Delaware Health
And Social Services
Division of Health Care Quality
Office of Long Term Care Residents Protection

January 9, 2020

Donna Winegard– Administrator
Brandywine Senior Living at Seaside Pointe – Assisted Living
36101 Seaside Blvd.
Rehoboth Beach, DE 19971-1189

RE: Brandywine Senior Living at Seaside Pointe Annual and Complaint Survey ending December 18, 2019

Dear Ms. Winegard:

I wish to thank you and your staff for the courtesy shown to the surveyors who conducted the Annual and Complaint survey, which ended on December 18, 2019. The survey findings show that your facility had State requirements that were not met. Enclosed is the State Survey Report which provides specific details.

An acceptable Plan of Correction (PoC) for the deficiencies must be submitted, with the required signature, on the enclosed forms within ten (10) days of receipt of this letter.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur; and
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

You have the opportunity to question cited State deficiencies through an informal dispute resolution process ("IDR"). The parameters for State IDR are consistent with those applicable to the Federal IDR process.

To request an IDR, you need to submit a written request that identifies the specific deficiencies being disputed and includes an explanation of the basis for disputing the deficiencies. Written requests should be submitted to me at the address listed on the letterhead.

If you have any questions concerning this letter or the survey report, please contact me at (302) 421-7410.

Sincerely,

Robert H. Smith
Licensing and Certification Administrator

RHS/tj

Enclosure

cc: Jill McCoy, LTC Ombudsman
Richard McKee, DLTCRP
File

BRANDYWINE LIVING
at Seaside Pointe

Life is Beautiful

January 19, 2020

RE: Brandywine Living at Seaside Pointe Annual and Complaint Survey
Plan of Correction

Robert Smith,

Our Plan of Correction for the annual and complaint survey ending December 18, 2019 is included in this email. If you have any questions or need additional information please contact me at (302) 226-8750.

Cordially,
Donna Winegar
Donna Winegar NHA, CDAL
Executive Director

36101 SEASIDE BLVD. REHOBOTH BEACH *delaware* 19971

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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7410

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Seaside Pointe

DATE SURVEY COMPLETED: December 18, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning December 10, 2019 and ending December 18, 2019. The facility census on the entrance day of the survey was 119 residents. The survey sample was composed of 17 (seventeen) residents plus 18 additional residents in the subsamples. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. **Abbreviations/definitions used in this state report are as follows:** ED - Executive Director; WD - Wellness Director; AWD -Assistant Wellness Director; RN - Registered Nurse; LPN - Licensed Practical Nurse; WN - Wellness Nurse (may be RN or LPN); ADLs (Activities of Daily Living) -tasks for daily living, like dressing, hygiene, toileting, bathing and eating; AL- assisted living; Cognitively impaired - mental decline including losing the ability to understand, talk or write; Continence - control of bowel and bladder function; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; eMAR (Electronic Medication Administration Record) - list of daily medications to be administered; Mobility-walking; Neuropsychologist - doctor specializing with the brain's effect on behavior; NSAID - non-steroidal anti-inflammatory drug; PET alarm - small device worn as a necklace with a button, when pressed, alerts staff the resident needs assistance; PRN - as needed; Psychiatric (psych) - treatment of mental disorders; Reflections unit - locked area for supervision of residents with dementia; Rehab - Rehabilitation; Service plan/ agreement - document developed with each resident that describes the services to be provided, who will provide the services, when the	

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	services will be provided, how the services will be provided, and if applicable, the expected outcome; Skilled nursing facility- nursing home; Suicidal thoughts (suicidal ideation) - thinking about hurting/ killing oneself which can range from wishing one was dead to developing a detailed plan to end one's life. These thoughts are common when the person is undergoing stress or experiencing depression. Tuberculosis - lung infection that is spread to others; UAI (Uniform Assessment Instrument) -assessment to collect information on the physical condition, medical status and psychosocial needs of an applicant/resident to determine eligibility for an assisted living facility.	
3225.0	**Regulations for Assisted Living Facilities**	
3225.8.0	**Medication Management**	
3225.8.3	**Medication stored by the assisted living facility shall be stored and controlled as follows:**	
3225.8.3.5	All expired or discontinued medication, including those of deceased residents, shall be disposed of according to the assisted living facility's medication policies and procedures. **This requirement is not met as evidenced by the following:** Based on observation and interview it was determined that, for one out of three medication carts Inspected for medication storage, the facility failed to dispose of expired medications. Findings include: 12/15/19 beginning at 1:26 PM - During an Inspection of the medication cart containing medications for the second floor of the assisted living section the following expired medications were observed: 1. M1's bottle of an NSAID medication to be used once a day PRN expired 10/29/19. 2. M2's box of a medication to treat diarrhea PRN expired 11/30/19.	3225.8.3.5 1.M1 & M2 expired medication were disposed of per facility policy as soon as they were brought to Wellness Nurse attention. New medication was ordered for M1 & M2. 2.All residents are at risk of having expired medications. An audit was performed by Wellness Director to ensure no further drugs were expired. 3. Wellness nurses will be educated on the importance of disposing expired medications per facility policy. New procedure implemented for night nurse on Sunday nights to check all med carts for expired meds. Random spot checks will be done on all carts by Assistant Wellness Director monthly with results reported quarterly QI 4. Monthly audit on all carts will be completed by Assistant Wellness Director. Results will be reported at quarterly QI. Ongoing. January 22, 2020

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3225.8.8.1	E25 immediately confirmed the medications were expired and informed the surveyor they would be disposed of immediately. Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM. **Medications are properly labeled, stored and maintained.** **This requirement is not met as evidenced by the following:** Based on observation and interview it was determined that, for one out of three medication carts inspected for medication storage, the facility failed to ensure each medication had a pharmacy-generated label containing the required information. Findings include: 12/15/19 beginning at 1:26 PM - During inspection of the medication cart containing medications for the second floor of the assisted living section the following incorrectly labeled medications were observed: 1. MI's bottle of an NSAID medication to be used once a day had PRN hand-written on the label in black marker. 2. M3's Novolog (insulin) FlexPen was not labeled with the date it was opened. Manufacturer recommended storage conditions for this insulin included that this medication should be used within 28 days after its first use. Without an open date, it was unclear as to when the medication would need to be discarded. https://www.novonordiskmedical.com/our-products/storage-and-stability.html An interview during the medication cart inspection with E25 (WN) confirmed the label had not been changed with a new pharmacy-generated label when MI's order was changed to PRN. E25 also confirmed the insulin pen was not dated when it was opened and that both	**3225.8.8.1** 1.M1 bottle of NSAID was replaced by pharmacy. M3 Novolog (insulin) was replaced with another pen and dated upon opening that same day. 2.All residents are at risk of not having a pharmacy generated label with required information on their medication. All residents are at risk of not having the date opened assigned to their medication. An audit of all carts has been done to ensure all pharmacy labels were in place and all meds were dated as to when they were opened. 3.Wellness nurses will be re-inserviced on dating medications when opened. 4.Labels will be checked as well as dates meds were opened on the weekly cart audits done by Night Nurse on Sunday Nights. Any discrepancies will be reported immediately to Wellness Director January 22,2020

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	medications would be immediately discarded. Findings were reviewed with E1 (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
3225.9.0	**Infection Control**	
3225.9.5.1	**The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** **This requirement is not met as evidenced by the following:** Based on record review, interview and review of other facility documentation it was determined that the facility failed to maintain an effective infection prevention and control program by not ensuring tuberculosis (TB) testing was completed for two (R3 and R11) out of 17 sampled residents. For R3 and R11, the facility failed to ensure the residents received the second tuberculin skin test (TST) of the required 2-step testing. Findings include: CDC guidelines for Tuberculin Skin Testing (TST), last revised 5/11/16, documented the ability to react to the skin test diminishes years after infection creating a false-negative reaction [person has tuberculosis but the skin test does not show it]. The skin test may stimulate the immune system causing a positive reaction on subsequent tests. Giving a second test after the initial one is called two-step testing. Two-step testing is useful for the initial testing of adults who would be tested periodically, to reduce the chance of a boosted reaction. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm 1. Review of R3's clinical record revealed: 3/23/19 - R3 had a negative TST prior to admission to the facility. 4/1/19 - R3 was admitted to the facility.	3225.9.5.1 1.Both R3 & R11 will have the 2 step process repeated and completed. 2.All new residents are at risk of having incorrect documentation reflecting outcomes of PPD testing. A chart audit will be conducted by nursing on all residents to ensure correct documentation that reflects each step being given and results of each test. 3.An inservice will be given on January 21, 2020 to all nursing staff by Wellness Director on correct documentation and administration of PPD. 4.Wellness Director or designee will input PPD orders into new residents MAR manually and will be responsible to check for completion at designated time by keeping track on desk calendar. February 1, 2020

