SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint survey was conducted at this facility beginning February 9, 2018 and ending February 15, 2018. The facility census on the entrance day of the survey was 75 residents. The survey sample was composed of 6 residents and 2 subsampled residents. 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; DON- Director of Nursing; RN – Registered Nurse; LPN – Licensed Practical Nurse; RA – Resident Aide. ADLs (Activities of Daily Living) – tasks needed for daily living including dressing, hygiene, walking, toileting; Alzheimer's Disease - brain disorder causing loss of memory, thinking and language; Day shift – 7:00 AM – 3:00 PM; Elopement – walking away from facility without staff knowledge; Evening shift- 3:00 PM – 11:00 PM; Fahrenheit (F) – temperature scale; Laceration – a cut; Mandate/Mandation – require staff member to work the next shift; Night shift – 11:00 PM – 7:00 AM; Psych (Psychiatric) - related to mental disorders; Stroke – reduced blood flow to brain; Sutures (Stiches) – medical device used to sew skin together after injury/surgery; UAI (Uniform Assessment Instrument) –	Responses to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

NAME OF FACILITY: State Street Assisted Living **DATE SURVEY COMPLETED: February 15, 2018**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility; Vol – volunteer; Wanderguard – device a resident wears on an ankle or wrist to alert staff when exiting the facility to prevent a resident from wandering away.	
3225	**Regulations for Assisted Living Facilities**	3225 Regulations for Assisted Living Facilities
3225.5	**General Requirements**	3225.5 General Requirements
3225.5.5	**The assisted living facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. However, residents may be permitted to wander safely within the perimeter of a secured unit.** Based on record review, interview, observation, and review of other facility documents, it was determined that the facility failed to follow established policy and procedure to prevent one (R6) out of 6 sampled residents from wandering away from safe areas. R6, the legally blind resident who wore a Wanderguard entered a stairwell through an alarmed door, walked down three flights of stairs and out of the facility through an unalarmed exit door around 2:30 AM when the outside temperature was in the 20's F. The resident was found lying in the street in her nightgown with a small laceration over the	3225.5.5 The assisted living facility shall develop and adhere to policies and procedures to prevent residents with diagnosed memory impairment from wandering away from safe areas. However, residents may be permitted to wander safely within the perimeter of a secured unit. 1. E5 employment was terminated for not following facility Door Alarm Policy. E6 & E7 were inserviced immediately on the Door Alarm Policy. E6 was disciplined for not notifying the nurse that a door alarm occurred & not checking the alarming door. E7 was disciplined for not properly monitoring the walkie. R6 was placed on the wait list for the secure unit & moved to that unit on 04/03/18. 2. All door alarms were assessed by the Maintenance Director on 01/26/18 & were in good working order. A Resident Elopement Risk Assessment audit was completed on 04/04/18. (Attachment A) 3. Staff was inserviced on the Door Alarm Policy on 01/26/18 & various other dates. (Attachment B) Door Alarm Policy was added to the General

Provider's Signature [signature] Title Executive Director Date 4/9/18

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	left eye and abrasion (scrape) to left leg. Findings include: Review of R6's clinical record and other documents revealed: 12/29/17 – Resident admitted to the facility after a hospitalization for altered mental status (confusion). R6 was legally blind in both eyes with a history of stroke, difficulty walking, dizziness, deaf in right ear and hard of hearing in left ear. 12/29/17 – R6's service agreement documented s/he required supervision for transfer and walking, was unsteady on feet, used a rolling walker and had some disorientation. 12/29/17 - Elopement Risk assessment documented the resident had a history of wandering at night prior to admission. January, 2018 – Resident Care Flowsheet documented R6 was oriented to person, place and time but had confusion and was forgetful. 1/26/18 (1:08 AM) - Facility door alarm log revealed the door to the stairwell on R6's floor (third floor) was activated at 1:08 AM, restored itself and was acknowledged by E5 (RA) at 1:09 AM. An undated facility policy entitled Door Alarms included the procedure: - When a door alarm is activated, the staff will quickly proceed to the door and investigate the cause. - If the cause cannot be determined, the staff member will exit through the door and search the surrounding area. If	Orientation classroom packet on 01/26/18. The Exterior Emergency Exit doors that open to the outside will have door alarm censors installed by 04/16/18. Staff inservicing on Walkie Monitoring will be completed by 04/16/18. 4. Facility will continue to conduct Elopement Drills according to facility policy. The results of the drills will be reported by the DON/Designee to Quality Assurance Committee until substantial compliance is met for 2 consecutive quarters.

