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

DHSS - DHCQ
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STATE SURVEY REPORT

NAME OF FACILITY: Milford Place Assisted Living

DATE SURVEY COMPLETED: June 1, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from May 23, 2022, through June 1, 2022. The deficiencies contained in this report are based on observations, interview, record review and other facility documentation as indicated. The facility census on the first day of the survey was sixty-seven (67). The survey sample totaled twenty- two (22) residents. **Abbreviations/definitions used in this report are as follows:** Alzheimer's Disease - brain disorder causing loss of memory, thinking and language; Cognitively Impaired – abnormal mental processes/thinking OR mental decline including losing the ability to understand, talk or write; C – Celsius; CSM – Care Services Manager; CSN – Care Services DelVAX - Delaware's state immunization registry and serves as a database that contains the immunization records of Delaware residents; Dementia – brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; DHCQ – Division of Health Care Quality (Office of Long Term Care Residents Protection); Elopement - a form of unsupervised wandering that leads to the resident leaving the facility; Emergency pendants - a wearable button that seniors can press in an emergency, such as a fall; F – Fahrenheit; Immunization – a process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with vaccination or inoculation; Influenza - a viral infection (commonly called the flu) that attacks your respiratory system - your nose, throat and lungs;		

Provider's Signature [signature] Title Executive Director Date 7/26/2022

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	LRCP – Lead Resident Care Partner; MCM – Memory Care Manager; RCP – Resident Care Partner; Mini Mental Exam - a tool that can be used to systematically and thoroughly assess mental status; Nurse; ED – Executive Director; Parkinson's Disease - brain disorder affecting movement leading to shaking/tremors and difficulty walking; Sanitized – made clean and hygienic; disinfected; Service Agreement - allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living facility provides. These include: lodging, board, housekeeping, personal care and supervision services to the resident according to the State Law Regulations Department that oversee senior housing certification and licensure; Tuberculin test - a skin test to determine past or present infection with the tuberculosis bacterium (TB); Uniform Assessment Instrument (UAI) – an assessment and collection of information regarding an assisted living applicant/resident's physical condition, medical status and psychosocial needs.		
3225.0	**Regulations for Assisted Living Facilities**		
3225.9.0	**Infection Control**		
3225.9.5	**Requirements for tuberculosis and immunizations**		
3225.9.5.1	**The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** **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 residents (R9 and R22) out of twenty-	A. The facility is unable to correct the deficient practice for R9, and R22 since both residents no longer reside within the facility. This identified deficient practice had the potential to negatively impact residents R9 and R22, along with residents and employees of the facility. On 07/08/2022 the Executive Director (ED) educated the CSM and ACSM on Enlivant Policy titled, "Tuberculosis (TB) Testing Policy", policy dated 3/1/2022. **(Attachment 1).** B. By 07/15/2022, the CSM and Assistant Care Service Manger (ACSM) will audit current resident tuberculin skin test administration records to validate that a two-step tuberculin skin test was administered upon admission. For instances identified where a two-step tuberculin skin test was not administered upon admission, the CSM and or ACSM will request a medical providers order for a two-step tuberculin test and administer the test per order. **(Attachment 2)** C. Root cause analysis determined the LPN on first shift did not administer the second step tuberculin skin test as ordered and transcribed to resident R9s Medication Administration Record (MAR). Root cause analysis also determined that R22's tuberculin skin test orders were not requested by a facility LPN, secondary to the LPN being unaware Tuberculin skin tests were required upon admission. D. Starting 07/11/2022 the CSM, ACSM and/or designee will review the tuberculin skin test administration records of newly admitted residents, validating that the first and second tuberculin administrations were administered and read. The audit will occur weekly until 100%	

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	two sampled residents, the facility failed to complete the two-step tuberculin testing. Findings include: 1. Review of R9's clinical record revealed: 1/21/22 – R9 was admitted to the facility. 1/29/22 – R9's tuberculin test was completed with negative results. The facility lacked evidence that R9's second step of the tuberculin test was administered. 1. Review of R22's record revealed: 4/1/22 – R22 was admitted to the facility. The facility lacked evidence that R22's two-step tuberculin test was administered. Findings were reviewed on 6/1/2022 with the E1 (ED) and E2 (CSM) at the exit conference beginning at approximately 12:30 PM.	compliance is maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month. **(Attachment 3)** Results of the audit will be discussed during monthly QI meetings. Completion date 07/15/2022 A. The facility is unable to correct the deficient practice for R8, R9, and R22 since the 2021-2022 influenza vaccine initiative has ended and the three residents no longer reside within the facility. This identified deficient practice had the potential to negatively impact residents R9 and R22, along with residents and employees of the facility. On 07/08/2022 the Executive Director (ED) educated the CSM and ACSM on Enlivant Policy titled, "Influenza Policy", policy dated 3/1/2022. (Attachment 4). B. By 07/15/2022 the CSM and ACSM will have audited current resident influenza vaccine administrations and declinations. Although, corrective action cannot be immediately implemented due to the 2021-2022 Influenza season being over, and the 2022-2023 flu season not yet starting, the audit will serve in the investigation towards a root cause analysis. (Attachment 5) C. Root cause analysis determined there was a lack of established process to monitor newly admitted residents' influenza vaccine administration/declination status. D. At the initiation of the 2022-2023 influenza vaccination season, no later than 10/30/22, the CSM and ACSM or designee will audit current and newly admitted resident influenza consents, administrations, and declinations weekly until	
3225.9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, 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 influenza 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:** Based on record review, interview and other facility documentation, it was determined that for three (R8, R9, and R22) out of twenty-two sampled residents, the facility failed to complete influenza vaccinations. Findings include:		