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	4/1/19 12:15 PM - A nursing service note documented, "Will need a 2-step PPD (TST) on 4/3/19." 4/23/19 -The facility's Immunization form indicated that R3 received a TST on 4/23/19, but no results were documented. 12/13/19 9:27 AM - During an interview E2 (WD) confirmed the facility does two-step TST on admission, unless they had it elsewhere in the last year. 12/18/19 10:50 AM - During an interview, E2 (WD) confirmed that she could not find the results of the 4/23/19 TST. 2. Review of RII's clinical record revealed: 1/18/18 - RII had a negative TST prior to admission to the facility. 1/22/18 - RII was admitted to the facility. 12/13/19 10:50 AM - A review of RII's medical record revealed no documentation a second TST was done. 12/13/19 9:27 AM - During an interview E2 (WD) confirmed that the facility does two-step skin testing on admission, unless they had it elsewhere in last year. 12/18/19 10:50 AM - During an interview, E2 (WD) confirmed there was no evidence that RII received a second TST. Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
3225.9.5.2	**Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test {TST) or single Interferon Gamma Release Assay (GRA or TB blood test) such as Quantiferon. Any required subsequent testing according to risk category shall be in accordance with the recommend-dations of**	3225.9.5.2 As we are unable to identify the affected employees, we will do a complete audit of all current employee 2 step PPD. Every new employee is at risk.

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	the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category. **This requirement is not met as evidenced by the following:** Based on review of other facility documentation and interview it was determined that the facility failed to ensure, for ten (E4, E7, ES, E9, Ell, E12, E14, E17, E18 and E19) out of 16 employees sampled for infection control review, that each employee received the first TB test pre-employment and/or received a second step as indicated. Findings include: 6/1/07 (last revised November 2009) - Review of a facility policy entitled Staffing Requirements DE (Delaware) included the requirements for employment. TB Test: Two step testing is used for initial screening unless you (employee) provide documentation of a negative PPD test in the preceding 12 months. The testing will establish a reliable baseline of information for your file. Two step testing means that if the first test is negative, a second test will be given one to three weeks later. Review of a State Personnel Audit Sheet completed by the facility for 16 randomly-selected employees revealed the following TB testing concerns: -E4 (7/25/19): second step not completed. - *El* (7/9/19): first step done 7/12/19, 3 days later. - E8 (8/13/19): second step not completed. - E9 (10/30/19): no TB testing completed. - Ell (10/14/19): first step done 10/17/19, 3 days later. - E12 ((9/6/19): second step not completed. - E14 (3/13/19): first step done 3/25/19, 12 days later; no second step completed. - E17 (3/13/19): first step done 3/22/19, 9 days later; no second step completed. - E18 (5/24/19): first step done 8/15/19, 83 days later.	**3225.9.5.2 (continued)** All employees found not to have 2 step completed PPD will be sent to Quality Access to have Quantiferon blood test drawn. Current employees needing appropriate PPD testing will be required to have Quantiferon blood test by February 15, 2020. All new employees will be required to have Quantiferon blood test done with pre employment physical before starting work. Human Resource Director will review all pre-employment paperwork and not allow any employee to begin work without appropriate PPD testing. February 15, 2020

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	- E19 (9/27/19): first step done 11/11/19, 40 days later; no second step completed. 12/17/19 (afternoon)- During an interview E1 (ED) confirmed that the TB testing data was accurate and that some staff failed to have their skin test read in a timely fashion, which resulted in an incomplete test. Findings were reviewed with E1 (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
3224.11.0 3225.11.4	**Resident Assessment** **The resident assessment shall be completed in conjunction with the resident.** **This requirement is not met as evidenced by the following:** Based on record review and interview it was determined that, for one (R13) out of 17 sampled residents, the facility failed to ensure the UAI assessment was completed in conjunction with the resident or responsible party (RP) or that the resident or RP was aware of the assessment results. Findings include: Review of R13's clinical record revealed: 9/20/19 - R13 was admitted to the facility. Review of the UAI found no evidence that the initial assessment, completed the day before admission, was discussed/ reviewed with the resident or responsible party. 12/10 /19 (12:14 PM) - During an interview with E3 (AWD), who had been at the facility for around 8 weeks, stated she "had a lot to sign so If you are looking for UAIs and service plans they might be in my office." E3 expressed that obtaining responsible party signatures has been challenging.	**3225.11.4** UAI for R13 reviewed and signed by him. All residents are at risk to have an unsigned UA1. Wellness Director and Assistant Wellness Director will review every current resident's UAI to insure signature/phone conversation with POA is documented. Random audit of 10% of census will be completed by Community Operations Manager monthly and reported quarterly to QI. February 15, 2020.

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	12/13/19 at 10:35 AM- During an interview E2 (WD) confirmed the missing signatures and stated, "I usually write discussed with and put their name, but I didn't." Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM. Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	**3225.11.5** The UAI was completed for R2, R13 & R17. R4 no longer reside at the facility. All residents are at risk for this issue. Wellness Director and Assistant Wellness Director will review every current resident's UAI to insure timely completion of 30 day, annual and significant change. Wellness Director and Assistant Wellness Director will insure timely completion through use of a tickler file for each unit (AL & Reflections). Random audit of 10% of census will be completed by Community Operations Manager monthly and reported to quarterly QI twice. February 16, 2020.
3225.11.5	The UAI, developed by the Department, shall be used **to update the resident assessment. At a minimum,** regular updates must occur 30 days after admission, annually and when there is a significant change in the **resident's condition.** **This requirement is not met as evidenced by the following:** Based on record review, observation, interview and review of other facility documentation it was determined that for four (R2, R4, R13 and R17) out of 17 sampled residents, the facility: - failed to review R13's resident assessment within 30 days of admission; - failed to complete an annual assessment timely for one (R17) resident; and - failed to conduct a resident significant change assessment when two (R2 and R4) residents had recurrent falls and when R6 was readmitted after being in a rehabilitation facility. Findings include: 1. 30-day Review Review of R13's clinical record revealed: 9/20/19 - R13's initial UAI was completed the day prior to admission. There was no evidence that the initial UAI assessment was initially acknowledged by the resident or responsible party (no signature) nor was it reviewed within 30-days of admission.	

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	12/13/19 at 10:35 AM - During an interview E2 (WD) confirmed that the 30-day review was not completed. 2. Annual Assessment A review of R17's clinical record revealed: 4/29/14 - R17 was admitted to the facility. 11/16/18 - R17's annual UAI was completed. There was no evidence that the UAI was completed in November 2019. 12/18/19 at approximately 11:30 AM - During an interview, E2 (WD) confirmed that R17's UAI "was late" and had not been completed yet for November 2019. 3. Significant Change Facility policy entitled Resident Fall Interventions (last revised 9/2014) included that "All residents have some risk to be at risk for falling: the resident's service plan/support plan/care plan will identify interventions on the typeof risk... - "Post Fall assessment and treatment. Complete post fall form prior to the end of the shift. Determine the resident's cause of fall and identify and change or add interventions...Wellness Director/ designee will review post fall investigation, review fall interventions and modify service plan/ plan of care as indicated. Will communicate changes in service plan/ plan of care to all appropriate staff." Undated - Facility List of "Don't Bring in" items included, "Slip on slippers - do not use treaded slipper socks." a. A review of R4's clinical record and facility fall incident documentation revealed: 12/3/14 - R4 was admitted to the facility with dementia. 4/7/19 - 11/26/19 - R4 sustained 41 falls: - April: 5 falls.	

