion and concurrent with all UAI-based as-	acknowledgement of receipt,	
	sessments, the assisted living facility shall	weekly, times 4 weeks, then	
		monthly, until 100% compliance	
	arrange for an on-site review by an RN of	and then reviewed during	
	the resident's medication regime if he or	Quality Assurance meetings.	
	she self-administers medication. The pur-	quanty, assertance	
	pose of the on-site review is to assess the		5/20/2023
	resident's cognitive and physical ability to	3225.8.0 MEDICATION MANAGEMENT	1987
	self-administer medication or the need for	1	
	assistance with or staff administration of	A. Individual/Resident impacted	
	medication.		
3225.8.7	The assisted living facility shall ensure that	Two residents (R1) and (R7) were	
	the review required by section 8.6 is docu-	impacted by this deficient practice	
	mented in the resident's records, including		
	any recommendations given by the re-	(R1) was corrected by the	
		Resident Care Director on 5/1/2023	
	viewer.	to the terms	
	This requirement was not met as evidenced	(R7) is no longer self-administering	
	by:	medications.	
		B. Identification of other Resi-	
	Based on record review, interview and re-	B. Identification of other Residents/Family Member(s) with the	
	view of other facility documentation, it was		
	determined that for two (R1 and R7) out of	potential to be affected	
	two residents sampled, the facility failed to	All residents have the potential to	
	provide evidence of completed resident	be impacted by this deficient prac-	
	evaluations for self-administered medica-	tice.	
	tions in a timely manner. Findings include:	tice.	
1		The Resident Care Director/RN has	0
	1. 8/9/21 - R1 was admitted to the facility	re-assessed all remaining residents	
	with a Physician's order written on 8/9/21	who self-administer medication.	
	and again on 7/5/22 for R1 to self-adminis-		
	ter her own medications. R1's record indi-	The Resident Care Director has ob-	
	cated that the RN's onsite assessment to	tained physician's orders on	
	determine the resident's cognitive and	4/27/23 and 5/1/2023, for all resi-	
	physical ability to self-administer medica-	dents who self-administer medica-	
	tion was only evident on the following	tions.	
i i	dates: 3/22/22, 6/13/22 and 8/22/22. The		
	facility lacked evidence that an assessment		
0	for self-administration of medications was		1

Provider's Signature \_\_\_\_\_ Date \_\_\_\_



## STATE SURVEY REPORT

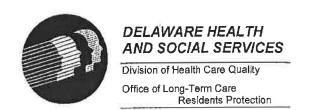
Page **7** of **18** 

Date\_\_\_\_

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

SECTION		ADMINISTRATOR'S PLAN FOR COMPLE-
10.22	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR COMPLE- CORRECTION OF DEFICIENCIES TION DATE
	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.

Provider's Signature \_\_\_\_\_ Title \_\_\_\_



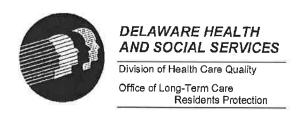
## STATE SURVEY REPORT

Page 8 of 18

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
	Infection Control		
3225.9.5	Requirements for tuberculosis and im-	3225.9.0 INFECTION CONTROL	5/20/2023
	munizations:	A. Individual/Resident Impacted	
3225.9.5.2	Minimum requirements for pre-employ- ment require all employees to have a base line two step tuberculin skin test (TST) or	Three (3) individuals were impacted by this deficient practice.	
	single Interferon Gamma Release Assay (IGRA or TB blood test) such as Quanti- Feron. Any required subsequent testing	B. Identification of other Residents with the potential to be affected	
	according to risk category shall be in ac- cordance with the recommendations of the Centers for Disease Control and Pre-	All residents have the potential to be affected by this deficient practice.	
	vention 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	The Human Resource Director/ designee, will ensure all two-step Tuberculin tests are administered for all new hires.	
	Center for Disease Control for the appropriate risk category.	C. System Changes	
	This requirement was not met as evidenced by:	The facility did not ensure all new hires received their second step of the Tuberculin test screening.	
	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:	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	
	1. 7/28/22 – E7 was hired. The first step Tu- berculin test was done 7/27/22. The facility	100% compliance is achieved.	
	lacked evidence of a second step Tubercu- lin test being administered.	D. Success Evaluation  The Human Resource Director/de	
	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.	signee, will monitor the Tuberculin two-step checklist, weekly, times 4 weeks, then monthly, until 100% compliance, and then reviewed during Quality Assurance meetings.	