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	the search reveals no cause for the alarm, an immediate count of all residents will be conducted by the licensed staff. - If all residents are accounted for the maintenance supervisor/designee will be notified to assess the door alarm and the Executive Director will be notified of the alarm. - If all the residents are not accounted for a missing resident search will be conducted immediately. 1/26/18 – Hospital record revealed R6 arrived in the emergency department at 3:07 AM after being "found outside in the road outside" the assisted living facility and was "wearing a tracking anklet." R6 required 4 stiches to repair the cut above the left eye and cleaning of the left leg abrasion (scrape). The resident's temperature was low at 96.4F rectally and was required to be under a blanket warmer for nearly 5 hours before her body temperature increased to normal. Rectal temperatures are 0.5 to 1 degree F higher than oral temperatures. R6 was admitted to the hospital. Review of facility incident investigation packet discovered R6 was found lying in the street, yelling for help around 2:35 AM when the neighbor's dog alerted the owner. There were numerous facility failures: - E5 [RA] (assigned third floor residents plus a couple first floor rooms) heard the alarm on the walkie talkie but did not leave the RA area on the second floor and physically check the alarming third floor door. - E6 (RA) heard the alarm on the walkie	

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	talkie but did not physically check the alarming door since it was not on his/her assigned area on the first and second floors. - E5 and E6 (RA) did not inform the nurse of the activated door alarm heard on the walkie talkie. - E7 (LPN) did not monitor the walkie talkie system and did not hear the door alarm. During an interview with E8 (Maintenance Assistant) on 2/9/18 around 11:40 AM E8 escorted the surveyors into the stairwell from the third floor door used by R6. E8 confirmed that all doors leading into the stairwell were alarmed but exit door at the bottom was not alarmed. It is unclear if the resident would have been found sooner if the exit door was alarmed and alerted staff when that door was opened. During an interview with E1 (ED) on 2/13/18 at 1:20 PM to review the investigation into R6's elopement, E1 stated that the door alarm log would have shown other door openings if E5 followed the policy and entered into, and checked, the stairwell. All staff received education on the door alarm process. E5 was terminated and both E6 and E7 were disciplined. When asked how the door alarm response is being monitored, E1 commented that the "walkies are up and [staff are] listening." The facility had conducted several elopement drills since the incident and they (staff) did what they were supposed to, actually going up and down stairwells to check for residents.	

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	During an observation on 2/15/18 around 11:30 AM, a door alarm was activated and staff ran to the stairwell. Administration advised staff to perform a resident count when no cause for the alarm was initially found. All residents were present in the building and it was determined that staff from an ambulance company used the stairwell instead of waiting for the elevator. This finding was reviewed with E1 and E2 (DON) during the exit conference on 2/15/18 at 2:45 PM.	
3225.11 3225.11.5	**Resident Assessment** **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. 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.** Based on record review and interview it was determined that the facility failed to complete a resident assessment at the time of a change in condition for one (R5) out of 6 sampled residents. Findings include: Review of R5's medical record revealed: 11/18/16 – UAI documented R5 *assessment* documented "no falls", and was independent with mobility.	3225.11 Resident Assessment 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. 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. 1. R5 no longer resides at facility. R5 was returned to Skilled Nursing Facility for continued rehabilitation on 07/18/17. Wife notified E1 on 08/29/17 that R5 would be staying at the Skilled Nursing Facility. R5 was discharged from State Street on 09/01/17. R5 did have a Fall Risk Intervention Addendum added to his UAI on 05/19/17 status post his first fall on 05/19/17. (Attachment C) 2. An audit of all current residents will be completed by the DON/Designee to insure that residents who have a history of falls have a Fall Risk Intervention Addendum in place by 04/16/18. (Attachment D)

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	12/12/16 – Admission to facility with spouse. 12/13/16 – UAI and service agreement documented R5 needed supervision for mobility (walking) and a Wandergaurd was initiated. 12/13/16 - Resident service agreement documented R5 needed supervision for walking. Nursing notes documented R5 had falls on the following dates: - 5/19/17: Fall with transfer to local hospital for evaluation due to striking head. - 7/8/17: Found on floor next to the bed. - 7/10/17: Found on the bathroom floor with transfer to local hospital for evaluation of pain. - 7/13/17: (2 falls around 4 hours apart) Found on floor next to the bed both times. - 7/17/17- Found on floor by sofa. 7/17/17 - Nursing note documented new onset weeping leg edema with increased difficulty walking. There was no evidence in the record that R5 was assessed for the clinical change of condition nor the need for additional interventions to prevent further falls. 7/18/17 – Transferred to a nursing home for higher level of care. During interview with E3 (Charge Nurse) on 2/13/18 at approximately 1:00 PM, E3	3. The DON/Designee will review all Fall Incident Reports & initiate/or update the Fall Risk Intervention Addendum. The DON/Designee will update the UAI/Service Agreement per facility policy (Attachment E) when change in condition occurs. 4. DON/Designee will complete a monthly audit to insure that residents who fall have a Fall Risk Intervention Addendum in place (Audit to be printed monthly from incident reporting system) & that the UAI/Service Agreement is updated per facility policy as changes in condition occur (Attachment F). The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	stated that whenever a resident has a change in status it should be reflected on the UAI, service agreement, and resident flowsheet. This finding was reviewed with E1 (ED) and E2 (DON) during the exit conference on 2/15/18 at 2:45 PM.	
3225.12 3225.12.3	**Services** **The assisted living facility shall ensure that the resident's service agreement is being properly implemented.** Cross Refer 3225.11.5 Based on record review and interview it was determined that the facility failed to provide supervision with walking for one (R5) out of 6 sampled residents. Findings include: Review of R5's clinical record revealed: 12/13/16 – UAI and service agreement updated after admission documented R5 needed supervision for walking. January through July 2017 – Resident Care Flowsheet's indicated that R5 was independent with walking and was not updated to reflect the level of the need for supervision with walking. During interview with E3 (Charge Nurse) on 2/13/18 at approximately 1:00 PM E3 stated that whenever a resident has a change in status it should be reflected on the UAI, service agreement, and resident flowsheet. This finding was reviewed with E1 (ED)	3225.12 Services 3225.12.3 The assisted living facility shall ensure that the resident's service agreement is being properly implemented. 1. R5 no longer resides at facility. 2. An audit of all current residents will be completed by the DON/Designee to insure that residents' ambulation status is updated by 04/16/18. (Attachment G) 3. The DON/Designee will update the UAI/Service Agreement/Resident Care sheet when a change in condition occurs. 4. DON/Designee will complete a monthly audit to insure the UAI/Service Agreement is updated per facility policy as changes in condition occur (Attachment F). The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.