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	- May and June: 1 fall each month. -July: 10 falls. - August: 4 falls. - September: S falls. - October: 8 falls. - November: 7 falls. 7/9/19 - R4's annual UAI assessment documented that R4 was cognitively impaired, only oriented to self and sometimes place, had a short-term memory problem, and was a fall risk. R4 was independent (using a walker) with walking, transferring and toileting, There was no evidence that the facility completed a significant change UAI assessment after R4 began experiencing recurrent falls to determine if any additional fall prevention interventions should then be included in R4's service plan. 12/11/19 10:00 AM - During an interview, E2 (WD) reported that any new interventions for falls were only passed on in the 24-hour report and would not be included in the service plan. b. Review of R2's clinical record revealed: 12/20/18 -The Annual UAI assessment documented that R2 was independent with mobility, transferring and toileting. The 12/20/18 service plan included, under the fall risk section, Standard Fall Risk Protocol and resident checks "at meals and PRN." The special approaches section included "reminders/ redirection 4+ /shift. Frequent checks" including "checks at night." Occasional, one-person assistance with toileting. January- November 2019 - Review of R2's clinical record and facility incident documentation for falls found R2 experienced 13 (thirteen) falls (January Sand 30; February 11; May 13 and 28; June 15; July 2, 7 and 16; September 30; October 2 (two falls); and November 15. There was no evidence that the facility completed a significant change UAI assessment after R2 became	

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	unsteady and began experiencing recurrent falls to determine if any additional fall prevention interventions should be included in R2's service plan. 12/11/19 at 10:00 AM - During an interview E2 (WD) stated that if adding non-skid socks, there would be no change in the service plan since socks were to be put on anyway. E2 added that toileting/ offering "toileting should be done with the hourly checks on the Reflections unit" (locked dementia unit where R2 resided). 12/16/19 (11:56 AM)- R2 was observed walking with assistance of E20 (CM) and E24. (CM) from the living room to the dining room. R2 was bent forward at the waist around 45 degrees and took fast steps. E24 verbally advised R2 to "slow down." There was no instruction for R2 to stand upright. 12/17/19 at 3:05 PM - During an interview with E2 (WD) and E3 (AWD) to determine the difference between standard fall protocol and fall alert program (an option on the service plan), E2 said the "first time she saw" the listing of fall interventions in the policy was "when the surveyor showed" her the other day. [E2 had been employed by the facility since April 2008.] The facility failed to reassess R2 after the resident became unsteady on her feet began to experience recurrent falls to determine additional care and services were needed to maintain safety. c. Review of R6's clinical record revealed: 1/16/17 - R6 was admitted to the facility. 9/25/19 - A nursing note documented, "...911 was called and [R6] was transported to the emergency Room...Resident admitted to the hospital for a [left] leg wound..." 10/31/19 -A nursing note documented, "Resident readmitted from [name of rehabilitation facility] ..."	

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	10/31/19 - R6's significant change service plan was signed by E2 (WD). 12/18/19 at 10:55 AM - During an interview, E2 (WD) confirmed that she was unable to find the significant change UAI assessment for 10/31/19. Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
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;** **3-304.15 Gloves, Use Limitation** (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when **interruptions occur in the operation.** **This requirement is not met as evidenced by** the **following:** Based on observation and interview it was determined that the facility failed to prevent contamination of ready-to-eat food when single-use disposable gloves were not used for only one task and not changed after contamination. Findings include: 12/16/19 (11:50 AM -12:30 PM)-The surveyor observed the following during a random lunch observation on Reflections 1 (first floor): - E26 (CM), while wearing disposable gloves, E26 served glasses of water then opened a kitchen cabinet and pushed the dirty dish cart, contaminating the gloves. - E26 placed oven mitts on both hands (over the gloves) to remove re-plated hot foods from the food cart to place on the counter. After removing the right oven mitt, E26 reached into an open bag of tortilla chips with	**3225 12.1.3** All staff will be re-inserviced on proper use of single use gloves by completing a self-instruction packet and signing off on adherence to policy. All staff are at risk for improper use of single use of single use gloves. Random observations of glove use during meal pass will be conducted by Wellness Director, Assistant Wellness Director, Executive Director, Dining Services Director, and Community Operations Manager. Any misuse will be addressed immediately and a coaching form will be completed. Any employee who continues to be non-compliant with single use glove use will receive progressive disciplinary action as needed. Executive Director will monitor all employee coachings and progressive disciplinary actions. February 16, 2020. (See attachments A & B)

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	the contaminated gloved hand and placed the chips on a plate. The process repeated several times with placing the oven mitt on the right hand, removing the mitt and reaching into the bag to retrieve tortilla chips to put on plates. - E24 (CM) served several entree plates wearing disposable gloves, contaminating the gloves. Without hand hygiene and changing gloves, E24 cut D4's sandwich while touching the food with the contaminated gloved left hand. 12/17/19 at 8:45 AM -During an interview, E1 (ED) confirmed the gloves should have been changed prior to touching food items. Findings were reviewed with E1 (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
3225.13.0	Service Agreements	
3225.13.1	**A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement.** **This requirement is not met as evidenced by the following:** Based on record review and interview it was determined that the facility failed to ensure a service agreement (service plan) for three (R6, R10 and R15) out of 17 sampled residents was reviewed with, and signed by, the resident or responsible party. Findings include: 1. Review of R6's clinical record revealed: a. 1/10/17 -An initial Resident General Service Plan/ Assessment (service plan) was signed by E2 (WD). The boxes labelled yes or no to indicate if a copy was given to the resident/family were blank. The box labelled	3225.13.1 Cannot correct R6 as resident is no longer here. Have corrected R10 & R15. All residents are at risk for this issue. Wellness Director/Assistant Wellness Director will review every current resident's service plan to insure signature/phone conversation with POA is documented. Random audit of 10% of census will be completed by Community Operations Manager monthly and reported quarterly QI. February 15 2020.

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	reviewed was checked. 1/16/17 - R6 was admitted to the facility. b. 10/31/19 -A nursing note documented, "Resident readmitted from [name of rehabilitation facility] ..." 10/31/19 - A significant change service plan was signed by E2 (WD). The boxes labelled yes or no to indicate if a copy was given to the resident/family were blank. The box labelled reviewed was checked. 12/18/19 at 10:55 AM - During an Interview, E2 (WD) confirmed that there was no documentation that R6 (or her representative) signed or received a copy either service plan (1/10/17 or 10/31/19). 2. Review of RIO's clinical record revealed: 6/6/16 - Admission to the facility. 11/7/19 - The annual service plan was not signed by the nurse, resident or family even though the response to the question if a copy of the plan was given to the resident/ family upon request was marked "reviewed." 12/18/19 (around 11:30 AM)- During an interview E2 (WD) confirmed the findings. 3. Review of RIS's clinical record revealed: 6/6/16 -Admission to the facility. a. 9/13/18 - The significant change service plan was not signed by the nurse, resident or family. The response to the question whether a copy of the plan was given to the resident/ family upon request was marked **/(reviewed."** b. 6/7/19 - A significant change UAI assessment was completed. There was no evidence that a service plan was completed for this significant change. 12/17/19 (1:20 PM)- During an interview E2 (WD)	

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	confirmed the two findings. Findings were reviewed with El (ED), E2 (WO) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by the following:** Based on record review and interview it was determined that the facility failed to ensure the service plan for one (R13) out of 17 residents was available for the staff to review and follow. Findings include: Review of R13's clinical record revealed: 9/20/19 - R13 was admitted to the facility to the Reflections unit. 10/25/19 - R13 moved to another unit in the facility. There was no initial service plan in the clinical record. 12/13/19 (around 10:15 AM) - During an interview with E2 (WO) and E3 (AWD), E2 stated that she usually made a copy of the service plan for the CM care book and placed the original in the chart. E2 was unable to locate any copy of R13's service plan in the care book on the unit where the resident currently resided. 12/13/19 (around 10:35 AM) - During an interview, E3 (AWD) stated there were two copies of the service plan in the CM care book on the Reflections unit where R13 was originally admitted. Findings were reviewed with El (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	3225.13.5 The service plan for R13 was made available for staff immediately. All residents are at risk for a care plan not available to staff. The Lead C.N.A. on each unit will review the care plan books weekly to insure all care plans are available to staff. They will utilize a current census sheet printed the day of the audit. Any missing care plans will be reported to Wellness Director/Assistant Wellness Director immediately. Wellness Director/Assistant Wellness Director will insure care plan is placed in book. Wellness Director/Assistant Wellness Director will document number of times a care plan was not available on audit tool and report quarterly to QI January 22, 2020.

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3225.14.0 16 Del. Part II, Chapter 11 § 1121	Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein. **Patient's rights.** **(1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement is not met as evidenced by the following:** Based on observation and interview it was determined that the facility failed to provide care and services in a dignified manner. Findings include: 12/16/19 - During observations on the Reflections I unit the following was discovered: 1. 11:35 AM: E20 (CM) moved the wheelchair in which D2 was sleeping and startled D2 without first getting the resident's attention. E20 then placed a folded blanket under D2's left side as D2 was leaning to that side. 2. 11:40 AM -11:56 AM: Residents were assisted from the living room to the dining room. Hand hygiene was not offered to residents who self-feed prior to the meal that contained a finger food - R2, D4, D5, D6, D8 and D10. 3. 11:58 AM: E20 (CM) placed a clothing protector on D1from behind without first saying anything to the resident. 4. 12:00 PM: E26 (CM) served drinks while wearing disposable gloves. 5. 12:05 PM: D4 was served her soup and began eating. Within a couple minutes, E20 began feeding D1	1121 Unable to correct immediately as deficient practice already occurred. All residents are at risk for their patients rights to be infringed upon. All employees will have re-inservice on resident's rights and dignity/TRUST pledge by February 16, 2020. Signed acknowledgement will be maintained on file. Ongoing observation and monitoring by all management shall occur. Any infraction of TRUST policy will be immediately addressed through coaching or performance improvement action as warranted. (attachments A, B, C). February 16, 2020.