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	1. Review of R8's record revealed: 8/6/22 - R8 was admitted to the facility. The facility lacked evidence that the influenza vaccine was offered to R8 or a record of declination. 2. Review of R9's record revealed: 1/21/22 - R9 was admitted to the facility. The facility lacked evidence that the influenza vaccine was offered to R9 or a record of declination. 5/25/22 11:00 AM - During an interview E2 (CSM) confirmed the facility lacked evidence of the influenza vaccines being offered or declined. E2 further stated that she made an attempt to get immunization records on all newly admitted residents, however, she was unable to access the DEL VAX site to view records. Findings were reviewed on 6/1/2022 with the E1 (ED) and E2 (CSM) at the exit conference beginning at approximately 12:30 PM.	100% compliance is maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month. The audits start date is dependent upon influenza vaccine availability. (Attachment 6) Results of the audit will be discussed during monthly QI meetings. Completion date 07/15/2022.	
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.1.3	**Food service complies with the Delaware Food Code** **This requirement was not met as evidenced by:** Based on observations and interviews during tours of the kitchen on 5/23/22, it was determined that the facility failed to comply with the following sections: 2-101.11, 2-101.12, 3-501.17 (A), 4-701.10, 4-702.10, and 4-702.11 of the State of Delaware Food Code.	A. On or before 07/15/2022 E16 will have attained a current Food Protection Manager certification. This identified deficient practice had the potential to affect residents and staff of the facility. On 07/08/2022 the ED educated E9, Dining Services Director (DSD) and kitchen staff, as to the requirements of 2-101.11, 2-101.12, 3-501.17 (A), 4-701.10, 4-702.10, and 4-702.11 of the State of Delaware Food Code. **(Attachment 8)** B. On 07/08/2022 the ED audited the kitchen operations employee schedule to ensure a qualified PERSON IN CHARGE is scheduled during hours of operation. **(Attachment 9).** C. Root cause analysis determined E16 failed to recertify his Safe	

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2-1 2-101 2-101.11	**Supervision** **Responsibility** **Assignment** (A) Except as specified in ¶ (B) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation.	Serve Certification. In addition, the ED failed to validate the status of E16 Safe Serve Certificate. D. Beginning 07/12/2022 the ED or designee will audit the kitchen operations employee schedule to ensure a qualified PERSON IN CHARGE is scheduled during hours of operation. The audit will occur weekly until 100% compliance is maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month. **(Attachment 9A)** Results of the audit will be discussed during monthly QI meetings. Completion date 07/15/2022.	
2-102.12	**Certified Food Protection Manager** (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. **This requirement was not met as evidenced by:** An interview with E9 (Director of Dining Services), on 5/24/22 at 11:48 AM revealed that E16 (Assistant Chef), who was occasionally the designated PERSON IN CHARGE did not possess a current Food Protection Manager certification.	A. On 5/23/22, at approximately 12pm, the trays of ice cream and sherbet in glass serving dishes without a covering or date labels was discarded by the DSD. In addition, the unlabeled and undated package of raw chicken breast, the lunchmeat sandwich, the plastic container of tomato sauce and several cartons of thickened juice were discarded by the DSD. This identified deficient practice had the ability to negatively affect the residents of the facility. On 07/08/2022 the ED educated the DSD and kitchen staff as to the requirements of 2-101.11, 2-101.12, 3-501.17 (A), 4-701.10, 4-702.10, and 4-702.11 of the State of Delaware Food Code. **(Attachment 8)**	
3-501.17	**Temperature and Time Control – Ready – to – Eat, Potentially Hazardous Food, Date Marking** (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.	B. On 07/08/2022 the DSD audited the walk-in and reach in refrigerators and freezers for foods that were undated and or unlabeled. No additional undated/unlabeled foods were noted. C. Root cause analysis determined there was a lack of education for kitchen staff regarding the covering, labeling, and dating of foods. D. Beginning 07/15/2022 the DSD will audit the walk-in and reach in re-	