## **STATE SURVEY REPORT**

Page 9 of 18

NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: March 21, 2023

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 INFECTION CONTROL  A. Individual/Resident Impacted Five residents were impacted by this deficient practice.  A. Individual/Resident Impacted Five residents were impacted by this deficient practice.  R1 – Current Resident R2 – Discharged 3/5/23 R7 – Current Resident R6 – Discharged 3/5/23 R7 – Current Resident R6 – Discharged 3/5/23 R7 – Current Resident R7 – Discharged 3/5/23 R7 – Current Resident R8 – Discharged 3/5/23 R7 – Current R8 – Discharged 3/5/23 R7 – Current R8 – Discharged 3/5/23 R7	SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
mented in the resident's medical record.  B. Identification of other Resident	SECTION 32225.9.7	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.  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	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	
		mented in the resident's medical record.	1	



### STATE SURVEY REPORT

Page 10 of 18

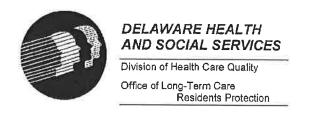
DATE SURVEY COMPLETED: March 21, 2023 NAME OF FACILITY: Rockland Place COMPLE-STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR SECTION CORRECTION OF DEFICIENCIES TION DATE SPECIFIC DEFICIENCIES affected by this deficient practice. Based on record review and review of other facility documentation, it was determined All residents will be offered the that for five (R1, R2, R5, R6 and R7) out of Pneumococcal Vaccination by May seven residents sampled, the facility failed 15, 2023. to provide evidence of the vaccination against pneumococcal pneumonia or a vac-C. System Changes cination declination. Findings include: The facility did not ensure that evi-1. 8/9/21 - R1 was admitted with a diagnodence for pneumococcal vaccinasis of hemiplegia. The facility lacked evitions were being offered or declined dence of a pneumococcal vaccination or of prior to or upon admission/re-ad a declination of such. mission. 2.12/19/19 - R2 was admitted with a diag-The Resident Care Director/designee nosis of dementia. The facility lacked eviwill conduct a monthly audit of all dence of a pneumococcal vaccination or of resident admissions and re-admis a declination of such. sions for Pneumococcal vaccinations 3. 12/30/22 - R5 was admitted with a diaguntil 100% compliance is achieved. nosis of alcohol dependence with induced dementia. The facility lacked evidence of a The Resident Care Director/designee will utilize the DELVAX website to pneumococcal vaccination or of a declinaverify resident status of pneumococ tion of such. cal vaccination. 4. 1/18/23 - R6 was admitted with a diagnosis of cerebellar stroke syndrome. The fa-The Resident Care Director/designee will ensure that the pneumococcal cility lacked evidence of a pneumococcal vaccination will be offered to all res vaccination or of a declination of such. idents during the facility's annual Flu 5. 11/11/22 - R7 was admitted with a diag-Vaccine Clinic. nosis of dementia. The facility lacked evidence of a pneumococcal vaccination or of D. Success Evaluation a declination of such. The facility will review all resident 3/21/23 - Findings were reviewed with E1 pneumococcal vaccination audits (ED), E2 (DRC), E9 (Maintenance Director), weekly, times 4 weeks, then E10 (Sales Director), E11 (Memory Care Dimonthly, until 100% compliance, rector) and E12 (Director of Community and then reviewed during Quality Life) at the exit conference, beginning at Assurance meetings. approximately 2:00 PM. 5/20/2023 3225,10.0 3225.10.1 Contracts Contracts

Provider's Signature

3225.10.10

Title \_\_\_\_

A. Individual/Resident Impacted



#### STATE SURVEY REPORT

Page 11 of 18

ADMINISTRATOR'S PLAN FOR COMPLECORRECTION OF DEFICIENCIES TION DATE

NAME OF FACILITY: Rockland Place SECTION STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES 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. 3225.11.0 Resident Assessment 3225.11.2 A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) act-

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 agree ment/contract.

ing 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 assess-

ment shall be reviewed by an RN within 30

Provider's Signature \_\_\_

Title.