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	and D2. D3 sat at the table without her meal until 12:26 PM. 6. 12:05 PM -12:30 PM - E20 (CM) and E24 (CM) served meals to residents wearing disposable gloves. 7. 12:03 PM: E20 (CM) served D10 a bowl of soup and D10 started to feed himself. -12:06 PM: D10 finished the soup and banged on the table three times with his hand. After banging on the table again, a family member of a resident seated at the same table said to D10, "Be patient, it is coming." D10 sat quietly for a few minutes. -12:09 PM: D10 then banged the table three times in a row with his hand and yelled incomprehensibly. E24 (CM) shouted from the kitchen area across the dining room, **"We are waiting for the food to come down."** 12:14 PM: D10 banged the table three times in a row again without response from staff. 12:15 PM: While the food cart was arriving on the unit, D10 banged the table several times with his hand. D10 repeated the banging three more times, then banged continuously for a few seconds. The same family **member said to D10, "Be patient it is coming." 010** immediately returned to banging the table two more times. E24 yelled from the kitchen area located on the opposite side of the room from where D10 was seated, "Okay [DI0's first name] just one minute." while facing away from the resident. D10 continued to bang the table until served his meal at 12:18 PM. 12/17/19 (8:5 AM)-During an interview El (NHA) was informed by the surveyor the dignity findings from the observations on the Reflections I unit. El acknowledged that the findings were, indeed, dignity issues and added that the staff should have addressed D10 directly or offered the resident something else to eat or drink. Findings were reviewed with El (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	

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3226,19,0 3225.19.1	Records and Reports The assisted living facility shall be responsible for **maintaining appropriate records for each resident.** These records shall document the implementation of **the service agreement for each resident.** **This requirement is not met as evidenced by the following:** Based on record review and interview it was determined that the facility failed to complete a fall assessment for one (R13) out of 17 sampled residents and failed to ensure the resident's name was on the form. Findings include: Review of R13's clinical record revealed: 9/19/19 - The fall risk assessment was without a resident name, without the signature of the person completing the form, nor was the form totally completed. The only section completed was the continence section. 12/13/19 at 10:35 AM - During an interview E2 (WD) confirmed that the fall risk assessment was not completed. E2 stated, while pointing to the continence section, "it looked like we stopped here." E2 added "There is no excuse for that. " Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	3225.19.1 Fall assessment has been completed on R13. All residents may be affected by this issue. Wellness Director and Executive Director will develop a checklist of forms to be completed upon admission including fall assessments. Random audit of 10 % of census will be completed by Community Operations monthly to make sure checklist of admission paperwork is accurate and complete. Results of audits will be reported quarterly QI for 2 quarters. February 1. 2020.
3225.19,5 3225.19.5.5.2	**Incident reports, with adequate documentation, shall be completed for each incident, Records of incident reports shall be retained in facility files for the following:** **Falls without injury and falls with injuries that do not require transfer to an acute care facility or do not require reassessment of the resident.** This requirement is not met as evidenced by the	3225.19,5 Unable to correct as this incident has already occurred.. All residents are at risk to not have fall investigation completed. Wellness Director/Assistant Wellness Director or designee will be responsible to make sure all components of fall investigation including witness statements are included with each incident report. Executive Director will audit all incident reports and back up documentation on a weekly basis. Executive Director signature on incident report will indicate full completion. February 1, 2020.

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	following: Based on record review, interview and review of other facility documentation it was determined that the facility failed to thoroughly investigate a fall for one (R2) out of 17 sampled residents. Findings include: Review of R2's clinical record and fall investigation documentation revealed: 1/5/19 -An investigation statement written by E27 (CM) included that the housekeeper had informed E27 that R2 was on the floor. There was no evidence that the facility obtained a statement from the housekeeper. 12/16/19 (1:11PM)- During an interview the surveyor asked E2 (WD) if a statement was obtained by the housekeeper who found R2 on the floor. E2 did not provide any additional information to the surveyor. Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
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.** Based on record review, interview and review of other facility documentation it was determined that the facility failed to report an allegation of mistreatment immediately for one (RI) out of six residents sampled for investigation of abuse or neglect. Findings include: June 2006 (last revised April 2015) - Review of the facility policy entitled T.R.U.S.T. Program: Abuse Prohibition included "any incident of suspected or actual resident abuse or neglect will be immediately reported to the on-site supervisor." Review of RI's clinical record and facility investigation documentation for an allegation of mistreatment	

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	revealed: 5/3/19 (9:30 PM)- E28 (CM) heard RI screaming in RI's room. E29 (CM) was exiting the room when E28 entered the room. - E28's written statement dated 5/3/19 included that RI had "two slashes bleeding" and when E28 asked RI what happened, RI responded "the other girl did it." E28 immediately told E33 (WN), - E33's written statement dated 5/3/19 included that E33 heard RI say "Get out of here!" several times. E33 saw E29 exit RI's room and "threw her hands up in the air stating I'm done." RI told E33 "I don't want that girl in here ever again. She's mean and nasty... she hurt me look what she did" while E33 was dressing the skin tear to RI's right lower arm. E33 notified E34 (AWD at the time of the incident). a. Reporting to State Agency 5/3/19 - Review of the State Agency incident reporting found that E34 (former AWD) did not report the allegation of mistreatment, abuse or neglect within 8 hours of the 5/3/19 (9:30 PM) incident. 5/9/19 - EI (WD) reported the allegation, six days after the incident. b. Review of abuse investigation documentation from the facility and the State Agency, including facility investigation written statements, revealed other allegations of mistreatment, abuse, neglect were not immediately reported within the facility, thus not reported to the State Agency: 5/7/19 - E30's (CM) written statement documented that E29 "has been forceful with (RI) and her seat ...(RI) always sits in the same chair in the dining room and (E29) "pulled the chair with (RI) in it to a different table after resident refused to change tables. Another family member was in the dining room at this time & (and) saw this. I have never witnessed (R29) being physically abusive. I have spoken with her about her forceful tone & when a resident says no it's their right ...I did not report this because I thought after we talked	3225.19.6 The incident noted was reported to DHQ but not timely. All residents are at risk of having a reportable incident not reported timely. Nurses will be re-inserviced on what a reportable event is and the time frame in which to report it. When incident reports are reviewed by Wellness Director/Assistant Wellness Director/Executive Director (See 3225.19.5.5.2) timely reporting to DHQ of the incident will be monitored. 1/22/2020

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	she understood that was not okay to do." 5/7/19 - E31's (CM) written statement included that E29 "proceeded to jerk the chair back from the table (with [RI] in it) to another table where she wanted her to sit ...when multiple residents ask to use the bathroom ...(E29) yells at them that they 'just went to the bathroom' and refuses to take them ...(E29) gets very annoyed and upset when (R4) asks questions repeatedly and says statement such as 'I just told you that' ...(E29) tends to get very angry with residents easily and tends to verbally abuse residents ...I have spoken with E32 (WN) on multiple occasions as well as E34 (former AWD) a few times and other coworkers." 5/7/19 - E28's (CM) written statement included that E29 (CM) had not toileted resident AI "and was yelling at her for the past hour to sit down and she was upset and had to use the bathroom. So she went out of her way to say she's going to toilet (resident A4) then toilet (AI) in 10 mins (minutes) even though A4 didn't have to go and (AI) was crying...Many occasions (E29's) yelling at either RI, A2 or AI when she does (resident AS is) angry she sort of eggs him on ...One time (resident A3) was sitting in the chair facing away and (E29) was sitting down and plucked (A3's) hair and she said 'ow' and E29 laughed ...Many occasions (E29) makes residents sit down to get their nails done every day so (E29) has a reason to sit down. Even if resident is upset and does not want their nails painted ...Me and E31 (CM) have reported this to our nurse as well." 5/7/19 - E33's (WN) written statement included she heard E29 (CM) raise her voice and speak in what I **consider a mean tone of voice to some residents... I** have tried to educate her on how to handle these **situations ...there have also been several occasions with** some residents who I feel should not be left alone in there (sic) rooms because they are high fall risks (especially R4) but she continues to ignore my advice..." Undated - E32's written statement documented "I have observed (E33) become frustrated with residents stating things such as 'I've told you already' and	