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	and E2 (DON) during the exit conference on 2/15/18 at 2:45 PM.	
3225.12.5	**The assisted living facility shall assess each resident and provide or arrange appropriate opportunities for social interaction and leisure activities which promote the physical and mental well-being of each resident, including facilitating access to spiritual activities consistent with the preferences and background of the resident.** Based on record review and interview it was determined that the facility failed to complete an activities / social assessment for one (R6) out of 6 sampled residents. Findings include: Review of R6 clinical record revealed: 12/29/17 – Resident admitted to facility. Activities Assessment / Social History was incomplete, unsigned and was dated with the incorrect year (12/29/18 instead of 2017). This finding was reviewed confirmed with E1 (ED) and E2 (DON) during the exit conference on 2/15/18 around 2:45 PM.	3225.12.5 The assisted living facility shall assess each resident and provide or arrange appropriate opportunities for social interaction and leisure activities which promote the physical and mental well-being of each resident, including facilitating access to spiritual activities consistent with the preferences and background of the resident. 1. R6 Activity Assessment was completed on 04/05/18. (Attachment H) 2. The Activities Director/Designee will complete an audit on all Residents to insure they have an Activity Assessment completed & filed in their medical record by 04/16/18. (Attachment I) 3. The Activities Director/Designee will complete an Activity Assessment per facility policy on all new residents. 4. The Activities Director/Designee will complete a monthly Activity Assessment Audit. (Attachment J) The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.
3225.13.0	**Service Agreements**	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**	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. All persons who sign the

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	receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement. Based on record review and interview it was determined that the facility failed to ensure that for one (R1) out of 6 sampled residents and one (SS1) subsampled resident the service agreement was signed by the resident and/or resident agent. Findings include: 1. Review of R1's clinical record revealed: 6/22/17 - R1's service agreement was signed by E2 (DON) but was never signed by resident or resident agent. 2. Review of SS1's clinical record revealed: 12/22/16 - SS1 service agreement was signed by E2 and a handwritten notation on the bottom of the signature page was "12-22-16 to sign on next visit "[E2's initials] RN" however there was no signature by the resident or resident agent. These findings were reviewed and confirmed with E1 (ED) and E2 at exit conference on 2/15/2018 around 2:45 PM.	agreement must be able to comprehend and perform their obligations under the agreement. 1. On 02/19/18 DON noted the update on R1's UAI & Service Agreement that on 06/27/17 DON left message for the POA to sign. The POA came in & picked up the assessments but refused to sign them as she does not agree with the diagnosis Dementia & wanderguard. SS1 No longer resides at the facility. 2. The DON/Designee will complete a Signature Audit of all current residents' UAI/Service Agreements by 04/16/18. (Attachment K) 3. The DON/Designee will note attempts to contact resident/POA & refusals to sign on the UAI/Service Agreement when they occur. 4. DON/Designee will complete a monthly audit to insure the new UAI/Service Agreement is signed by the resident/POA, attempts made to sign listed, or refusals to sign are noted. (Attachment L). The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.
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.** Based on record review and interview it	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. 1. R4 no longer resides at the facility. R6 Service Agreement was updated on 02/27/18.

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	was determined that the facility failed to ensure the accuracy of the service agreement in the area of vision for two (R4 and R6) out of 6 sampled residents. 1. Review of R6's clinical record revealed: 12/28/17 – Initial UAI documented the resident was legally blind in both eyes. 12/29/17 – Resident admitted to facility. 12/29/17 – The vision/glasses section of R6's service agreement had nothing marked, including the item "legally blind" or any indication the resident was legally blind in both eyes. During an interview with E2 (DON) on 2/13/18 at 2:40 PM the error was confirmed. 2. Review of R4's clinical record revealed: 6/7/17 – Initial UAI documented that R4 was blind in the left eye. 6/17/17 – Admission to the facility. 12/13/17 – The vision/glasses section of R6's significant change service agreement when hospice initiated had "clean glasses daily" marked but not "poor vision" or any indication the resident was blind in the left eye. During an interview with E2 (DON) on 2/13/18 at 2:40 PM the error was confirmed. These findings were reviewed with E1 (ED) and E2 during the exit conference on	2. The DON/Designee completed a Vision Audit on all current residents on 02/27/18. (Attachment M) 3. The DON/Designee will note vision deficits on the UAI/Service Agreement & the Resident Care Sheet upon Move-In, Annual Assessment, & with change in vision diagnosis. 4. DON/Designee will complete a monthly audit to insure visual deficits are current on the UAI/Service Agreement & Resident Care Sheet. (Attachment N). The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
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STATE SURVEY REPORT

