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

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Serenity Gardens

DATE SURVEY COMPLETED: May 23, 2013

REVISED

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 May 22, 2013 and ending May 23, 2013. The facility census on the entrance day of the survey was 14. The survey sample was composed of 2 residents. The survey process included interviews, review of residents' clinical records, facility documents and facility policies and procedures.	
3225.0	**Assisted Living Facilities**	
3225.19.0	**Records and Reports**	
3225.19.5	**Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:**	3225.19.5 #1 Facility reported injury of unknown source on 5/4/2013. The same day we were notified (see attached report).
3225.19.5.4	**Injuries of unknown source.**	#2 No other resident was identified as being affected
	This requirement is not met as evidenced by:	#3 All staff was in-serviced on 5/28/2013 on Common Skin Issues in Geriatric Residents (see attachment).
	Based on clinical record review and staff interview it was determined that the facility failed to complete an incident report of an injury of unknown origin sustained by one resident (Resident #1) out of two sampled. Findings include:	Facility has instituted skin sheet to include changes in condition, ulceration and injuries which are kept on file for 30 days.
	Clinical record review revealed that Resident #1 was transported by paramedics to an acute care facility on 5/4/2013 for an evaluation of inability to move her left side.	Completion Date: 5/28
	Further review of Resident #1's clinical record revealed a nurse's note dated 5/4/2013 and without a specific time that	

Provider's Signature Heather Lynch-James RN Title DON Date 7/15/13

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	stated "...Received call at (9:22 AM) from (nursing staff at acute care facility) inquiring if (Resident #1) had a fall...(Informed) her that I was not aware of any fall. Advised by (nursing staff at acute care facility) that (Resident #1) had (old) hematoma on (right) hip. (Told) her that I was not aware but would investigate...". The facility was unable to provide a written incident report of the above referenced hematoma of unknown origin sustained by Resident #1as reported by the acute care facility.	
16 Del., C., Chapter 11, Subchapter III, § 1131	**Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **Definitions.** **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.** **(9) "Neglect" shall mean:** **a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.** **This requirement is not met as evidenced by:** Based on clinical record review, review of facility documents and staff interviews it was determined that the facility failed to ensure the safety of one resident (Resident #1) out of two sampled who	**16 Del.,C., Chapter 11,Subchapter .$1131** #1 Resident was hospitalized and subsequently discharged to a Skilled Nursing Facility. No correction can be made. #2 No other resident was affected by this deficiency. #3 A skin monitoring sheet has been instituted in staff identification #4 Care plans will be reviewed and updated on an ongoing basis to include specific intervention for residents more at risk for falls and skin alterations (i.e. increased body checks). Families will be educated regarding risk about falls and skin issues (see attached disclosures). Completion Date: 7/26/13

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	sustained an injury. Findings include: Clinical record review revealed that Resident #1 was admitted to the assisted living facility on 2/25/2013 with diagnoses that included dementia, Alzheimer's type, a recent history of deep vein thrombosis and pulmonary embolism, osteopenia and hypertension. Review of the initial UAI (Uniform Assessment Instrument) completed 2/25/2013 revealed that Resident #1 was oriented to person only and experienced short-term and long-term memory problems. Further review of the UAI dated 2/25/2013 revealed that Resident #1 was independent for eating but required assistance with toileting and the physical assistance of one staff member for mobility, transferring, grooming and dressing. Additionally Resident #1 was dependent upon staff for bathing and medications. The section of the UAI dated 2/25/2013 and labeled "Fall Risk Assessment" revealed that Resident #1 was at risk for falling due to the factor of impaired balance. The initial UAI dated 2/25/2013 also indicated that Resident #1 had a history of wandering inside. Additionally Resident #1 was receiving anticoagulant therapy until it was discontinued on 5/4/2013. Clinical record review revealed a nurse's note dated 5/4/13 and without a specific time that stated "Received call from E2 (facility resident assistant) at (7:45 AM) stating (Resident #1) was eating breakfast when suddenly she slumped over to the left side...unable to move (left) side. Resident #1 was transported by ambulance to an acute care facility for an evaluation. According to the above referenced nurse's note dated 5/4/2013 E1(RN/administrator) was contacted at	

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	9:22 AM and 11:30 AM by the acute care facility inquiring if Resident #1 sustained a fall due to the presence of a hematoma on the right hip. In an interview conducted on 5/22/2013 with this surveyor E1 (RN/administrator) stated that an investigation was completed but no fall and/or hematoma affecting Resident #1 was reported to her by facility staff. Review of three out of four investigative statements completed by facility staff members assigned on duty between May 3, 2013 and May 4, 2013 denied any knowledge of a fall or observation of a hematoma /bruise sustained by Resident #1. However E3 (facility resident assistant) acknowledged she "saw a dark spot" on Resident #1's buttock. Another nurse's note documented 5/4/2013 and timed 11:30 AM revealed that E3 (facility resident assistant) stated she "saw a darkened area on Resident #1's right buttock but thought the other facility staff were aware and did not report it...". Although the assisted living facility conducted an investigation to determine cause for the presence of a hematoma on Resident #1's right hip as reported by the acute care facility, it failed to reveal that Resident #1 was found on the floor by E2 (facility resident assistant) at 6:00 AM on 5/4/2013. In an interview conducted by this surveyor on 5/23/2013 E2 (facility resident assistant) was asked if Resident #1 had a fall or was discovered on the floor and responded that Resident #1 was found on the floor at 6:00 AM on 5/4/2013 wrapped up in a bedspread and sleeping. E2 (facility resident assistant) further stated that Resident #1 had arisen from bed on another occasion, wrapped herself in a bedspread and slept on the floor. Further review of the investigative	

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	statement prepared by E2 (facility resident assistant) gave no mention of having found Resident #1 asleep on the floor at 6:00 AM on 5/4/2013. This finding was reported to E1 (RN/administrator) on 5/23/2013. Review of the nurse's notes from 3/10/2013 beginning at (7:00 PM) through 5/4/2013 until admission to an acute care facility revealed the absence of any documentation of Resident #1 being found wrapped in a bedspread sleeping on the floor. The facility failed to ensure the safety of Resident #1 who sustained a hematoma without the knowledge of staff. Documentation in the nurse's note on 5/4/2013 at (8:00 PM) revealed that E1 (RN/administrator) was contacted again by the acute care facility and informed that Resident #1 was admitted with diagnoses of a right gluteal hematoma and an "acute C4 (cervical spine #4) fracture". Review of Resident #1's hospital records revealed the above referenced admitting diagnoses were confirmed by CAT (computerized axial tomography) scans of the her cervical spine and pelvis. Further review of the hospital record revealed Resident #1 was discharged from the acute care facility with diagnoses that included chronic C4 fracture, UTI (urinary tract infection), and right gluteal hematoma measuring "8cm x (centimeters by) 10cm (4 inches by 5 inches)". These findings were reviewed on 5/23/013 with E1 (RN/administrator).	