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	becoming visually agitated. It has been reported to me that (E33) is rude and impatient ...I have never witnessed or been told of physical abuse from E33. I reported to immediate supervisor about reports of (E33) being rude to residents." 12/17/19 (8:45 AM)- During an interview with EI (ED) to discuss E29's performance issues identified prior to RI's allegation of abuse, EI pulled up the documentation on the computer: E29 was coached on 3/22/19 about being lazy and sitting and letting others do the work or using her cell phone. Verbally talked to E29 about toileting before, after dinner and bedtime, and mouthcare. On 4/25/19 E29 received a verbal warning about not completing vital signs. EI stated she was on leave in April and May 2019 and added she was "surprised when I read about the other issues" in the statements. EI "was not informed" about those concerns. The facility failed to ensure the Executive Director was informed about all allegations of mistreatment, abuse or neglect. This led to the failure to immediately report allegations of mistreatment, abuse or neglect. c. The facility failed to provide the 5-day follow-up in a timely manner. The 5/3/19 incident was reported on 5/9/19 and the 5-day follow-up was provided on 6/6/19. Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	
16 Del. Part 11, Chapter 11 **§ 1131**	**Nursing Facilities and Similar Facilities** **Subchapter III** **Definitions (9) Neglect** **(a) Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals, and safety.** **c. Failure to carry out a prescribed treatment plan for**	

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	a patient or resident. **This requirement is not met as evidenced by:** Based on record review, staff interviews, observation and review of other facility documentation as indicated, it was determined that three (R2, R4 and R6) out of 17 sampled residents experienced neglect while residing in the facility. For R2 and R4, the facility failed to re-assess the resident after falling to implement a new plan of care to provide care and services to prevent them from falling again. Also, for R2, the facility to provide/ offer toileting hourly as per the Reflections unit protocol. For Reflections 1, there was a 15-minute time period with no staff supervision for residents in the lounge area. For R6, the facility failed to provide mental and psychosocial care and services after the resident verbalized suicidal thoughts to facility staff on 11/14/19. Findings include: Facility policy entitled Resident Fall Interventions (last revised 9/2014) included that "All residents have some risk to be at risk for falling: the resident's service plan/support plan/care plan will identify interventions on the type of risk. All direct care staff will be made aware and documentation will be noted on assignment sheet and the 24-hour nursing communication report. Resident fall intervention status will be communicated during shift report. Interventions for falls pages may be added to the (service plan) ...and may be adjusted as the needs of the resident are adjusted... - "Interventions for falls pages" included 65 (sixty-five) fall prevention strategies in the areas of "Fall History; Ambulation Gait/ Balance; Continence; Sensory Deficits; Mental Status; Predisposing Disease; Medications; and Environment." - "The Standard Fall Risk Protocol included ... Bowel and Bladder determination and individualized plan established...Repeat risk assessment with Service Plan reviews and with significant changes." - Post Fall assessment and treatment section included to "complete post fall form prior to the end of the shift. Determine the resident's cause of fall and identify and change or add interventions...Wellness Director/	§ 1131 R4 is no longer in the facility. R6 issue was addressed the very day she verbalized suicidal thoughts (attachment D). Based on the Neuro-Psychologist evaluation it was determined that resident was not a danger to herself or others. R2 UAI & Service Plan were updated to include significant change. All residents may be at risk for some form of neglect. All nurses will be re-inserviced on Fall Policy. Attention will be given to utilizing the Intervention Form (see attachment E) for each resident's individual plan and placing that with the care plan books for all staff accessibility. A note will be placed on the 24 hour report log of each unit when a new fall intervention has been implemented for a resident. Wellness Director/Assistant Wellness Director and Executive Director will meet weekly to review all falls and implement appropriate interventions. Monitoring will occur as noted in response to 3225.19.5.5.2. Executive Director will insure new fall interventions for each resident will be attached to the Incident Report. January 22, 2020.

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	designee will review post fall investigation, review fall interventions and modify service plan/ plan of care as indicated. Will communicate changes in service plan/ plan of care to all appropriate staff." 1. A review of R4's clinical record revealed: 12/3/14 - R4 was admitted to the facility with dementia. 7/9/19 - R4's annual UAI assessment documented that R4 was cognitively impaired, only oriented to self and sometimes place, that R4 had a short-term memory problem, and was a fall risk. R4's fall-risk interventions included: "checks at meal times and PRN (as needed) and standard fall risk protocol." Facility Policy Standard fall risk precautions included: "repeat risk assessments with Service plan reviews and with significant changes." The clinical record lacked evidence of any further assessments and/or changes to the 7/9/19 UAI. The following dates and times are facility documented incidents of R4's forty-one falls in the facility spanning over approximately eight months: 4/7/19 at 5:20 AM; 4/7/19 at 10:15 AM; 4/13/19 at 5:00 PM; 4/22/19 at 9:20 AM; 4/28/19 at 7:20 PM; 5/24/19 at 1:IS PM; 6/11/19 at 10:10 AM; 7/10/19 at 4:45 PM; 7/12/19 at 3:00 AM; 7/14/19 at 7:00 PM; 7/16/19 at 6:IS PM; 7/18/19 at 4:00 PM; 7/20/19 at 12:00 PM; 7/21/19 at 4:20 PM; 7/29/19 at 2:45 PM; 7/29/19 at 10:30 PM; 7/31/19 at 2:38 AM; 8/3/19 at 5:00 AM; 8/17/19 at 6:00 AM; 8/28/19 at 8:30 PM; 8/30/19 at 3:00 PM; 9/2/19 at 6:30 AM; 9/14/19 at 10:30 PM; 9/24/19 at12:00 AM; 9/28/19 at 11:45 AM; 9/30/19 at 10:15 PM; 10/3/19 at 11:45 AM; 10/3/19 at 4:15 PM; 10/4/19 at 2:00 PM; 10/5/19 at 5:15AM; 10/6/19 at 4:15 PM; 10/20/19 at 10:00 PM; 10/21/19 at 12:15 AM; 10/22/19 at 9:45 PM; 11/12/19 at 6:00 AM; 11/15/19 at 8:15 PM; 11/17/19 at 3:30 AM; 11/19/19 at 9:30 AM; 11/23/19 at 2:20 AM; 11/25/19 at 7:20 AM; and 11/26/19 at 4:15 AM. Throughout these falls the facility lacked evidence of implementing any new interventions to prevent R4	

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	from falling again. Review of R4's forty-one falls revealed that ten of the falls (4/22/29; 7/10/19; 7/14/19;7/18/19; 7/21/19; 7/29/19; 8/3/19; 8/17/19; 9/30/19; and 10/6/19) **occurred in, near, or R4 attempting to use the** bathroom. Review of the twenty incident reports submitted to the state agency revealed that in the section for "expanded incident follow-up" the section for care plan changes and system changes lacked any documentation of **implementation of new interventions.** The facility failed to recognize a pattern of R4's falls attempting to toilet, which led to a failure to re-assess and develop a new (service) plan of care and an individualized toileting plan. 12/11/19 at 10:00 AM - During an interview E2 (WD) reported that interventions for falls were only passed on in the 24-hour report and were relayed to care managers by the nurse. E2 confirmed that the new interventions that were communicated to the other members of the care team were not documented anywhere for staff to reference to be aware of the plan of care for a fall risk resident who had a history of falls. When the surveyor inquired whether a toileting program was initiated related to multiple falls in the bathroom, E2 stated that R4 was not appropriate for a toileting program because she toileted herself. E2 stated that on the Reflections unit the care managers complete every hour checks on all their residents and ask if they need to be toileted. E2 explained that no toileting programs, personal safety devices (such as alarms etc.) are implemented in the facility and only use fall mats for Hospice patients. 12/12/19 at 1:30 PM - During an interview with E7 (CM) and E21 (CM), it was reported that they had daily documentation for each resident. E21 provided R4's daily documentation to the surveyor which revealed that the care managers completed every one-hour checks and documented food and fluid consumption for	

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	each resident. E21 also pointed out that they have care plans (service agreements). Review of R4's individualized service plan lacked evidence of fall precaution interventions. E7 and E21 confirmed there was no documentation on the service plan to alert staff to implement specific fall interventions. E21 reported, "We do every hour checks during the daytime and ask the residents if they need to use the bathroom. At night we do every two hour checks so as not to wake them as often. If they have been falling the nurse will tell us to monitor the resident more. We work together and if an aide (care manager) is new we (the care managers) give them report." E21 stated that "(R4) has always thought that she was independent and always wanted to go back to her room. (R4) always walked leaning back and needed more assistance. We tried to keep her in the common area to entertain her, but (R4) always wanted to return to her room." Both E7 and E21 reported that (R4) did start to go "down-hill fast after she fell, hit her head and had to have staples in it." Both E7 and E21 stated that forty-one falls in eight months was a "real lot," and that they do not have alarms or non-skid socks at the facility. The facility failed to re-assess R4 after her falls, to implement a new plan of care, and to provide care and services to prevent R4 from falling again. 2. Review of R2's clinical record revealed: 12/20/15 - R2 was admitted to the facility with dementia. a. Falls 12/20/18 - The latest annual UAI assessment included that R2 was independent with mobility, transferring and toileting even though she had cognitive impairment, short-term memory loss and was at risk for falls. 12/20/18 - R2's service plan included, under the fall risk section, Standard Fall Risk Protocol and resident checks "at meals and PRN." The special approaches section included "reminders/ redirection 4+ /shift.	

