

DHSS - DHCQ 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 421-7400

#### STATE SURVEY REPORT

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NAME OF FACILITY: Peach Tree Health Group

Office of Long Term Care Residents Protection

DATE SURVEY COMPLETED: October 7, 2021

,	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	COMPLETION
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	DATE
	The State Report incorporates by reference and	25	
	also cites the findings specified in the Federal		
	Report.		,
	An unannounced Complaint Survey was con-		
	ducted by the State of Delaware Division of		
	Health Care Quality, Office of Long Term Care		
	Residents Protection from October 6, 2021		
	through October 7, 2021. The facility was found		
	to be out of compliance with the Title 16 Health		
	and Safety Delaware Administrative Code, 3225		
	Assisted Living Facilities infection control regula-		
	tions and has not implemented the State and		,×:
	Center for Disease Control and Prevention (CDC)		
2	recommended practices for COVID-19. The		
	sample size was ten (10) residents. The facility		
	census on the first day of the survey was 34.		
	Abbreviations/Definitions used in this state re-		
	port are as follows:	Preparation and/or execution of this	
		Plan of Correction does not consti-	
	ED – Executive Director;	tute admission of agreement by the	
	DON - Director of Nursing;	Provider of the truth of the State-	
	LPN - Licensed Practical Nurse;	ments of Deficiencies. This Plan of	
	SG — Security Guard.	Corrections is prepared and/or exe-	
		cuted solely because it is required by	
3225	Regulations for Assisted Living Facilities	the provisions of Federal and State	
		Laws.	
3225.2.0	Authority and Applicability		
		Plan of Correction	
3225.8.0	Medication Management	3225.8.0 Medication Management	
		1. No residents were harmed by the	
3225.8.8.2	Each resident receives the medications that	deficient practice.	
	have been specifically prescribed in the manner	2. Medication Management and Ad-	
	that has been ordered.	ministration policy updated to include	
		the 8 rights of Medication Administra-	
	This requirement was not met as evidenced by:	tion and reflect Lippincott's Nursing	
		Drug guide.	
	Based on interview, review of clinical records,		
	review of the facility's policy and procedure, and	***	

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Title <u>Executive Director</u>

Date 11/1/21



## **DELAWARE HEALTH** AND SOCIAL SERVICES

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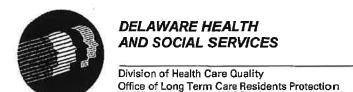
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SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	COMPLETION
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	review of the facility medication	F	
	review of the facility medication error reports, it was determined that the facility failed to safely	3. Medication Error policy updated to	
	administer medications for two (R1 and R9) out	include the 8 rights of Medication Ad-	ł
	of 17 sampled residents based on the standard	ministration and reflect Lippincott's	
	of practice for medication administration which	Nursing Drug guide.	
	resulted in a medication error. Findings include:	4. Education and individual copies	
	Thomas in a medication error. Timangs include.	provided to nursing staff regarding	
	A facility policy entitled Medication Manage-	the updated policies and procedures	
	ment and Administration, last revised 9/5/19,	for Medication Management and Administration along with the Medica-	
	included: "Those residents who upon admission	tion Errors policy, to reflect changes.	7
	are incapable of self-administration shall have	5. Medication Management and Ad-	
	their medications administered according to the	ministration policy and Medication	
	Nurse Practice Act."	Error policy will be reviewed with	
		Q&A committee for 9 months or until	
	An additional facility policy entitled Medication	substantial compliance is met. Policy	
	Error, included: "The 7 rights of medication ad-	and Procedure Manual will be re-	
	ministration are to be followed by all persons	viewed annually to ensure compli-	
	providing, assisting, or administering medica-	ance with regulations.	
	tions to residents. Medication errors include: In-		
	correct medication (administration of the wrong medication)."		
	medication).		
	1. Review of R9's clinical record and the State		
	Agency's documentation revealed the fol-		
	lowing:		
	7/12/21 - A facility medication error re-		
	port included: E4 (LPN) administered a		
	wrong medication to R9. The description of		
	the error documented: "This nurse was ad-		
	ministering medications and picked up the		
	(medication card) and made the mis take of		27
	not looking at the nameI handed the card		
	to another nurse to punch out for me, then I		
	administered the med (medication). (It) was		
	(the) wrong medication."		
	E4 did not follow the remained and the		
	E4 did not follow the required medication rights, did not note the name of the resident	1	
	on the modification and and allowed		

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on the medication card and allowed another