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	This requirement was not met as evidenced by: 5/23/22 – Multiple observations of the walk in refrigerator and walk in freezer between 8:42 AM and 11:47 AM revealed trays of ice cream and sherbet in glass serving dishes with no covering or date labels. In addition, a package of raw chicken breast, a lunchmeat sandwich, a plastic container of tomato sauce, and several cartons of thickened juice, were found to be unlabeled and undated. E9 (Director of Dining Services), stated that staff has been instructed often that the food inside the walk in and unit refrigerators must be labeled and dated.	frigerators for undated and or unlabeled foods. The audit will occur daily until 100% compliance is maintained for four consecutive days. Then weekly until 100% compliance is maintained for four consecutive audits. Then Bi-Weekly for four consecutive audits. Then, monthly until 100% compliance is maintained for one month **(Attachment 10).** Results of the audit will be discussed during monthly QI meetings. Completion date 07/25/2022.	
4-702.10	**Food Contact Surfaces and Utensils** EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED.	A. The facility is unable to correct this finding, since the sanitizing buckets with solution and wet wipes were not utilized by kitchen staff on 5/23/22. This identified deficient practice had the ability to negatively affect the residents of the facility.	
4-702.11	**Before Use After Cleaning** UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning. **This requirement was not met as evidenced by:** 5/23/22- Multiple observations between 8:52 AM and 12:06 PM revealed there were no red sanitizer buckets containing sanitizing solution and wet wiping cloths available to sanitize work surfaces during meal preparation. 5/24/22 - Findings were reviewed with E9 (Director of Dining Services) beginning at 12:24 PM.	On 07/08/2022 the ED educated the DSD, and the kitchen employees as to the requirements of 2-101.11, 2-101.12, 3-501.17 (A), 4-701.10, 4-702.10, and 4-702.11 of the State of Delaware Food Code. **(Attachment 8)** B. On 5/24/22, at approximately 12:25pm the DSD ensured the red sanitizing buckets with sanitizer were readily available in the kitchen. C. Root cause analysis determined kitchen staff were utilizing green buckets filled with sanitizer instead of red buckets filled with sanitizer, due to lack of education. Additionally, the sanitizer was in the DSD's office, which was locked. D. Beginning 07/15/2022 the ED or designee will audit the presence of red sanitizing buckets in the kitchen daily until 100% compliance is maintained for four consecutive days. Then weekly until 100% compliance is maintained for four consecutive audits. Then Bi-Weekly until four consecutive audits. Then, monthly until 100% compliance is maintained for one month. **(Attachment 10)** Results	
3225.13.0	**Service Agreements**		
3225.13.6	**The Service Agreement shall be reviewed when the needs of the resident have changed and minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.**		

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	This requirement was not met as evidenced by: Based on record review and interview, it was determined that for four (R1, R4, R20 and R21) out of five residents sampled for service agreements, the facility failed to update services agreements with measurable interventions for residents whose needs changed related to elopements. In addition, for two (R5 and R20) out of five residents sampled for Service Agreements, the facility lacked evidence that the Service Agreement were signed by the facility or the resident representative. Findings include: A facility policy, effective 3/1/22, entitled Elopement or Missing Resident Policy included: Post-Response Plan and Incident Analysis (After Event). A facility policy entitled "Enlivant Negotiated Service Plan Interpretive Guidelines", effective 3/22 included: Have you ever wandered outside or left the building unsupervised...This question accounts for the staff time required for monitoring the risk associated with exit-seeking behavior. Be sure to address this concern on the Negotiated Service Plan and alert all staff about the potential for elopement. ED (Executive Director) or CSM (Care Services Manager) reviews the incident with the team and discusses resident risk, implementation of risk reducing interventions, and documents on the Care Plan. 1. Review of R1's clinical record revealed: 10/9/19 – R1 was admitted to the facility with Parkinson's disease and dementia. 11/16/21 – R1's mini mental exam revealed that she was cognitively impaired. 3/23/22 10:16 AM – R1 eloped from the facility.	of the audit will be discussed during monthly QI meetings. Completion date 07/25/2022. A. Unable to correct the action for R21, R5, and R20, as these residents no longer reside within the facility. This deficient finding had the potential to affect residents residing within the community who were at high risk for elopement. On 07/08/2022 the Executive Director educated the CSM and ACSM on Enlivant Policy titled, "Wandering Policy", policy dated 3/1/2022. **(Attachment 11)** On 07/08/2022 the service agreements for R1 and R4 were revised by the CSM to include Individualized interventions secondary to being at high risk of elopement. **(Attachment 12).** B. By 07/15/2022 the CSM and ACSM will audit the service plans of residents identified as being heightened risk for elopement (as evidenced by an elopement risk score equal to or greater than 36) to ensure their service plan included individualized interventions. **(Attachment 13)** By 07/15/2022 the CSM and ACSM will audit current resident service plans to ensure each service plan was signed by a licensed nurse, the resident, or their designated representative. Unsigned service plans were then signed by a licensed nurse and presented to the resident and/or residents designated representative **(Attachment 14).** C. Root cause analysis determined that the CSM was unaware that individualized interventions were required on a resident's service plan. D. Beginning 07/18/2022, the CSM or designee will audit the service agreements of 5 current residents who are at heightened risk for elopement (as evidenced by an elopement risk score equal to or greater than 36) to ensure: A individualized interventions are documented and B. a licensed nurse	