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(302) 421-7410

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Seaside Pointe

DATE SURVEY COMPLETED: December 18, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Frequent checks" including "checks at night." R2 needed occasional, one-person assistance with toileting. January- November 2019 - Review of R2's clinical record and facility incident documentation for falls found R2 experienced 13 (thirteen) falls: -January 5 (2:30 PM): found laying in hallway by elevator; Needs frequent reminders to slow down when walking. Intervention for service plan included frequent reminders but was not specific. -January 30 (2:55 PM): witnessed fall onto knees while R2 was walking toward the elevator. No intervention for service plan. - February 11 (3:15PM): found on the floor in the living room between two chairs. No intervention for service plan. - May 13 (1:00 PM): witnessed walking in hall at brisk pace and lost balance. No intervention for service plan. No intervention for service plan. - May 28 (3:20 PM): found on floor in hallway and stated hit head hard -to ER for evaluation. No intervention for service plan. -June 15 (9:40 AM): witnessed/ assisted fall to knees when walking in dining room with CM. Intervention suggestion included that lace-up shoes might be better. -July 2 (6:30 PM): witnessed moving between dining room chairs without assistance and sat on floor. No intervention for service plan. -July 7 (2:25 PM): found face down in another resident's bathroom. Intervention suggestion to lock doors. -July 16 (8:00 PM): witnessed fall to buttock while walking with CM. No intervention for service plan. - September 30 (4:15 PM): found on floor in another resident's (different from July 7 incident) bathroom barefooted. No intervention for service plan. - October 2 (6:52 AM): found sitting on floor in hallway without footwear. No intervention for service plan. - October 2 (2:45 PM): found on floor in the hallway- had been in bed prior. No intervention for service plan. - November 15 (1:40 PM): found on floor near living	

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	room. No intervention for service plan. Analysis of the facility fall incident documentation found 9 falls occurred within a 3.5-hour time frame (1:00 PM -4:30 PM) and 5 falls were in the hallway. R2's current service plan contained no additional fall prevention interventions after any of R2's 13 falls. 12/11/19 at 10:00 AM - During an interview with E2 (WO), while reviewing the "interventions for fall pages" listing 65 additional fall prevention strategies, stated if using non-skid socks, there would be no change in the service plan since socks were to be put on anyway. When asked how the care managers would know when to use non-skid socks, E2 said the information would be "passed in report" or included "in the 24-hour report." E2 added that toileting/ offering "toileting should be done with the hourly checks on the Reflections unit" (locked dementia unit where R2 resided). 12/16/19 (10:50 AM) - During an interview with E20 (CM) and E24 (CM) when asked about how they were aware about the care each resident need, E24 stated it was "in the care book." The care book contained the service plans for each resident which included R2's service plan that had not been updated in 2019 after any of the 13 falls. 12/16/19 at 11:00 AM - The surveyor observed three CMs setting the dining room tables while ten residents sat unsupervised in the living room. Four residents (R10, D5, D6 and D8) were awake. 12/16/19 (11:56 AM)-The surveyor observed R2 walking, while wearing non-kid socks, with E24 (CM) from the living room to the dining room. R2 was bent forward at the waist around 45 degrees and R2 was taking fast steps. E24 verbally advised R2 to "slow down." There was no instruction for R2 to stand upright. The facility failed to re-assess R2 after each of her 13 falls, to implement a new plan of care, and to provide	

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	care and services to prevent RZ from falling again. b. Toileting 12/11/19 (10:00 AM) - During an interview, EZ (WD) informed the surveyor that toileting should occur during the hourly checks on the Reflection units. The CM can toilet them or to offer assistance to toilet. 12/16/19 - During an observation from 10:30 AM until 12:50 PM, R2 was not offered or taken to the toilet. **c. Supervision** 12/16/19 (11:00 AM) - During an observation on Reflections I unit, three CMs were preparing the dining room for lunch, cleaning and setting the tables. Ten residents were in the lounge area without direct supervision by staff for approximately 15 minutes. Three residents had a walker within reach, five were seated in a wheelchair and two residents without an assistive device. 3. Review of R6's clinical record revealed: 1/16/17 - R6 was admitted to the facility. 11/14/19 7:22 AM - E22 (RN) documented in a service note: "Resident called Wellness and said she wants to end her life. RN went to assess resident and she said she is ready to end her life, she does not want medication, therapies, etc. Resident was asked if she has a plan to kill herself and she said no she wants to speak with her daughter and [E2, WO] first. [E23, Medical Director] notified via phone call and he said to have [E2] speak with [R6] when she comes in and consult psych. Called [E2] to notify her and she will speak with resident when she gets in." 11/14/19 12:00 PM - E2 (WO) documented in a service note: "Spoke with resident this morning. Resident stated she did not want to kill herself, but she wanted to die. 'Resident stated she is tired. She has hurt shoulders, constipated, diarrhea, can't move her feet to help pivot while transferring and she is done.' Resident was offered to go back to skilled rehab as she is in her 30 day window so she could get stronger and would be	

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	appropriate for AI. Resident said she is done doing rehab. She just wants to die. This writer explained **because someone wants to die does not mean they are** and she needs to help with her care as this is assisted living and resident said she doesn't care and wanted to go on hospice. It was explained to resident that we could contact hospice for an eval if that is what she wanted but even being on hospice she had to remain a **safe no more than two person assist transfer to remain** at this level of care. Resident said she understood that she may 'have to go to a nursing home to die' but she just wants to die. This writer informed her that the Neuropsychologist will be in today to talk with her. She also stated that she told her daughter all of this this morning...Nurse [E22] was in the room for this **conversation."** 11/22/19 12:20 PM - E22 (RN) documented in a service note: "Resident sent to [Skilled Nursing Facility]. Report **given to nurse via phone. Pharmacy notified via fax."** 12/17/19 2:00 PM - During an interview with EI (ED) and E2 (WD), EI stated the Neuropsychologist was in the building on 11/14/19 and told her it was ok to send R6 to rehab, but they do not have documentation from the Neuropsychologist. E2 stated she will ask him to provide his note from this visit to the facility. 12/18/19 10:40 AM - During an interview, E2 (WD) confirmed that there was no evidence that the Neuropsychologist ever visited R6, that E23's (Medical Director) order to consult psych was never written as an order or carried out, that there was no further documentation about R6's suicidal thoughts after E2's notes on 11/14/19 at 12:00 PM and that the facility does not have a policy or procedure related to resident's verbalizing suicidal thoughts. When asked why the facility did not increase supervision or conduct suicide checks after R6 stated she wanted to end her life, E2 said because R6 did not have an actual plan in place to kill herself and if she had a plan they would have sent her to the emergency department because the facility does not have enough staff to provide **increased supervision.**	

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§ 1141	12/18/1911:15 AM - During an interview, when asked if she told the nurse when she gave report to the Skilled Nursing Facility that R6 was transferred to that R6 had verbalized that she wanted to die, E22 (RN) said no she did not. When asked why the facility did not increase supervision or conduct suicide checks after R6 stated she wanted to end her life, E22 said because R6 did not have an actual plan in place to kill herself. When asked if the Neuropsychologist saw R6 on 11/14/19, E22 said she did not know. Findings were reviewed with EI (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM. **Subchapter IV** **Criminal background checks.** **(c) No employer may employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not directly employed by the facility must be provided to the facility upon the person's commencement of work.** **This requirement is not met as evidenced by the following:** Based on review of other facility documentation and interview it was determined that the facility failed to obtain the criminal history from the background check center (BCC) and fingerprinting for 14 (E4 to E6, ES, EIO to E19) out of 16 randomly sampled employees prior to start of employment. Findings include: Review of the State Agency Personnel Audit Form completed by the facility revealed 14 staff members did not have their BCC and/ or fingerprints completed prior to starting employment in the facility: - E4 (CM): hired 7/25/19, BCC (adult and child) done 8/9/19. - ES (WN): hired 6/24/19, BCC (adult and child) done 7/16/19, no fingerprinting within 6 months. - E6 (CM): hired 10/8/19, BCC adult done 10/14/19. BCC	§ 1141 All employees that were currently working in the building that were found not to have finger prints left immediately or did not come in until their finger printing was completed. All new employees are at risk to not complete criminal background checks. Human Resources Director will not allow any employee to be put into time clock and start work until they have received all new hire documentation. A report will be printed monthly from our company electronic employee record system to insure that every new employee has their BCC documentation. January 20, 2020