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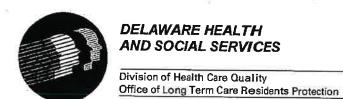
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	nurse to prepare the medication, which resulted in a medication error.  10/7/21 at approximately 1:30 PM — During		
	an interview, E2 (DON) confirmed that the medication error was substantiated, and the standard of practice was not to administer any medication that another nurse prepared.		
	Review of R1's clinical record and the     State Agency's documentation revealed     the following:		
	9/9/21 – The Medication Administration Record (MAR) documented that R1 was administered his four (4) medications scheduled for 8 PM by E2 (DON).		
	9/13/21 – The State Agency's Incident Reporting System documented that on 9/9/21 at approximately 12 AM, R1 stated that he did not get his medications.	Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the Statements of Deficiencies. This Plan of	
	10/7/21 10:30 AM – An interview with E2 (DON) revealed that on 9/9/21, a nurse scheduled for the 7 PM to 7 AM shift called out, thus, E2 dispensed the medication into a cup and provided it to E3 (LPN) for E3 to administer to R1. E2 confirmed that she did not observe R1 taking the medication, despite the fact that E2 signed off that she administered the medication on the MAR.	Corrections is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.	
3225.9.0	10/7/2021 4:10 PM – Findings were reviewed during the Exit Conference with E1 (ED) and E2 (DON).  Infection Control	Plan of Correction 3225.9.0 Infection Control 1.2 All rules of the Delaware Division of Public Health are followed so there is minimal danger of transmis- sion to staff and residents.	

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SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	DATE
		COMMENTAL OF DEFICIENCIES	DAIL
3225.9.1.2	All rules of the Delaware Division of Public Health are followed so there is minimal danger of transmission to staff and residents.  This requirement was not met as evidenced by:  Based on interview, review of the facility policy and procedure, and review of the State of Delaware's Division of Public Health Testing Guidance for Long Term Care Facilities, it was determined that the facility failed to thoroughly screen all visitors in accordance with the State of Delaware's Long Term Care Orders and Guidelines. Findings include:  Review of the facility's policy and procedure titled COVID-19 Screening, with an effective date of 3/24/20, stated, the following questions would be asked upon their arrival (Staff and Visitors) "1. Do you have any respiratory symptom? 2. Have you traveled outside of the state? 3. Have you had contact with any other healthcare facility? 4. Have you knowingly been exposed to COVID-19? 5. Are you suffering from altered taste or smell? 6. Are you experiencing any other COVID-19 symptoms as defined by CDC?"  The CDC published on their website, dated 2/22/21, "Symptoms of Coronavirus" that stated, "People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea".  Review of the State of Delaware's LTC (Long Term Care) Order and Guidelines, dated 7/2/21, stated, "Core Principles of COVID-19 infection	1. No residents were harmed by the deficient practice. 2. COVID-19 screening tool has been updated to include all known "Symptoms of Coronavirus" to reflect CDC's update on 2/22/21. 3. COVID-19 screening tool also updated to include screening question for visitors/staff about close contact with positive COVID-19 recipient (e.g., within 6 feet for more than 15 minutes with confirmed COVID-19 infection). 4. Security staff (or screening party) provided education on new updated screening tool to reflect changes. 5. All logs will be reviewed on a weekly basis for 3 months or until substantial compliance will be met with the Q&A committee.	





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SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	DATE
	19 infection before being allowed access to the facility.  b. 10/6/21 8:43 AM — The third Surveyor (S3) arrived at the facility and was screened by E5 (SG) for COVID-19 by having their temperature taken. No other required screenings were performed prior to S3 being allowed access to the facility.  10/6/21 3:00 PM — An interview with E1 (ED) confirmed that the facility's screening for visitors did not include all the signs and symptoms of COVID-19 and possible exposure to COVID-19 and possible exposure to COVID-19.  2. Staff Screening:  10/6/21 6 AM through 8:52 AM — Review of the "Temperature Log", utilized by the facility for COVID-19 screening for staff and visitors revealed that, 23 facility staff were screened. The screening included the following questions, "Respiratory Symptom?Traveled internationally/out of stateContact with any other Healthcare FacilityAny known exposureAltered Sense of Taste or Smell". There was lack of evidence that the 23 staff were asked about symptoms of chills, headache, fatigue, muscle or body aches, sore throat, nausea, vomiting, or diarrhea. In addition, staff were not asked whether they had been in close contact (e.g. within 6 feet for more than 15 minutes) with a person with a confirmed COVID-19 infection before being allowed access to the facility.		