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	5/10/22 – Although R1's Service Agreement was signed by the facility and R1's resident representative, R1's Service Agreement lacked evidence of individualized interventions to address R1's risk for elopement. 2. Review of R4's clinical record revealed: 8/7/20 - R4 was admitted to the facility with dementia. 8/28/20 5:45 PM – R4 eloped from the facility. 12/27/20 – Although R4's Service Agreement was signed by the facility and R1's resident representative, R4's Service Agreement lacked evidence of individualized interventions to address R4's risk for elopement. 3. Review of R5's clinical record revealed: 10/7/20 – R5 was admitted to the facility with dementia and hallucinations. 8/28/20 – R5 eloped from the facility 12/9/20 – R5's Service Agreement addressed the 10/19/20 and 12/2/20 elopements but was not signed by the facility or R5's resident representative. 4. Review of R20's clinical record revealed: 12/10/19 – R20 was admitted to the facility with lung cancer and dementia. 8/23/20 and 8/24/20 - R20 eloped from the facility. 8/17/20 – R20's Service Agreement lacked evidence of individualized interventions to address R20's risk for elopement and was not signed by the facility or R20's resident representative. 5. Review of R21's clinical record revealed: 8/2/20 – R21 was admitted to the facility with dementia and lung cancer. 12/21/21 – R21's Service Agreement lacked evidence that R21's Service Agreement was updated	and the resident and/or the resident's designated representatives' signatures are present. The audit will occur weekly until 100% compliance is maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month (**Exhibit 15**). Results of the audit will be discussed during monthly QI meetings Completion date: 07/15/2022	

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	with interventions to address his elopement risk after R21 eloped on 12/23/21. 5/26/22 approximately 10:45AM – During an interview, E2 (CSM) stated that elopements were supposed to go on the task report for the RCP's (Resident Care Partners) to alert them of special needs. E2 confirmed that R1's task report included "elopement risk", and R4's task report included "needs redirection at times". E2 also confirmed that the RCP special needs tasks were not reflected in R1 or R4's Service Agreements to address interventions for their elopement risk. E2 also added that the task reports were not a part of the resident clinical record (because they had multiple resident names on them), and therefore could not take the place of the Service Agreement. The facility lacked evidence of R5, R20, and R22's special needs RCP task report, and the facility lacked evidence that their elopement risk was reflected in their Service Agreements. 6/1/22 at approximately 11:00 AM - During an interview, E2 (CSM) confirmed R5's and R20's Service Agreements were not signed by the facility or the resident representative. Findings were reviewed on 6/1/22 with E1 (ED) and E2 (CSM) at the exit conference beginning at approximately 12:30 PM.		
3225.17.0	**Environment and Physical Plant**		
3225.17.1	**Each assisted living facility shall comply with applicable federal, state and local laws including:**	A. On 6/1/2022 a resident care partner (RCP) was assigned by the ED to supervise the elevators operability until it was repaired. In addition, the RCP was trained by E13 on how to reset the elevators' function. This identified deficient practice had the ability to negatively affect residents, staff, and visitors of the facility.	
3225.17.1.1	**Rehabilitation Act, Section 504;**		
3225.17.1.2	**Fair Housing Act as amended; and**		
3225.17.1.3	**Americans with Disabilities Act.**		
3225.17.2	**Assisted living facilities shall:**		

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3225.17.2.1 **3225.17.2.3**	**Be in good repair; and** **Have a hazard-free environment.** This requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed be in good repair related to the only elevator in the facility malfunctioning for approximately one month and the facility failed to educate staff regarding how to safely reset the elevator when a malfunction occurred. Findings include: 5/31/22 9:50 AM - During an interview, E7 (LRCP – Lead Resident Care Partner) and E8 (CSN) reported that the elevator malfunction had been happening for about a month and the issue had gotten worse in about the last week and one half or 2 weeks. E7 and E8 stated that residents and staff had been getting "stuck in it" (the elevator) but could not give an exact number of times. E7 reported that a R23 was trapped in the elevator about 7:30 or 8:00 AM that morning and was incontinent of bowel related to the delay. E7 and E8 reported that you have to reset a big lever on the circuit breaker and "throw the breaker." They both reported that they were afraid that the circuit breaker would "blow up in their faces." 5/31/22 11:00 -11:33 AM - During an observation and interview with E13 (MM – Maintenance Manager), E13 stated that the elevator had started to malfunction approximately one month ago, and that it has really had some issues in the last week and one half to two weeks. E13 stated the elevator had malfunctioned frequently. E13 stated that when the elevator won't open it has to be reset by staff by throwing the circuit breaker to reset it. E13 stated that the part required to fix the elevator had been on back-order for about a month. During an observation of the circuit breaker room, E13 showed the Surveyor two levers, and stated	On 07/08/2022 the ED educated the facility Maintenance Manager on Delaware code 3225.17.2.1 and 3225.17.2.3 **(Attachment 16)** B. On 6/8/2022 at approximately 2pm the elevator was repaired by Delaware Elevator Inc. **(Attachment 17)** C. Root cause analysis determined that staff were not adequately instructed by the Maintenance Manager on how to reset the elevators' function, while the ordered part was on back order. D. Beginning 07/11/2022 the ED or designee will audit the elevators operability weekly until 100% compliance is maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month **(Attachment 18)**. Results of the audit will be discussed during monthly QI meetings. Completion date: 07/08/2022.	