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3225.16.0 3225.16.2	2/15/18 around 2:45 PM. **Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** Based on record review, interview, observation and review of other facility documentation it was determined that the facility failed to: - adequately monitor R6 and appropriately respond to door alarms resulting in the legally blind resident walking down three flights of steps and out of the building after 1:10 AM. R6 was found lying in the street around 2:30 AM with a facial laceration and leg abrasion and was hospitalized with low body temperature. - consistently monitor residents in the common areas on the locked unit resulting multiple instances of sexual abuse of R3 over several months by one resident. - deploy staff in sufficient quantity, quality and manner (location) to meet the needs of residents requiring assistance with ADLs when two RAs were assigned to residents on the unlocked floors. - ensure the Memory Care Coordinator or nurse designee was dedicated for an eight hour shift on weekdays for the locked unit. Findings include: a. Elopement Cross Refer 3225.5.5 Review of R6's clinical record and facility investigation packet revealed: - R6 wore a Wanderguard at the facility	3225.16.0 Staffing 3225.16.2 A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations. a. 1. E5 employment was terminated for not following facility Door Alarm Policy after she admitted to sitting in the CNA office, heard the alarm & chose not to go physically check the alarming door and reset the alarm from the office. E6 & E7 were

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	due to nighttime wandering and leaving the house prior to admission. - R6 resided on the third floor of the facility. - R6 exited the third floor into the stairwell by an alarmed door. - Two RAs were assigned to the unlocked section, where R6 resided, and one nurse covered both the locked and unlocked areas of the facility. - No staff was on the third floor at the time of the elopement (1:08 AM). - No staff responded to the third floor door alarm when R6 entered the stairwell. - Even though legally blind, R6 walked down three flights of stairs and out an unalarmed exit door and was discovered by a neighbor around 2:30 AM lying in the street. There was not sufficient quantity, adequately trained and qualified staff to adequately monitor and prevent R6 from walking down three flights of steps and out of the building on night shift. b. Sexual Abuse Cross refer 16 DEL.C.,Chapter 11, Subchapter III, section1131, Cross Refer to 3225.19.7.1.2 Review of R3's clinical record and facility reported incidents revealed: - R3 resided on the locked memory care unit (Rose Lane) on the first floor. - Rose Lane capacity was 12 residents. - Two staff were to be present on the locked unit at all times. - Between 6/30/17 and 8/28/17 R3 was sexually abused by SS2 on four separate occasions. - SS2 first displayed inappropriate sexual behaviors in February 2017 with another female resident.	inserviced immediately on the Door Alarm Policy. E6 was disciplined for not notifying the nurse that a door alarm occurred & not checking the alarming door. E7 was disciplined for not properly monitoring the walkie. R6 was placed on the wait list for the secure unit & moved to that unit on 04/03/18. 2. All door alarms were assessed by the Maintenance Director on 01/26/18 & were in good working order. A Resident Elopement Risk Assessment audit was completed on 04/04/18. (Attachment A) 3. Staff was inserviced on the Door Alarm Policy on 01/26/18 & various other dates. (Attachment B) Door Alarm Policy was added to the General Orientation classroom packet on 01/26/18. The Exterior Emergency Exit doors that open to the outside will have door alarm censors installed by 04/16/18. Staff inservicing on Walkie Monitoring will be completed by 04/16/18. 4. Facility will continue to conduct Elopement Drills according to facility policy. The results of the drills will be reported by the DON/Designee to Quality Assurance Committee until substantial compliance is met for 2 consecutive quarters. b. 1. On 08/28/17 @ 0633, Rose Lane common area was left unattended although there were 2 staff members on the unit. Both staff members were disciplined for leaving the common area unattended. On the other 3 occasions, there were staff in the common area but were unable to react in time to prevent incidents. On all 4 occasions, the residents were separated immediately. 2. There will be 2 staff members on the Rose Lane unit at all times. One staff member will remain in the common area for supervision. The Rose Lane

