

STATE SURVEY REPORT

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NAME OF FACILITY: Ingleside Assisted Living DATE SURVEY COMPLETED: March 1, 2023 SECTION STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR COMPLE-**SPECIFIC DEFICIENCIES CORRECTION OF DEFICIENCIES** TION DATE **REVISED REPORT** The following is the Plan of Correction for Deficiency 3225.11.3 Requirements for Ingleside Assisted Living regarding the Resident Assessment. Within 30 days statement of Deficiencies dates March 1, prior to admission, a prospective resident shall have a medical evaluation completed by a physician. 3225.11.3 was removed March 14, 2023 as facility provided evidence of compliance. An unannounced Annual and Complaint Survey was conducted at this facility from February 28, 2023 through March 1, 2023. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was forty-six (46). The survey sample totaled six (6) residents. Abbreviations/definitions used in this report are as follows: DelVAX - Delaware's State immunization registry serving as a database that contains the immunization records of Delaware residents: Dementia - the loss of cognitive functioning — thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities; DON - Director of Nursing; ED - Executive Director; UAI (Uniform Assessment Instrument) - a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each



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	2. 9/28/21 – R5 was admitted to the facility. The facility failed to provide evidence that a pneumococcal pneumonia vaccine was administered or that it was offered and declined.		
	2/28/23 at 10:40 AM – Per interview with E2 (DON), E2 confirmed the information was not captured in the UAI assessment or other documentation and confirmed he does not have access to the DelVAX site to check immunizations.		
	3/1/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 2:00 PM.		
3225.15.0	Quality Assurance		
	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:	3225.15.0 The Quality Assurance policy has been reviewed by the Executive Director/designee. No negative outcomes were identified. The Quality Assurance program will be es-	May 31, 202
	3/1/23 at 11:45 AM- The facility's Quality Assurance (QA) policy was reviewed. The facility failed to provide evidence of QA meetings, attendees or minutes. Findings include:	tablished. The Quality Assurance meeting will be held quarterly. The Quality Assurance meeting will be conducted by the Executive Director/designee. An audit will be ongoing quarterly until 100% compliance is met, then at the facility	
	3/1/23 at 1:55 PM – Per interview with E1 (ED) and E2 (DON), it was confirmed that the facility's QA Program was yet to be established. E2 stated that daily meetings are held with staff to review any outstanding issues or resident concerns.	discretion.	



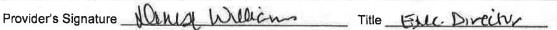
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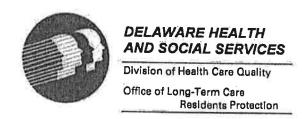
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- 111	3/1/23 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 2:00 PM.		
3225.19.0	Records and Reports		
3225.19.6	Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.		
3225.19.7	Reportable incidents include:		
3225.19.7.7	Significant injuries.		
3225.19.7.7.2	Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic re-	3225.19.7.7.2	Completion Date:
	assessment of the resident's clinical status by facility professional staff for up to 48 hours.	Resident R3 medical records have been reviewed by the Director of Nursing and physician. No negative outcomes were identified.	May 31, 2023
	This requirement was not met as evidenced by:	Director of Nursing/designee to re-educate all staff about reportable and non-reporta-	
	Based on record review, interview and review of other facility documentation, it was determined that for one (R3) out of six sampled residents, the facility failed to report a fall leading to an emergency room (ER) evaluation. Findings include:	ble events and emphasize falls that result to injury and transfer to acute care setting for treatment or require periodic reassessment by a professional staff up to 48 hours will be reported to the state promptly within 8 hours of occurrence.	
	3/21/22 - R3 was admitted to the facility with a diagnosis of dementia. Per the medical record, the resident fell on 4/1/22 at 8:20 PM and was sent to the ER for evaluation. Emergency Room documentation	A list of Incident Reports will be bought to daily stand-up meetings to be reviewed by Director of Nursing/designee as per State guideline and Ingleside policy.	
	revealed that R3 sustained a compression fracture from the fall.	Director of Nursing/designee will audit Incident reports weekly x 4 weeks, then 2 times per months x 2 months. Audit will be on-	
	3/1/23 at 1:55 PM – Per interview with E1 (ED) and E2 (DON), it was confirmed that	going until 100% compliance is met, then at the facility discretion.	





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	this fall resulted in an ER evaluation with		1
	an Injury and it was not reported to the State.		
	3/1/23 – Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 2:00 PM.	±	
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