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	that they were the elevator circuit breakers. E13 stated that the lever for the circuit breaker to reset the elevator was the one on the top. The surveyor asked how the staff would know which lever to reset he stated that he did not know. E13 confirmed that facility staff should have been trained for safety, but they were not. E13 confirmed that there was not a maintenance person in the building at night. E13 confirmed there was only one elevator to access the second floor and added that facility staff and residents were very concerned that it was a safety issue. 5/31/22 – 12: 46 PM – During an interview, E1 (ED) and E2 (DON) confirmed that the facility lacked evidence of training/education of how to reset the elevator with the circuit breaker when it was necessary. 5/31/20 1:15 PM – During an interview, R14 reported that his biggest concern about the facility was the broken elevator and it "getting stuck." 6/1/22 8:57 AM – During an interview, E9 (Director of Dining Services) reported that the elevator was "shut down." E9 stated that this morning they had to deliver take-out container meals to the second-floor residents "Like they did with COVID." E9 also reported that he had conversations with three residents who stated they were scared to go on the elevator. 6/1/22 approximately 10:15 AM – During an interview E1 (ED) stated that the elevator was being shut down in increments throughout the day "to allow it to cool". Findings were reviewed on 6/1/22 with E1 (ED) and E2 (CSM) at the exit conference beginning at approximately 12:30 PM.		

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3225.19.0	**Records and reports**		
3225.19.5	**Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:**	A. R3 no longer resides at the community. The facility is unable to correct this deficient finding. R3 and other residents of the community had the potential to be affected by this deficient practice. B. On 07/08/2022, the Regional Director of Care Services (RDCS) educated the ED, CSM and ACSM on Enlivant Policy and Procedure titled "*Abuse, Neglect and Exploitation Policy – Delaware Communities*", "*Incidence and Accidents Policy*", and Delaware code 3225.19.6 pertaining to incidents and reporting. **(Attachment 19)** By 07/15/2022 the ED and CSM educated current staff on the on Enlivant Policy and Procedure titled "*Abuse, Neglect and Exploitation Policy – Delaware Communities*", "*Incidence and Accidents Policy*", and Delaware code 3225.19.6 pertaining to incidents and reporting. **(Attachment 20)** C. On 07/08/2022, the ED filed a state reportable incident pertaining to resident R3 and FM1 allegation(s) of abuse. **(Attachment 21)** By 07/15/2022, the ED, CSM, and ACSM will have audited current residents, asking them if they have experienced or witnessed abuse while residing at the community. **(Attachment 22) By 07/15/2022,** the ED, CSM and ACSM will have audited current staff members, asking them if they have witnessed resident abuse while employed at the community. **(Attachment 23).** In addition, by 07/15/2022 the CSM will audit internal incident reports that occurred over the preceding 90 days to ensure allegations of abuse or reportable incidents were reported and investigated per Enlivant Policies "Abuse, Neglect and Exploitation," and "Incident Reporting Guidelines" and Delaware code 3225.19.6. **(Attachment 24).**	
3225.19.5.1	**All reportable incidents.**		
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (R3) out of four residents reviewed for abuse the facility failed to report and provide adequate documentation of a known allegation of abuse. Findings include: A facility policy entitled "Abuse, Neglect and Exploitation" (last revised 7/14/17) included: "It is our duty to protect residents from physical, mental, fiduciary (financial) sexual and verbal abuse or neglect. Abuse is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. In any case of known or suspected/alleged abuse, neglect or exploitation, the staff member will ensure the safety of the resident(s) involved." The executive Director or designee will be notified immediately and will report the suspicion or allegation of abuse to the appropriate authorities within 8 hours and initiate a facility investigation. Review of R3's clinical record revealed:		

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	1/6/19 – R3 was admitted to the facility and was independent with ADL's. 1/30/20 – R3 sustained a fall resulting in a broken hip, was sent to the hospital and underwent hip surgery. 2/24/20 – R3 was re-admitted to the facility and was non-weight bearing on the affected side, thus R3 required more assistance with her ADL's and walking. 2/25/20 – A letter from FM1 to E1 (NHA) documented, when visiting R3 she noticed a bruise to R3's left forehead. R3 had stated "the aid was in a hurry and hit my head on the doorway." There was no communication from the facility to FM1 about the bruise to R3's forehead. 3/7/20 During late evening to early morning of 3/8/20 – A letter from FM1 to E1 documented that R3 had pushed her call bell for assistance with no response from staff. R3's neighbor heard R3 trying to get help and ultimately walked downstairs to the nurses' station to get help. That morning R3 informed FM1 of what had happened overnight. FM1 had called the facility and spoke to E1 who assured FM1 that the situation would be investigated and E1 would follow-up as to any resolutions. FMI did not receive any response from E1. 3/24/20 – A letter addressed to E1(ED) from family member (FM1) documented E17 (MEDASST), E18 (RCP), E19 (RCP), and E20 (RCC) had been "awful, hateful, spiteful, and uncaring towards R3. FM1 did not receive any response from E1. The facility lacked evidence of an investigation or that it was reported to the State agency. 5/31/22 9:10 AM – During a telephone interview FM1 confirmed she had spoken to E1 many times	D. Root cause analysis determined that R3 was not a resident of the facility at the time the allegation was received by the ED. In addition, the ED failed to investigate and report the allegation. E. Beginning 07/12/2022 the ED, CSM, or designee will audit internal incident reports to ensure allegations of abuse or reportable incidents were reported and investigated per Enlivant Policies, "Abuse, Neglect and Exploitation," and "Incident Reporting Guidelines" and Delaware code 3225.19.6. This audit will occur weekly until 100% compliance is maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month. **(Attachment 25)** Results of the audit will be discussed during monthly QI meetings. Completion date: 07/15/2022.	