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	There was not sufficient quantity, adequately trained and qualified staff to adequately monitor residents in the common area on the locked unit to prevent multiple instances of sexual abuse of R3 by one other resident. c. Assisted Living – Unlocked Areas 2/9/18 - Resident list supplied by the facility upon entry showed the facility census was 75 residents and 9 residents were out of the facility (i.e., at hospital). Of the 75 residents in the facility, 11 lived on the locked unit and 64 resided outside that unit. Review of the floor plan provided by the facility upon entry on 2/9/18 showed that apartments not on the locked unit were distributed on three floors of the facility. The apartments on the first floor were along both sides of one hallway since the locked unit occupied the other hallway. The hallways on the second and third floor each joined together in an "L" shape with resident apartments along both sides of the two hallways. The number of apartments on these two floors were divided between the two hallways. - First floor: 10 apartments (9 one bedroom, 1 studio). - Second floor: 31 apartments (12 one bedroom, 17 studio). - Third floor: 35 apartments 2 one bedroom, 33 studio). During an observation on 2/9/18 between 4:50 AM – 5:15 AM on the second and third floors, when standing in the middle or at the far end of one hallway, the other hallway was not visible. The only place to	Coordinator will be scheduled for 8 hours per day Monday-Friday. There will be an Activity Assistant scheduled for 8 hours per day 7 days per week. Activity Assistant/nurses will relieve and assume the Rose Lane monitoring duties while the RA is on break. 3. The staff will be inserviced on proper monitoring of the Rose Lane unit by 04/16/18. The Rose Lane Coordinator will be stationed on the unit by 04/30/18. 4. The Rose Lane Coordinator/Designee will audit the staffing on Rose Lane to insure the above noted stated guidelines are followed utilizing the Daily Assignment Sheets. The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters. c. 1. The census referenced was accurate only on 02/09/18 as census changes on a daily basis. The Resident Care Sheets were accurate only 02/15/18 when they were requested by the survey team as resident care changes on a daily basis. Therefore, the care needs referenced do not correlate with the multiple other referenced dates 04/29/17-02/12/18. Staffing will be adjusted daily based on care needs & census by the DON/Designee. 2. Revisions have been made to the 11-7 staffing schedule to include 2 RAs for the entire 11-7 shift on the Assisted Living effective 04/04/18. The DON/Designee will reconcile the Daily Assignment sheets for accuracy beginning 02/14/18. 3. The staff will be inserviced that the RAs may not leave prior to the arrival of their relief coverage which may require them to be mandated for the next shift by 04/16/18.

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	visualize down both hallways was to be at the "L" where the two hallways meet. During an interview with E1 (NHA) and E2 (DON) at the exit conference on 2/15/18 around 2:45 PM the surveyor stated that staffing would be examined after the survey since copies of the Resident Care Flowsheets were provided shortly before exit. E2 commented that when a significant number of residents were in the hospital, the number of RAs was reduced. Review of Resident Care Flowsheets for residents living in unlocked areas: - Resident rooms were on three different floors in the facility. - 13 residents were independent with ADLs, including bathing. - 12 residents required assistance and/or supervision only with bathing. - 37 residents need assistance and/or supervision with transfer in/out of bed or chair, walking, dressing, grooming and/or toileting. Review of the assignment sheet (last revised 12/18/17) showed resident distribution when two RAs were working. Analysis of the Resident Care Flowsheets for residents present the first day of survey, provided a snapshot in time for the assignment for each of the two RAs: - Each RA was assigned residents on two separate floors in the facility. - <u>Assignment 1</u>: included 20 residents needing assistance/supervision with ADLs: * Transfer – 11 (two residents needed 2 staff for the task) * *Walking - 17* * Dressing - 18	4. The DON/Designee will audit the staffing on Assisted Living to insure the above noted stated guidelines are followed utilizing the Daily Assignment Sheets. The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.

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	* Grooming - 13 * Toileting - 17 - Assignment 2: included 15 residents needing assistance/supervision with ADLs: * Transfer – 5 (two residents needed 2 staff for the task) * Walking - 11 * Dressing - 10 * Grooming - 9 * Toileting - 9 - Residents in rooms 217, 222 and 228 were not included on either assignment. (all three needed supervision or assistance with ambulation or dressing). 2/21/18 (12:27 PM) - Email sent to E1 and E2 to inform of the missing residents on the two-person assignment sheet with provided during survey. E1 responded that E3 (Charge Nurse) updates the list as residents change and emailed a new assignment sheet (revised 2/18/18, after exit) used when two RAs were working. Review of this assignment sheet found residents in rooms 217, 222 and 228 were included in assignment 2 and three other residents from that assignment were moved to assignment 1. Based on the calculation of resident needs using the original two-person assignment, for each 8 hour shift when two RAs worked, the RA would only have limited time available to assist each resident identified as needing supervision or assistance with at least one ADL. The residents from the unassigned rooms were added to assignment 2 for the purpose of this analysis since that assignment included a lower number of residents	

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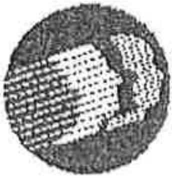
needing RA supervision/ assistance compared to assignment 1.
- Assignment 1: 24 minutes per resident.
- Assignment 2: 26.7 minutes per resident.