Date



### STATE SURVEY REPORT

Page 12 of 18

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

D. T. I. Of St. St.	Title	Data
Provider's Signature	TIME	Date
Trovidor o orginataro		



## STATE SURVEY REPORT

Page **13** of **18** 

Date \_\_\_\_\_

NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: March 21, 2023

SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CO	OMPLE-
	SPECIFIC DEFICIENCIES		N DATE
	r		
	days prior to admission, and once signed by	B. Identification of Other Residents	
	the resident, will upload into the EMR.		
	3/21/23 - Findings were reviewed with E1	All residents have the potential	
	(ED), E2, E9 (Maintenance Director), E10	to be impacted by this deficient	
	(Sales Director), E11 (Memory Care Direc-	practice.	
	tor) and E12 (Director of Community Life)	The Resident Care Director/de-	
	at the exit conference, beginning at approx-	signee, will ensure that all new	
	imately 2:00 PM.	admissions will receive their UAI	
3225.11.5	inately 2.00 Fivi.	prior to admission.	
	The UAI, developed by the Department,		
	shall be used to update the resident as-	C. System Changes	
	sessment. At a minimum, regular updates	, ,	
	must occur 30 days after admission, annu-	The facility lacked evidence to en-	
	ally and when there is a significant change	sure the pre-admission UAI was	
	in the resident's condition.	completed or done timely.	
	This requirement was not met as evidenced		
	by:	The Resident Care Director/design-	
	Sy.	ee, will audit potential new admis sions, within 48 hours prior to new	
	Based on record review, interview and re-	admission, to ensure UAI is com	
	view of other facility documentation, it was	pleted.	
	determined that for four (R2, R3, R4 and	p. e. e. e.	
	R5) out of seven residents sampled, the fa-	D. Success Evaluation	
	cility lacked evidence that the 30-day post-	-	
	admission UAIs were completed. Findings	All new admissions will be au-	
	include:	dited by the Executive Director	
	1 12/10/10 B2 was admitted with a diag	monthly, times 4 weeks until	
	1. 12/19/19 – R2 was admitted with a diagnosis of dementia. The initial UAI was com-	100% compliance, then	
		monthly, until 100% compli-	
	pleted on 12/20/19. The facility lacked evidence of the 30-day post admission UAI be-	ance, and then reviewed during	
	, ·	Quality Assurance meetings.	
	ing completed.	3225.11.5 UAI ASSESSMENT 5/	20/2023
	2. 5/23/17 - R3 was admitted with a diag-	SZZSITI.S ONI ASSESSIVICIVI	
	nosis of Alzheimer's. The facility lacked evi-	A. Individual/Resident Impacted	
	dence of a 30-day post admission UAI being	,	
	completed.	Four residents R1, R2, R3, R4 were	
	2.0/10/20	impacted by this deficient practice.	
	3. 8/10/20 – R4 was admitted with a diag-		
	nosis of Alzheimer's. The initial UAI was	R2 – Discharged on 6/27/2022	
	completed on 8/11/20 which was after the		

Provider's Signature \_\_\_\_\_ Title \_\_\_\_\_

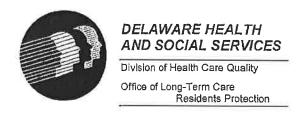


# STATE SURVEY REPORT

Page 14 of 18

DATE SURVEY COMPLETED: March 21, 2023

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
3225.13.0 3225.13.1	admission date. The facility facked 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



#### STATE SURVEY REPORT

Page **15** of **18** 

NAME OF FACILITY: Rockland Place

SECTION

DATE SURVEY COMPLETED: March 21, 2023

COMPLE-TION DATE

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:

STATEMENT OF DEFICIENCIES

SPECIFIC DEFICIENCIES

- 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.

ADMINISTRATOR'S PLAN FOR

**CORRECTION OF DEFICIENCIES** 

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.

Provider's Signature	Title	Date
FIOVIDEI S OIGHAIDE	THIC	Date



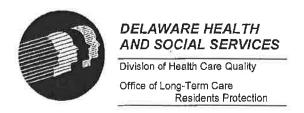
## STATE SURVEY REPORT

Page **16** of **18** 

NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: March 21, 2023

NAME OF FACILITY: Rockland Place		ADMINISTRATORIC DI AN EOR	COMPLE-	
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	TION DATE	
	3/21/23 at 2:00 PM - Per interview with E2 (DRC), E2 confirmed the service agree-	3225.13.3 SERVICE AGREEMENT	5/20/2023	
	ments were not located. E2 stated that some records are not current or not filed, and she plans to review all residents' as-	A. Individual/Resident Impacted		
	sessments to ensure compliance. E2 stated that going forward, she plans to use paper service agreement forms within 30 days	Residents R2 and R6 were impacted by this deficient practice.		
	prior to admission and once signed by the resident, will upload into the EMR.	R2 – Discharged 6/27/2022 R6 – Discharged 3/5/2023		
3225.13.3	3/21/23 - Findings were reviewed with E1 (ED), E2, E9 (Maintenance Director), E10 (Sales Director), E11 (Memory Care Direc-	B. Identification of other residents with the potential to be affected.		
	tor) and E12 (Director of Community Life) at the exit conference, beginning at approximately 2:00 PM.	All residents have the potential to be affected by this deficient practice.		
	The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.	The Resident Care Director/designee has updated all service plans with the PCC's name, address and telephone number.		
	This requirement was not met as evidenced by:	C. System Changes		
	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	The facility failed to provide evidence reflecting the service agreement included the resident's physician's name, address and telphone number.	s.	
	that the service agreement included the residents' personal Physician's name, address and phone number. Findings include:	The Resident Care Director/designee, will conduct monthly audits to ensure all new admissions and		
	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 con-	random audits of current residents' service plans include the physician's name, address and telephone number.		
	phone number. E2 stated that going forward, she plans to use paper service agree-	D. Success Evaluation		
	forms being used in the EMR do not contain the Physicians name, address and phone number. E2 stated that going for-	physician's name, address and telephone number.		



#### STATE SURVEY REPORT

Page **17** of **18** 

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

	T'11 -	D-4-
Provider's Signature_	litle	Date
TOTIGOTO CIGITATO	ALDERIN TO THE PROPERTY OF THE	



## STATE SURVEY REPORT

Page 18 of 18

NAME OF FACILITY: Rockland Place		DATE SURVEY COMPLETED:		March 21, 2023
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR' CORRECTION OF D	S PLAN FOR DEFICIENCIES	COMPLE- TION DATE
		meetings.	it	
			0.5	
		4		*
	*			
. =	ature	Title	Nata	