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	regarding her concerns and stated that she felt like they were just "sweeping it under the rug." FM1 only received one follow-up phone call from E1 which FM1 believed was because she had escalated her concerns to the corporate level, had sent a letter to a State Representative and made a report to the Division of Health Care Quality. In addition, FM1 hired a private aid until arrangements could be made to remove R3 from the facility. FM1 removed R3 from the facility back into her home with round the clock assistance. 5/31/22 At approximately 11:00 AM – During an interview A2 confirmed that she had observed behaviors from some staff members that were inappropriate towards R3. In the past A2 had reported her observations to both E1 and E2 (CSM) and nothing was ever done. A2 also stated that since reporting her concerns to management she feels targeted and being watched. 6/1/22 9:42 AM – During an interview E1 (ED) confirmed that he had received several letters from FM1 regarding allegations of abuse. E1 presented those letters dated from 1/30/20 thru 3/24/20. Review of the letters revealed many concerns involving, physical abuse by staff members (names included) towards R3 and concerns regarding response times for assistance. 6/1/22 10:50 AM – During an interview E1 (ED) confirmed that an internal investigation was not initiated, and these allegations had not been reported to DHCQ. In addition, the accused staff members except for one were still employed at the facility. Evidence of disciplinary action was only provided for one E17 out of six staff members accused. When asked why these allegations had not been fully investigated nor reported to DHCQ, E1 answered, "I really don't know what to say."		

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	The facility failed to report allegations of abuse and provide adequate documentation to the Division of Health Care Quality. Findings were reviewed on 6/1/22 with E1 (ED) and E2 (CSM) at the exit conference beginning at approximately 12:30 PM.		
16 Del. C. Chap.11§1121	**Definitions** **Resident rights** **(11) Each resident shall receive from the administrator or staff of the facility a courteous, timely, and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the resident.** **This requirement was not met as evidenced by:** Based on interview, and review of facility documentation, it was determined that the facility failed to develop a formal internal grievance process so that residents and or their family members were able to file a grievance either by name or anonymously. Findings include: 5/26/22 3:22 PM – During an interview, E1 (ED) and E2 (CSM) were asked for the facility grievance log. E1 replied "we don't have one, that is not an AL process but a SNF (Skilled Nursing Facility) process." E2 replied "I have an open-door policy" and she was not aware of any processes in place for residents and or their family members could report a grievance if they were not comfortable talking to staff members for fear of retaliation. 5/27/22 – At approximately 1:30 PM – A review of the facility's admission package form entitled; "Resident Concern Procedure" included: "We un-	A. On 06/02/2022 the ED established an internal grievance log. Residents of the community had the potential to be affected by this deficient practice. **(Attachment 26)** On 07/08/2022 the RDCS educated the ED and CSM on Enlivant Policy "*Resident Concern or Compliant Policy*" and "*Resident/Family Concern Form*" **(Attachment 27).** Following this education, the ED will educate current employees by 07/15/2022, informing them of the "*Resident Concern or Compliant Policy*" and "*Resident/Family Concern Form*". **(Attachment 28)** B. By 07/15/2022 the ED will draft a letter addressed to current residents and their responsible party, if applicable. The letter will detail how to file a concern or compliant and included a blank "*Resident/Family compliant Form*". By 07/15/2022 the ED will hand-deliver the letters to current residents, and ask each resident if they would like to file a concern. Concerns received will be logged and addressed timely and thoroughly by the ED. The letter will also be mailed via the United States Postal Service to resident responsible parties, if applicable. **(Attachment 29).** C. Root cause analysis determined that community leadership was unaware of the need for a resident/family grievance log. D. Beginning 07/15/2022 the ED or designee will audit "*Resident/Family Concern Forms*" log to ensure concerns are addressed timely and thoroughly. This audit will occur weekly until 100% compliance is	