This calculation did not include time needed for supervision or assistance with bathing. Resident Care Flowsheets designated the days of the week and shift for each resident's bathing which ranged from twice a week to daily:

Assignment 1	Day	Eve	Night
Monday	2	3	
Tuesday	4	1	
Wednesday	5	2	1
Thursday	3	4	
Friday	3	2	
Saturday	4	1	
Sunday	5	4	1

Assignment 2	Day	Eve	Night
Monday	5	3	2
Tuesday	5	3	2
Wednesday	4	4	1
Thursday	5	3	1
Friday	5	3	1
Saturday	5	4	1
Sunday	5	3	1

Review of 50 random Daily Assignment sheets between 4/29/17 – 2/15/18 that listed names of staff who worked, found three RAs were usually scheduled to work with residents on the unlocked floors on days and evenings and two RAs were scheduled at night. There were 44 out of 100 day and evening shifts when one of the three RAs called out and was not replaced or there was a blank on the



SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	assignment sheet with *nd* [indicated a need for staff]. Many assignment sheets included a handwritten note regarding identified needs "*nd mandation if no vol" or "If no vol * must mandate." [The facility would require staff to work the next shift if no one volunteered for overtime.] There were 6 additional shifts with two RAs working, but the assignment sheet did not designate a call out of an identified need, so these were not included in the analysis. The following day and evening shifts had less than three RAs working the entire shift to assist residents living on the unlocked side of the facility. [Baths for assignment 1 / assignment 2 and incidents listed]. - 4/29/17 (Saturday- 2 shifts): Day call out; Evening with two RAs after 9:00 PM [Day bath 4/5; Evening bath 1/4; Third floor resident fall at 11:55 PM]. - 7/11/17 (Tuesday – 2 shifts): Day and evening with unfilled need [Day bath 4/5; Evening Bath 1/3]. - 7/12/17 (Wednesday): Day RA call out [Day bath 5/4]. - 7/14/17 (Friday): Evening with unfilled need (Evening bath 2/4]. - 7/15/17 (Saturday): Day with unfilled need after 10:00 AM (Nurse worked until 10:00 AM as aide). Additional day RA call out and coverage found starting at 9:00 AM [Day bath 4/5]. - 7/16/17 (Sunday): Day with unfilled need [Day bath 5/5]. - 7/25/17 (Tuesday): Evening with unfilled need [Evening bath 1/3]. - 8/1/17 (Tuesday – 2 shifts): Day RA was moved to evening leaving two RAs on both shifts [Day bath 4/5; Evening bath 1/3]. - 8/7/17 (Monday): Evening with unfilled	

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	need [Evening bath 3/3]. - 8/13/17 (Sunday – 2 shifts): Day and evening with unfilled need [Day bath 5/5; Evening bath 4/3]. - 8/15/17 (Tuesday): Day with unfilled need [Day bath 4/5]. - 8/16/17 (Wednesday): Evening with unfilled need [Evening bath 2/4; resident fall at 5:33 PM]. - 8/17/17 (Thursday): Evening with unfilled need after 8:00 PM [Evening bath 4/3]. - 8/18/17 (Friday): Evening with unfilled need [Evening bath 2/3]. - 8/19/17 (Saturday): Day and evening with unfilled need [Day bath 4/5; Evening bath 1/4]. - 1/14/18 (Sunday): Day with unfilled need after 1:10 PM [Day bath 5/5]. - 1/15/18 (Monday): Evening with call out [Evening bath3/3]. - 1/16/18 (Tuesday – 2 shifts): Day and evening with call out [Day bath 4/5; Evening bath 1/3; third floor resident fall at 9:05 PM]. - 1/18/18 (Thursday – 2 shifts): Day shift with two RAs after 2:00 PM. Evening with one RA pulled to locked unit, leaving two RAs [Day bath 3/5; Evening bath 4/3; altercation between two residents at 3:15 PM]. - 1/24/18 (Wednesday): Day with call out and another aide leaving at 2:00 PM, leaving one aide on the floor for last hour [Day bath 5/4]. - 1/26/18 (Friday): Evening call out [Evening bath 2/3]. - 1/27/18 (Saturday): Evening with unfilled need [Evening bath 1/4]. - 1/28/18 (Sunday – 2 shifts): Day and evening with unfilled need [Day bath 5/5; Evening bath 4/3]. - 1/31/18 (Wednesday – 2 shifts): Day	

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	with unfilled need, evening with call out [Day bath 5/4]. - 2/1/18 (Thursday – 2 shifts): Day RA arriving 8:00 AM. Evening with call out and coverage until 9:00 PM [Day bath 3/5; Evening bath 4/3]. - 2/2/18 (Friday – 2 shifts): Day with need filled at 8:00 AM. Evening with unfilled need after 8:45 PM [Day bath 3/5; Evening bath 2/3]. - 2/3/18 (Saturday – 2 shifts): Day with call out. Evening with unfilled need [Day bath 4/5; Evening bath 1/4]. - 2/4/18 (Sunday – 2 shifts): Day with call out. Evening with unfilled need [Day bath 5/5; Evening bath 4/3]. - 2/8/18 (Thursday): Evening with call out [Evening bath 4/3]. - 2/12/18 (Monday): Evening with call out Evening bath 3/3]. - 2/15/18 (Thursday): Day call out, no coverage after 11:00 AM [Day bath 3/5]. Dates when night shift did not have two aides present the entire shift [including assignment 1 / assignment 2 baths]. - 6/23/17 (Saturday morning): one RA after 6:00 AM [0/1]. - 7/10/17 (Tuesday morning): one RA after 6:00 AM [0/2]. - 10/8/17 (Monday morning): one RA after 6:00 AM [0/2]. - 1/19/18 (Saturday morning): one RA after 6:10 AM [0/1]. - 1/24/18 (Thursday morning): one RA after 6:00 AM and NO RA after 6:30 AM [0/1]. - 1/27/18 (Sunday morning): one RA after 6:15 AM [1/1]. - 1/30/18 (Wednesday morning): one RA after 6:30 AM [1/1; third floor resident fall with injury at 6:57 AM].	