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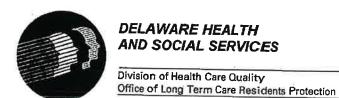
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SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	DATE
			(06)
3225.9.5.2	10/6/21 3:00 PM — An interview with E1 (ED) confirmed that the facility's screening for visitors and staff did not include all of the signs and symptoms of COVID-19 and possible exposure to COVID-19.  10/6/21 4:10 PM - Findings were reviewed during the Exit Conference with E1 (ED) and E2 (DON).  Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay_(IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.  A report of all test results shall be kept on file at the facility of employment.  This requirement was not met as evidenced by:  Based on interview and review of facility documents it was determined that for one (E3) LPN out of eight employees reviewed for TB screening, the facility failed to screen an employee upon hire. Findings include:  4/27/21 - Date of hire for (E3) LPN.	Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the Statements of Deficiencies. This Plan of Corrections is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.  Plan of Correction 3225.9.5 Tuberculin Testing 5.2.4 A report of all test results shall be kept on file at the facility of employment.  1. No residents were harmed by this deficient practice. 2. All current employees were audited to ensure that PPD/Quanti-FERON are present and clear. New hire preboarding checklist was created to ensure that PPD/Quanti-FERON are completed prior to orientation. 3. HR staff was educated regarding PPD/QuantiFERON requirements. 4. PPD/QuantiFERON will be audited on a biweekly basis for 3 months or until substantial compliance is met and reviewed in the Q&A committee.	

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3EC11ON	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	DATE
J-10	10/7/21 - Review of facility new Employee PPD documents lacked evidence of TB screening upon hire for E3.  10/7/21 1:20 PM — An interview with E1 (ED) confirmed that E3 had not received a TB test either prior or on the date of hire.  10/7/21 4:10 PM — Findings were reviewed during the Exit Conference with E1 (ED) and E2 (DON).	Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the Provider of the truth of the Statements of Deficiencies. This Plan of Corrections is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.	
3225.15,0	The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction.  This requirement was not met as evidenced by:  Based on interview, record review, review of the facility's policy and procedure, and review of the facility medication error reports, it was determined that the facility failed to have a QA program that identified quality issues, specifically, a nurse with reoccurring medication errors. Findings include:  A facility policy entitled Quality Assurance, last revised 9/7/19, included:  Policy Overview: The facility will perform quality assurance to maintain accepted standards of care as designated by DE REG, Title 16, Chapter 3225, 15.0.  Policy Purpose: To identify opportuni-	Plan of Correction 3225.15.0 Quality Assurance 1. Q&A program will review any med error/omission incidents from the past 90 days to ensure no further services are compromised. 2. Nursing staff will be educated accordingly based off these findings. 3. Med errors/omissions from the MAR's will be reviewed on a biweekly basis for the next 3 months or until substantial compliance is met and reviewed in the Q&A committee.	

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	3. 33.1.0 24.1.312.1.4120	COMMENTAL OF DEFICIENCE	
	problems or root causes to the services we provide; and implement plans of cor- rection or change and continue to mon-	36	
	itor our progress.	7	
	4/27/21 - E3 was hired by the facility as an (LPN).		
	The following facility medication error reports document E3's trending medication error administration performance:		
	5/14/21 – E3 failed to administer R6's herbal sleep medication at bedtime as prescribed by the physician.		
	2. 7/24/21 - E3 failed to administer R6's vitamin supplement and two seizure medications as prescribed by the physician.		
	3. 7/24/21 – E3 failed to administer R3's antipsychotic medications at 8:00 AM and 5:00 PM.		
	4. 7/24/21 – E3 failed to administer R5's seven medications including: a blood pressure medication, a dementia medication, a blood sugar medication, two blood thinner medications, a fluid reducing medication, and a nasal spray as prescribed by the physician.		
	5. 8/21/21 – E3 failed to administer R2 and R3's pain medications as prescribed by the physician.	g.	
	6. 9/8/21 - E3 failed to administer R10's blood pressure medication.	ja	

Provider's Signature

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Title Executive Director

Date 1/1/2

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sic cil ide tiv car 10 int me ate 10, dui	7. 9/16/21 - E3 failed to administer R4's allergy medication as prescribed by the physician.  8. 9/16/21 - E3 failed to administer eleven of R2's medications including: a blood thinner medication, a muscle relaxer, vitamin supplement, a seizure medication, a vitamin that reduces the risk of contracting bladder infections, a multivitamin, a blood pressure medication, an acid reducing medication for the stomach, a pain medication, and a steroid medication as prescribed by the physician.  Pespite all of the serious medication omisons from E3's date of hire on 4/27/21, the fallity lacked evidence that a quality issue was entified and addressed related to E3's repetive medication errors, until the 9/16/21 medition error that resulted in termination.  10/7/21 at approximately 1:45 PM - During an terview, E2 (DON) confirmed that all of the edication errors by E3 (LPN) were substantibled.  11 efacility failed to monitor E3 with poor permance in the area of medication administra-	CORRECTION OF DEFICIENCIES	1

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