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	derstand that a concern may arise during your residency. We encourage you or your family to report these concerns. If the Executive Director or designee is unable to resolve this concern to your satisfaction, you may contact the corporate quality assurance program"; with a telephone number attached. 5/27/22 3:25 PM – During an interview R17 was asked, "if you wanted to report a concern about the facility, do you know how to do that?" R17 stated that she would either call the Ombudsman or if she felt comfortable, speak with E1. 5/31/22 3:22 PM – During an interview, E1 and E2 confirmed that the facility did not have a formal internal grievance process in place. The facility failed to develop and implement a formal internal grievance process for residents and or their family members to file a grievance either by name or anonymously. 6/1/22 – Findings were reviewed with E1 (ED) and E2 (CSM) at the exit conference at approximately 12:30 PM.	maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month. **(Attachment 30)** Results of the audit will be discussed during monthly QI meetings. Completion date: 07/15/2022.	
16 Del. C. Chap. 11 §1131	**(12) Neglect** **(a) Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **This requirement was not met as evidenced by:** Review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation, with an effective date of 7/14/17, stated: Based on record review and interview, it was determined that for five (R1, R4, R5, R20 and R21) out of five residents sampled for being at risk for elopement, the facility failed to provide a safe and secure environment to ensure that exit doors	A) This deficient finding had the potential to negatively affect R1, R4, R5, R20, and R21, along with other residents residing within the community who were at risk for elopement **(Attachment 13)**. On 06/15/2022, the Maintenance Manager installed an operable alarm to the memory care courtyard door. By 07/11/2022, the Maintenance Manager will audit the facility's exit doors to validate that screamer alarms are affixed, the alarm control panel is functioning, and staff pagers are functioning properly. **(Attachment 33).**	

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	were secure, and the exit door alarms were addressed timely to prevent elopement. Findings include: **Cross refer 13.6 Service agreements.** "It is our duty to protect residents from physical, mental, financial, sexual and verbal abuse or neglect." "Definitions:...Neglect is a pattern of conduct or inaction of a care provider that fails to provide goods or services that maintain physical or mental health or that fails to avoid or prevent physical or mental harm or pain, or an act of omission that constitutes a clear and present danger to health." A facility policy entitled "Elopement or Missing Resident Policy", effective 3/1/22, included: "It is the policy of Enlivant to provide a systematic effort of all community staff to search when a resident is reported missing and that person is cognitively impaired and leaves the community without staff knowledge and/or supervision, lacks safety awareness and is unable to distinguish/identify his or her safety needs and/or has impaired appropriate decision-making ability." 1) Staff immediately conducts a thorough interior search of community... 2) If not found, one person conducts thorough exterior search of the immediate grounds... 3) If not found, one person searches the immediate neighborhood... 4) If preliminary search efforts fail to locate the resident (approximately 30 minutes of sustained search), the ED is to be called regardless of time of day or time...	B) By 07/15/2022, the ED will in-service staff on Enlivant Policy "*Elopement or Missing Resident*" (policy number 03-4.05) **(Attachment 11).** On 06/09/2022, the Executive Director conducted a mock elopement exercise and validated staff's proper response **(Attachment 32)** C) Root cause analysis determined that staff were not adequately trained to differentiate the audible ring of the beeper, alerting them an exit door was ajar, from the ring of a non-urgent resident pendant call. D) Beginning 07/15/2022, the ED or designee will audit the staff's response to mock elopement exercises on each shift. This audit will occur weekly until 100% compliance is maintained for four consecutive weeks. Then, bi-weekly until 100% compliance is maintained for two consecutive audits. Then, monthly until 100% compliance is maintained for one month. **(Attachment 35).** Beginning 07/15/2022, the Maintenance Manager will audit the facility's exit doors to validate alarms remain affixed, the alarm control panel is functioning, and staff pagers are functioning properly. This audit will occur three times per week, weekly until 100% compliance is maintained for four consecutive weeks. Then, three times per week, bi-weekly until 100% compliance is maintained for two consecutive audits. **(Attachment 36).** Then, monthly until 100% compliance is maintained for one month. Completion date: 07/15/2022.	

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	"ED and/or CSM reviews the incident and discusses resident risk, implementation of risk reducing interventions, and documents on Care Plan..." 1. 12/10/19 - R20 was admitted to the facility with dementia. 8/17/20 – R20's assessments revealed that R20 was cognitively impaired and at risk for elopement. 8/21/20 11:00 PM – A nurse's note documented that R20 was noted with increased anxiety, agitation, throwing things and exit seeking. 8/22/20 5:25 PM – A nurse's note documented that R20 was noted with increased anxiety, agitation and exit seeking behavior. 8/23/20 3:35 PM - An incident report submitted to the State Agency included: "Resident exited community via rear exit without notifying staff. Resident does not reside on memory care wing." An unsigned, undated and unknown staff member statement included: "The door by (room) 139 came through on my pager stating that the exit door was open. I went down to check, and I didn't see anyone. I checked resident's rooms and didn't see the one (R20), so I walked outside around the building and she was sitting out back." The facility lacked evidence that staff immediately went outside to investigate the grounds after the alarm went off and was sent to the staff pager. 8/24/20 7:10 PM – An incident report submitted to the State Agency included that R20 had exited through the back door and was seen walking around the building. This was the second day in a row that R20 had eloped from the facility with a functioning alarm system. 2. 8/2/20 - R21 was admitted to the facility with dementia and lung cancer.		