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	- 1/31/18 (Thursday morning): one RA after 4:00 AM [0/1]. - 2/12/18 (Tuesday morning): one RA after 6:00 AM [0/2]. Based on the calculation of resident needs from the resident care flowsheets received immediately prior to exit, when two RAs were assigned to residents on the unlocked floors, each RA would have only 22 to 26.7 minutes available per resident requiring supervision or assistance with ADLs. However, the number of minutes did not include additional time needed for bathing supervision / assistance for an additional 1-5 residents per shift, answering call lights, or requests from independent residents. At nighttime, there were times when only one RA was working and one occasion when no RA was on the unlocked assisted living side during the final hour of the shift. d. Memory Care Unit (locked unit) The plan of correction for the survey ending 9/22/15 included an increase in RAs for the locked unit (to have two RAs assigned at all times) along with a nurse to serve as the memory care coordinator. During an observation of the front lobby on 2/9/18 around 4:28 AM, while surveyors were awaiting entry into the facility (after ringing the doorbell), two RAs were seen leaving the locked unit to look through the window at the surveyors. They were off the unit approximately 1 minute, leaving no staff in the area, as the nurse approached the lobby from a different direction. Review of the 50 random daily assignment sheets also revealed two aides were	d. 1. The 2 staff members who exited Rose Lane on the morning of 02/09/18, will be inserviced not to leave Rose Lane without relief coverage-not even for one minute. 2. There will be 2 staff members on the Rose Lane unit at all times. One staff member will remain in the common area for supervision. The Rose Lane Coordinator will be scheduled for 8 hours per day Monday-Friday. There will be an Activity Assistant scheduled for 8 hours per day 7 days per week. Activity Assistant/nurses will relieve and assume the Rose Lane monitoring duties while the RA is on break. 3. The 2 staff members were inserviced on proper monitoring of the Rose Lane unit on 04/05/18 & 04/06/18. (Attachment O) The Rose Lane

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: State Street Assisted Living **DATE SURVEY COMPLETED: February 15, 2018**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	assigned to the unit on every shift and that the nurse was to cover meal breaks as to never leave less than two staff on the locked unit. There were 9 weekdays when a separate nurse was not assigned to the locked unit for an 8 hour shift [incidents listed]. - 6/23/17 (Friday) - 7/12/17 (Wednesday) [Resident fall at 6:23 PM] - 7/14/17 (Friday): 4 hours - 7/18/17 (Monday) - 7/25/17 (Tuesday) - 8/1/17 (Tuesday) pulled to med cart [resident-to-resident altercation at 7:05 PM] - 8/18/17 (Friday) 6 hours - 1/26/18 (Friday) - 2/12/18 (Monday) Observation 2/9/18 during the initial tour conducted between 4:45 AM – 5:30 AM found no office on the locked unit for E4 (Memory Care Coordinator). Observation throughout survey on 2/9/18, 2/12/18 and 2/13/18 E4 was seen most of the time in the nursing office on the second floor in the unlocked area of the facility. During an interview with E4 (Memory Care Coordinator) on 2/13/18 around 1:15 PM E4 stated that s/he worked 10:00 AM to 6:00 PM in order to be available for both day and evening shifts. During the exit conference with E1 (ED) and E2 (DON) on 2/15/18 around 2:45 PM the surveyor stated that staffing would be reviewed using the copies of the Resident Care Flowsheets provided shortly before	Coordinator will be stationed on the unit by 04/30/18. 4. The Rose Lane Coordinator/Designee will audit the staffing on Rose Lane to insure the above noted stated guidelines are followed utilizing the Daily Assignment Sheets. The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.

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3225.19.7.1.2 **16 Del., C., Subchapter III; §1131**	the exit conference. **Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.** **1b. Sexual abuse which includes, but is not limited to, any sexual contact, sexual penetration, or sexual intercourse, as those terms are defined in § 761 of Title 11, with a patient or resident by an employee or volunteer working at a facility. It shall be no defense that the sexual contact, sexual penetration, or sexual intercourse was consensual.** **Assisted Living Regulations defined sexual abuse as staff to resident sexual acts; resident to resident non-consensual sexual acts; and Other (e.g., visitor, relative) to resident non-consensual sexual acts.** Based on record review, interview and review of other facility documentation it was determined that the facility failed to protect one (R3) out of 6 sampled residents from repeated sexual abuse by another resident. Findings include: Facility policy entitled Resident Abuse (dated 4/2015) defined physical abuse as unnecessarily inflicting pain or injury to a patient or resident. This includes, but is not	3225.19.7.1.2 16 Del., C., Subchapter III; §1131 Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning. 1b. Sexual abuse which includes, but is not limited to, any sexual contact, sexual penetration, or sexual intercourse, as those terms are defined in § 761 of Title 11, with a patient or resident by an employee or volunteer working at a facility. It shall be no defense that the sexual contact, sexual penetration, or sexual intercourse was consensual. Assisted Living Regulations defined sexual abuse as staff to resident sexual acts; resident to resident non-consensual sexual acts; and Other (e.g., visitor, relative) to resident non-consensual sexual acts. 1. On 08/28/17 @ 0633, Rose Lane common area was left unattended although there were 2 staff members on the unit. Both staff members were disciplined for leaving the common area unattended. On the other 3 occasions, there were staff in the common area but they were unable to react in time to prevent incidents as the residents were out of their immediate reach. On all 4 occasions, the residents were separated immediately. Interventions were implemented on each occasion including sub-acute in-patient psychiatric rehab. No further incidents have occurred since SS2's return on 09/19/17. 2. SS2's EMAR updated to reflect "***Do NOT attempt dose reduction without POA consent!!" on