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§ 1142	child done 10/15/19, no fingerprinting within 6 months. - ES (WN): hired 8/13/19, BCC (adult and child) done 8/19/19. - E10 (CM): hired 2/28/19, BCC adult done 3/8/19, BCC child done 3/11/19, no fingerprints within 6 months. - E11 (WN): hired 10/14/19, BCC adult 10/31/19, BCC child 11/1/19, no fingerprints within 6 months. - E12 (CNA): hired 9/6/19, BCC (adult and child) done 9/17/19, no fingerprints within 6 months. - E13 (Activities): hired 2/19/19, BCC (adult and child) done 2/26/19. - E14 (Housekeeping): hired 3/13/19, BCC adult done 3/26/19, BCC child 3/27/19. - E15 (Dining): hired 6/21/19, BCC (adult and child) done 8/9/19. - E16 (AWD): hired 10/7/19, BCC adult done 10/14/19, BCC child done 10/15/19, no fingerprints within 6 months. - E17 (Concierge): hired 3/13/19, BCC (adult and child) done 3/26/19, no fingerprints within 6 months. - E18 (Dining): hired 5/24/19, BCC (adult and child) done 5/31/19. - E19 (Dining): hired 9/27/19, BCC adult done 10/14/19, BCC child done 10/15/19. 2/17/19 (afternoon) - During an interview, E1 (ED) confirmed that the information was accurate even if completed/ received after the hire date. Findings were reviewed with E1 (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM. 12/18/19 (around 1:40 PM) - After consultation with the State Agency employee who analyzed the Personnel Audit form completed by the facility, E1 (ED) was informed by the State Agency BCC employee that the seven employees without fingerprinting within the past 6 months could not continue to work until fingerprinting was completed. E1 stated she would contact all the involved staff to advise them of the situation. **Mandatory drug screening.**	

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§ 1144	**(b) No employer is permitted to employ any applicant without first obtaining the results of that applicant's mandatory drug screening.** **This requirement is not met as evidenced by the following:** Based on review of other facility documentation and interview it was determined that the facility failed to ensure mandatory drug screening results were obtained for 3 (E10, E14 and E1?) out of 16 randomly sampled employees. Findings include: Review of the State Agency Personnel Audit Form completed by the facility revealed three staff members did not have their mandatory drug screening results prior to starting employment in the facility: - E10 (CM): hired 2/28/19, results received 3/12/19. - E14 (Housekeeping): hired 3/13/19, results received 3/26/19. - E17 (Concierge): hired 3/13/19, results received 3/19/19. 2/17/19 (afternoon) - During an interview, E1 (ED) confirmed that the information was accurate even if completed/ received after the hire date. Findings were reviewed with E1 (ED), E2 (WD) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM. **Influenza Immunizations** **(a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1" through March 1st of the following year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine. (b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination. (c) Employment will not be contingent on influenza immunization.**	**§ 1142** Employees cited had a drug screen post – hire. All new employees may be affected by this practice. Human Resource Manager will insure that no new employee starts working until drug screen has been completed. A report will be printed monthly from our company electronic employee record system to insure that every new employee has their BCC documentation. January 20, 2020 § 1144 In lieu of employee list unable to determine who E10 is to have them sign declination form. All employees at risk Human Resource Manager will perform an audit to determine who has had a flu shot. Any employee not having a flu shot will sign a declination form. A list of employees receiving a flu shot will be completed every year by November 30. Any employee not receiving a flu shot will be required to sign a declination form. Flu shot clinic is offered annually in October. Employees will have until November 30 to bring in documentation of flu vaccine or sign the declination form or they will be removed from the schedule. February 16, 2020.

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	This requirement is not met as evidenced by the following: Based on review of other facility documentation and interview it was determined that the facility failed to ensure a signed statement of acceptance or declination of the influenza vaccination was received by one (EIO) out of five randomly sampled employees. Findings include: Review of the State Agency influenza vaccination form completed by the facility revealed that EIO (CM) did not have a signed influenza vaccination acceptance/ declination statement. 12/17/19 (afternoon)-During an interview, EI (ED) confirmed the missing statement. Findings were reviewed with EI (ED), E2 (WO) and E3 (AWD) on 12/18/19 during the exit conference beginning around 12:30 PM.	

Donna Meagan
January 19, 2020

Attachment A

Performance Improvement Notification

BRANDYWINE
SENIOR LIVING
Life is Beautiful

Team Member Name _____

Facility _____ Position _____

Department _____ Date _____

Check One (1) of the following steps in Progressive Discipline

Verbal Warning_____ Written Warning_____ Final Written Warning_____ Discharge_____

Suspension Pending Investigatin_____ ***If a serious situation arises, team member may be suspended pending an investigation***

Reason for Issuance:

Conduct/Work Rule Violation:_____(Refer to house rules listed on reverse)

Describe the unsatisfactory performance, misconduct, or inappropriate behavior. Include date, time, place, those involved, any previous discussions and any other important information.

_____

_____

_____

_____

_____

_____

_____

List previous discipline steps, dates given and house rule violation:

	STEP	DATE GIVEN	VIOLATION
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Review corrective action to be taken to assist in improving team member performance:

List training and specific needs to improve performance

_____

_____

_____

Team Member Response:

_____

_____

_____

Acknowledgements: Date:

Team Member_____ _____

Supervisor _____ _____

Administrator/Executive Director _____ _____

Team member signature acknowledges receipt of notification not necessarily agreement

Attachment B

Employee Performance Improvement Notification
Coaching Session

BRANDYWINE LIVING
Life is Beautiful

Employee Name: _____

Community: _____ **Position:** _____

Department: _____ **Date:** _____

Observation/Concerns:

Attach Supporting Documentation

Plan for Improvement:

Employee Comments:

Date for Follow Up: **Results/Solution:**

Employee Signature: _____ **Date:** _____

Supervisor/Manager Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Attachment C

BRANDYWINE LIVING
Life is Beautiful

The T.R.U.S.T. Pledge

Treating Residents with Understanding, Sincerity and Tenderness

I understand that joining the Brandywine Living team is my choice. That making this choice requires me to support the TRUST initiative.

I further understand that signing this pledge requires me to report any incident of abuse and I understand that my failure to report abuse may potentially subject me to the same penalties as the abuser.

I understand that abuse includes, but is not limited to, physical violence, mental cruelty, verbal assault, neglect, involuntary recklessness and misappropriation of property.

I make the choice to support the TRUST program not only because it is a condition of my employment, but because I believe that abuse of the elderly is morally and ethically wrong.

_____ _____

Employee Signature **Date**

Attachment D
page 1 of 2

J. Jason van Steenburgh, Ph.D.
Neuropsychologist
Brandywine Living

November 14, 2019
Marilyn Leibowitz, Brandywine Senior Living at Seaside, Assisted Living #243

Re: suicidal ideation/passive death wish

Ms. Leibowitz was admitted to Brandywine Living at Seaside Pointe on 1/16/2017. She has a history of atrial fibrillation, GERD, hypertension, and neuropathy. She has limited mobility and requires multiple staff for transfer. She currently takes Alprazolam, Buproprion, and Tramadol, among other medications.

Ms. Leibowitz expressed a desire that she not live anymore when speaking with staff. I spoke with her in her room in the personal care unit at Brandywine Living at Seaside Pointe, in Rehoboth Beach, Delaware. She was sitting in a chair by the window in her room. When I introduced myself, she was antagonistic and confrontational. She expressed anger and frustration at her poor health, especially her limited mobility, dental problems, and problems with constipation and diarrhea. We spoke for approximately 60 minutes. Ms. Leibowitz did not have any intent to end her life. She eventually described her previous statements as an expression of frustration rather than a true desire to take action to end her life. She did not have a plan to end her life and did not seem to have the means, although at one point she did state that she could refuse to eat. After further conversation, Ms. Leibowitz acknowledged that she was anxious about returning to rehabilitation and working hard, without any guarantee that it will help her. The idea of many weeks of possibly futile rehabilitation was overwhelming to her. Together we explored her options, which included 2 to 8 weeks of inpatient rehabilitation stay, the possibility of outpatient rehabilitation, or transitioning to a skilled nursing facility due to Brandywine Living's inability to manage residents who require more than a 2-person assist for transfers. Eventually, Ms. Leibowitz agreed to inpatient rehabilitation. She reiterated that she has no intent to end her life and voiced regret having made such statements. She acknowledged that she wanted assistance in moving forward and that the statements were more about her frustration than any plans or desires she has.