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	An undated staff statement documented that the Nurse Practitioner saw R21 outside from the Wellness Center. 12/23/21 – An untimed staff statement documented: "I went on my break. R21 was outside all by herself. She (R21) stated that she (R21) wheeled herself out. She (R21) was very cold." 12/23/21 1:00 PM – A facility universal incident report included: R21 was found by kitchen staff outside by the rear of the building. R21 stated that she propelled herself out of the door. 3. Review of R1's clinical record revealed: 10/9/19 – R1 was admitted to the facility with Parkinson's disease and dementia. 11/16/21 – R1's mini mental exam revealed that R1 was cognitively impaired. 3/2/22 – R1's elopement risk assessment revealed that R1 was at risk for elopement related to cognitive impairment, Parkinson's and dementia. 3/23/22 10:16 AM – An incident report submitted to the State Agency included: "Resident exited building at emergency exit at end of hallway and began to ambulate (walk) around the exterior of the building. Resident was redirected back into the community without incident when observed by a visitor (her daughter)." R1 was outside unattended (for) approximately 10 minutes. Although the security system was functioning, staff did not immediately respond to the exit door alarm. 4. Review of R4's clinical record revealed: 8/7/20 - R4 cognitively impaired on admission. 8/28/20 5:45 PM – An incident report to the State Agency included: "Resident exited the building from back door without informing staff, walked around to front door, and returned to the community. (This is the third elopement out of rear exit		

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	this month)." Although the security system was functioning, R4 had gotten all the way around from the rear exit to the front door, it is evident that there was not an immediate response to the exit door alarm. 9/3/20 – R4's assessments revealed that R4 was cognitively impaired and R4 was at risk for elopement. 5. Review of R5's clinical record revealed: 10/7/20 – R5 was admitted to the facility with dementia and hallucinations. 10/19/20 – A nurse's note (untimed) documented on a physician's order sheet included: "At approximately 4:00 PM it was found that resident (R5) had eloped from the facility, and it's grounds. Resident had exited through the back door. She (R5) was found on (said road) at the (named church)." R5 was approximately one-half of a mile away from the facility when located. The facility lacked evidence that the exit door alarm was responded to immediately. 10/31/20 – A nurse's note (untimed) documented that R5 was exit seeking and opened the exit near her apartment two times. 11/9/20 9:00 PM – A nurses note documented that R5 had been exit seeking throughout the evening shift. 11/15/20 2:30 AM – A nurse's note documented that R5 had increasing behaviors and exit seeking. 12/2/20 3:05 PM – An incident report submitted to the State Agency included: "Resident (R5) eloped from the side door of the community at 15:05 hrs. (3:05 PM). (R5) was on (the) periphery of property, about to leave, when (R5) was intercepted by homeowner of property bordering the community. Resident was escorted to staff member (by homeowner) who returned her (R5) to the		

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	community at approximately 15:08 hrs. (3:08 PM)." The security system was functioning, yet R5 was about to leave the facility grounds. 12/2/20 3:45 PM – A statement from E1 (ED) documented: "At approximately 15:00 hours (3:00 PM), I observed the alarm for the door next to Apt 138 alerted on my pager. I responded to the alarm and went to the exit indicated. I did not see any residents outside the exit." The facility lacked evidence that a search of the grounds was completed at that time. 12/2/20 – R5's assessment revealed that R5 was at high risk for elopement. 12/3/20 – R5 was assessed to be cognitively impaired. 6. 5/25/22 11:15 AM – During an observation and interview, E8 (CSN) stated that there was a panel in the Wellness Center that monitors resident pendants and exit doors. E8 confirmed the Memory Care Unit courtyard exit door alarm was not functioning. 5/25/22 11: 20 AM - During an interview, E7 (_RCP – Lead Resident Care Partner) confirmed that it was the responsibility of the RCPs (Resident Care Partners) and the nurses to ensure that the exit door alarms were being answered. E7 stated that the monitoring screen in the Wellness Center alerts staff when the exit doors have been opened. E8 (CSN) stated that it was the responsibility of maintenance to check the panel monitor and investigate when doors are not secure, pendants are not functioning or when pendants required their batteries to be changed. 5/25/22 at approximately 11:30 AM – During an observation and interview, E15 (Memory Care Manager) confirmed that she was not aware that the door to the courtyard in the memory care unit was unsecure and that residents could exit unattended. During the interview it was revealed that the memory care unit door alarm to the closed		

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	courtyard did not have a cover over it, batteries in it, and was not functioning. The Surveyor opened the door and demonstrated that the door was not alarmed and was unsecure. 5/25/22 12:00 PM – During an observation and interview, E13 (MM - Maintenance Manager) confirmed there were no batteries or a cover for the courtyard exit alarm, and that the alarm was not functioning. 5/25/22 3:25 PM – During an interview, E2 (CSM) confirmed the pagers that facility staff carry identify what exit door is open. E2 stated that the old exit alarms triggered when the door was opened and that the alarms shut off as soon as the door closes. The new screamer alarms that were installed 4/3/22 have to be manually turned off by staff to stop the ringing. During the time before the new screamer alarms were installed, there were six elopements from the facility between 8/23/20 and 4/3/22. Findings were reviewed 6/1/22 with E1 (ED) and E2 (CSM) at the exit conference, beginning at approximately 12:30 PM.		

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