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	limited to, hitting, kicking, pinching, slapping, pulling hair or any sexual molestation. When any act constituting physical abuse has been prove [proven], the inflection of pain shall be presumed. - Staff to resident with or without injury. - Resident to resident with or without injury. - Other - visitor/relative to resident with or without injury. - Sexual – staff to resident sexual acts, resident to resident non-consensual sexual acts, visitor/relative non-consensual sexual acts. Review of R3's clinical record revealed: 3/21/16 – Admission to facility with multiple diagnoses including Alzheimer's Disease. The resident resided on the locked unit. 3/21/17 – Annual UAI indicated R3 was oriented to self, had memory problems and word finding difficulty and was hard of hearing. 3/21/17 – Service agreement documented R3 had garbled speech, needed supervision for walking and the cognitive status / judgement section included that s/he needed staff intervention and monitoring to meet needs. May 2017 – January 2018 - Review of facility reported incidents for abuse revealed the following allegations of sexual abuse involving R3: - 6/30/17 (7:30 PM): SS2 rubbed R3's legs with his/her (SS2) hand(s) while both were seated on the couch in the lounge area. When R3 refused to go with SS2, s/he (SS2) rammed the walker into R3's	Provera & Zoloft per POA request. There will be 2 staff members on the Rose Lane unit at all times. One staff member will remain in the common area for supervision. The Rose Lane Coordinator will be scheduled for 8 hours per day Monday-Friday. There will be an Activity Assistant scheduled for 8 hours per day 7 days per week. Activity Assistant/nurses will relieve and assume the Rose Lane monitoring duties while the RA is on break. 3. The staff will be inserviced on proper monitoring of the Rose Lane unit by 04/16/18. The Rose Lane Coordinator will be stationed on the unit by 04/30/18. 4. The Rose Lane Coordinator/Designee will audit the staffing on Rose Lane to insure the above noted stated guidelines are followed utilizing the Daily Assignment Sheets. The results of the audit will be reported to Quality Assurance Committee each quarter until substantial compliance is met for 2 consecutive quarters.

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	legs.. - 7/7/17 (5:49 PM): SS2 took R3's hand and put R3's hand down SS2's pants in the hallway. - 7/9/17 (6:50 PM): SS2 pulled R3's face toward his/her own and kissed R3 in the lounge area. - 8/28/17 (6:33 AM): SS2 had his/her hands up R3's shirt fondling R3's breasts in the lounge area. The State Agency incident reporting system showed that these four occasions were not the only inappropriate sexual behaviors for SS2. On 2/9/17 SS2 exposed his penis and asked SS3 to touch it while SS2 had his hands inside R3's pull-up brief. Review of facility investigations into the aforementioned allegations of sexual abuse of R3 found: - 6/30/17: SS2 had a history of Alzheimer's Disease and inappropriate statements and touching. Environmental modifications included frequent random checks by staff. Also SS2 care plan for inappropriate statements and touching was in place and a dose of medication for depression was increased with notation that dose reduction failed (dose had been reduced 6/26/17). A side effect of this medication included reduced in sex drive. - 7/7/17: SS2 was tested for a urine infection, which was not present. The resident was also started on a prostate medication with a side effect of decreased sexual desire. Environmental modifications included frequent random checks by staff. - 7/9/17: No additional medication intervention at this time except for	

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	psychiatrist to evaluate on next visit. Environmental modifications included frequent random checks by staff. - 8/28/17: Physician ordered to reduce the antidepressant on 8/23/17 and the POA refused the reduction. Environmental modifications included frequent random checks by staff. A systems follow-up included training that aides not leave the lounge area unattended. SS2 went to a psychiatric hospital for treatment. Review of the State Agency facility reported incidents found no further sexual abuse allegations involving SS2 and R3 after SS2's return on 9/19/17. During an interview with E4 (Memory Care Coordinator) on 2/13/18 around 1:00 PM to review the interventions implemented to protect R3 from SS2's sexual advances, E4 stated that neither resident was capable of giving consent. The common area was to be monitored all the time by a RA. E4 added that the psychiatric hospital had success in medically treating inappropriate sexual behaviors so that's why SS2 went there. E4 added that R3 is "touchy feely" and likes to smile and hug people which may have given SS2 the wrong impression. It was unclear how the repeated sexual abuse occurred in the common area when the area was to be staffed with two staff. These findings were reviewed with E1 (ED) and E2 [DON] during the exit conference on 2/15/18 around 2:45 PM.	