Ms. Leibowitz is moderately to severely depressed. It is a situational depression, based primarily on her current health. She had difficulty describing a positive experience she has had in the last year and even such topics as were broached were viewed through a negative lens.

During our discussion, Ms. Leibowitz showed limited affective range that tended towards mostly negative affect. She expressed very little positive emotion. She made good eye contact. Her expressive language was of somewhat higher than normal volume, but of normal rate, rhythm, and prosody. She showed normal motor control and movements. In conversation, she showed poor pragmatics of language, often interrupting and challenging me. She was able to maintain conversational set and her thinking appeared linear and goal directed for the most part, although with an occasional tangent.

I do not believe that Ms. Leibowitz is a danger to herself or others at this time. I have no concerns about her cognitive ability to function in assisted living at this time, although I think her profoundly negative mood suggests that a change in anti-depressant medication could be appropriate at this time.

J. Joseph van Steenburgh, Ph.D.
Neuropsychologist

FALL INTERVENTIONS .DOC

BRANDYWINE SENIOR LIVING

INTERVENTIONS

Trigger	Start Date	Stop Date		Intervention	Evaluation/Outcome	Date	Initials
Fall History			1	Falls Alert Program or standard fall protocol			
			2	Family meeting to discuss alternatives			
			3	Education on fall risk factors, safety, limited mobility			
			4	Private duty caregiver			
			5	Revew level of care/alternative setting			
			6				
Ambulation Gait/Balance			7	Remind to call for assist (only if no STM loss)			
			8	OT for positioning/seating/adaptive equipment			
			9	PT for mobility/assistive devices /transfers			
			10	Hip protectors			
			11	Low bed			
			12	Defined perimeter mattress			
			13	Bed alarm (SNF only)			
			14	Chair alarm (SNF only)			
			15	Dicem on chair			
			16	Anti-tippers on wheelchair			
			17	Consult to podiatry for foot care			
			18	Restorative or carryover Ambulation Program			
			19	Ensure proper footware and/or clothing			
			20	**Exercise program for strenght & balance**			
			21	**Walkers/canes proper height, rubber tip in good shape**			
			22	**Able to use w/c safely, able to lock wheels**			
			23	**Elec w/c: use on low setting, no exposed wires**			
Continence			24	Toileting schedule before and after meals and bed/naps			
			25	Special toileting schedule:			
			26	Restorative or retraining Bladder Program			
			27	Restorative or retraining Bowel Program			
			28	**Commode: has no wheels**			
			29				

Resident: _____ **Room:** _____

BRANDYWINE SENIOR LIVING

FALL INTERVENTIONS TOOL

INTERVENTIONS

Trigger	Start Date	Stop Date		Intervention	Evaluation/Outcome	Date	Initials
Sensory Deficits			30	Eye consult: **last eye exam? How old are the glasses?**			
			31	Signs/pictures: **for reminders**			
			32	**Neurology consult**			
			33	**Cardiology consult**			
Mental Status			34	**Hearing aids: able to use properly, how old are they? Are the batteries working?**			
			35	Redirect as needed			
			36	Safety checks q _____			
			37	Verbal encouragement to participate in daily activities			
			38	Consult Geripsych for behavioral issues			
			39	Cueing			
			40	1:1 Supervision while awake			
			41	Structured activities;			
			42	**Activites are specific to resident cognitive functioning**			
			43				
Predisposing Disease			44	Instruct resident to rise slowly			
			45	Vital signs q _____			
			46	BP lying, sittingand standing q _____			
			47	Pacemaker check			
			48	Urinalysis to r/o UTI			
			49	Observe for s/s of hypoglycemia			
			50	**Diabetes/Neuropathy**			
			51	**Parkinsons**			
			52	**Equalibrium/Vertigo**			
			53	Review workup for symptoms/diseases			
Medications			54	Consult with Consulting Pharmacist			
			55	Pain assessment and management			
			56				
			57				
Environment			58	Ensure personal items within reach			
			59	Use cordless phone			
			60	Maintain room free from clutter **2 ft wide path**			
			61	Provide proper lighting in room: **should illumiate flooring**			
			62	Night lights			
			63	**Bed lighting at proper height, easy to reach**			
			64	**Non slip bedding**			

Resident: _____ Room: _____

BRAN[illegible]WINE SENIOR LIVING

FALL INTERVENTIONS [illegible]

		65	Bed height:22-25 inches tall with bedding			
		66	Shower chair or bench provided			
		67	Anti skid strips on floor (Shower)			
		68	**For Dementia: place bed against wall to remind			
		69	resident to get out on their stronger side			
		70	No throw rugs			
		71	No dust ruffle			
		72	Low coffee tables			
		73	Mobility aides placed next to be on their stronger side			
		74	Able to reach kitchen cabinets without a stool			
		75				
Miscellaneous		76				
		77				

Resident: _____

Room: _____

Attachment E Page 4 of 4

BRANDYWINE SENIOR LIVING **FALL TRACKING/INTERVENTIONS TOOL**™

Evaluation of Interventions

DATE	EVALUATION AND SIGNATURE

Resident: ______________ **Room:** ______________

Linderborn, Karen (DHSS)

From: Linderborn, Karen (DHSS)
Sent: Monday, November 2, 2020 3:29 PM
To: Donna Winegar
Cc: Smith, Robert (DHSS); Reed, Kim (DHSS); Jones, Tomeka N (DHSS)
Subject: POC review
Attachments: Seaside Pointe POC requests AV.CV 12.18.19 .docx

Categories: Egress Switch: Unprotected
Switch-MessageId: 9824955bf0b74062a7220cd72909a494

Donna - I was given your POC from the 12/18/19 survey to review TODAY. Upon review, in order to receive an acceptance letter, please make the revisions outlined in the attachment and resubmit by replying to all.

Working offsite, so email is the best means of communication
KAREN LINDERBORN, MS, RN, GCNS-BC
Compliance Nurse

Delaware Department of Health and Social Services
Division of Health Care Quality – Office of Long Term Care Residents Protection
Windsor Building
24 NW Front Street, Suite 200, Milford, DE 19963
Office: (302) 424-8623 Fax: (302) 424-2940
Karen.Linderborn@delaware.gov (NEW email address)

All citations

1. Include the rout cause analysis result for every citation in section 3……what was the reason for the failure?
2. Attach audit tools with the re-submission.
3. Attach education content and sign in sheets with the resubmission.

Citation specific

4. 8.3.5: Expired medications
    a. Section 2 - Were there any other expired medications found during initial audit?
    b. Section 3 - Who conducted the education on the new procedure?
    c. What is frequency of spot checks…this should be included under section 4 about monitoring.
    d. Attach policy related to Sunday night check for expired medications.

5. 8.8.1: Medication Labeling
    a. Section 2 – Were there any undated medications found during the initial audit?
    b. Section 3 – who conducted the education?
    c. Section 4 – are the weekly cart audits ongoing, will results be presented to QI?

6. 9.5.1: Resident TB testing
    a. Section 2 – Were there any other residents found during the initial audit?
    b. Section 4 – Any auditing of the desk calendar to ensure new system working…what frequency and how many audits at 100% before increasing time between audits? Will results be presented in QI?

7. 9.5.2: Staff TB testing
    a. Section 3 - What was done to make sure TB testing not missed? Any training for HR?
    b. Section 4 - Any audits of HR records to ensure compliance?

8. 11.4: UAI acknowledgement by resident/RP
    a. Section 4:- Is audits ongoing or what frequency and how many audits at 100% before increasing time between audits?

9. 11.5: UAI timely completion
    a. Section 3 - Is there a policy addressing the new tickler file on each unit. Was there any education about this, to whom, by whom?
    b. Section 4 - Is the monthly audit with presentation to QI twice mean the monthly audit done for 6 months?

10. 12.1.3: Food Code / glove use
    a. What is listed under section 1 should be under section 3. Also add who conducted the education.
    b. Section 1 - would be unable to correct immediately as deficient practice already occurred.
    c. What is listed under section 3 should be under section 4..how often are random observations, for how long? How often ED monitoring coaching, disciplinary action?

11. 13.1: Service Agreement done and signed