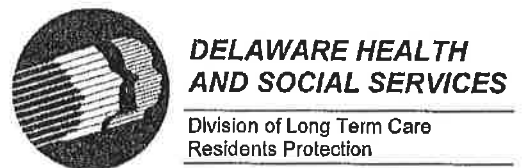

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
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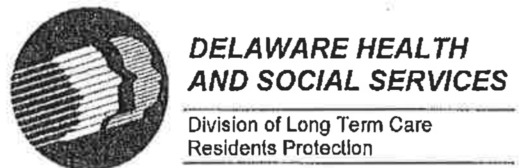
NAME OF FACILITY: Brandywine Senior Living at Fenwick **DATE SURVEY COMPLETED:** June 26, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility beginning June 19, 2017 and ending on June 26, 2017. The facility census on the entrance day of the survey was eighty-seven (87). The survey sample was composed of 9 residents, plus two additional sub-sampled residents. Three of the 9 residents were closed record reviews. Abbreviations used in this report are as follows: ED – Executive Director; NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CDC – Centers for Disease Control and Prevention; Dementia – brain disorder with memory loss, poor judgement, personality changes and disorientation; eMAR – electronic Medication Administration Record; POA – Power of Attorney; PRN – as needed; Service Agreement – a written plan signed by a facility representative and a resident / family member describing the agreed upon services to be provided to the resident by the facility;		

Provider's Signature [signature] Title Executive Director Date 8/22/17



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	UAI (Uniform Assessment Instrument) – standardized resident assessment used in assisted living facilities.		
3225 3225.8.0 3225.8.1.4	**Assisted Living Facilities** **Medication Management** **Administration of medication, self-administration of medication, assistance with self-administration of medication, and medication management by an adult family member/support person.** Based on record review and interview it was determined that the facility failed to adhere to policy and standards for medication administration for one (R2) out of 9 sampled residents. Findings include: 2002 - Pain management standards from the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. 2004 – Facility policy entitled Pain Management stated that: - Pain management will be uniformly recorded in a 1-10 format using either a verbal, visual or Wong-Baker face scale	<u>3225.8.1.4</u> **A.** R2's pain medication usage, location of pain and effectiveness was reviewed to ensure documentation supported appropriate pain management. **B.** Residents with orders for PRN pain medication and PRN anxiety medication have the potential to be affected by this practice. E2 reviewed policies for pain management (<u>SEE ATTACHMENT ONE</u>) and PRN medication administration (<u>SEE ATTACHMENT TWO</u>.) E2 and LPN conducted audit for this identified population to confirm appropriate documentation and pain management. Any findings were corrected at that time. **C.** E2 reviewed pain management policies and pain scales. E2 provided education to the licensed staff regarding pain assessment, documentation of pain and appropriate pain management. Assistant Wellness Director provided education to licensed nurses regarding checking in medications and entering them in to the computer to identify triggers for the required pain documentation. The Wellness Nurse Checklist was revised to include detail of pain management documentation with pre and post	September 1, 2017

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	depending on resident ability to comprehend the rating scales. Scales will be standardized so that a 1 will be mild pain and a 10 being the worst pain the resident has ever experienced. [0 means no pain] Residents who are unable to verbalize or comprehend a 1-10 scale will be assessed using the FLACC scale. [FLACC Pain Assessment Tool involves assessing resident behaviors in five separate categories to determine a 0-10 pain score. - The licensed nurse will document on the medication administration record after a one-hour interval the results of the pharmacologic intervention. 2016 - Lippincott's Nursing 2016 Drug Handbook documented the 8 rights of medication administration: 1. Right patient, 2. Right medication, 3. Right dose, 4. Right route, 5. Right time, 6. Right documentation, 7. Right reason, and 8. Right response. Review of R2's eMARs and progress notes in the clinical record revealed: March, 2017 – June, 2017 - R2 received 8 PRN doses of pain medication: 2 administrations (6/9/17 and 6/17/17) failed to include the location of the pain as well as the pain rating scale both before and after the PRN medication. - The resident received 12 PRN doses of medication for anxiety: 1 dose lacked assessment of behaviors both before and after the PRN medication (4/12/17); 11 administrations did not identify specific resident behaviors warranting the need for	administration evaluations. Education provided will be to all current licensed staff now, to newly hired licensed staff with orientation, and annually. The process will be evaluated in 3 months to determine if additional education on pain management is needed; individuals identified will be provided additional education. **D.** Monthly audits for residents receiving PRN pain medication will be conducted byE2 or designee. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters. **A.** R2 continues to have a PRN order for Lorazepam. Documentation identifies resident's behaviors are described accordingly and identifies effectiveness of the anti-anxiety medication administered. **B.** Residents with orders for PRN anti-anxiety medication given for behaviors have the potential to be impacted by this practice. E2 conducted audit for all residents receiving PRN medications given for behaviors to identify the reason and the specific behaviors, and the effectiveness of the PRN medication administered. **C.** E2 provided education to licensed staff regarding behavior management and documentation required for behavior management and	

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	the medication, general term like agitation and/or anxiety used (March 9, 22, 27 and 29; April 3, 12 and 21; May 6, 9 and 18; June 16). During an interview with E3 (LPN) on 6/23/17 at 11:30 AM it was confirmed that the assessments before and after the June 9 and 17 administrations of PRN pain medication were missing. E3 was also unable to locate any assessments in the record in regard to the 4/12/17 PRN medication for anxiety. During an interview with E2 (DON) on 6/26/17 around 9:45 AM she/he was informed about the missing assessments for the PRN medications. The DON expressed that the expectation for PRN pain medications would be to assess pain using the pain scale both before and after the medication. E2 added that not documenting specific resident behaviors prior to PRN anxiety medication administration was identified during a mock survey earlier this year. These findings were reviewed with E1 (NHA) and E2 on 6/26/17 at 1:10 PM.	effectiveness of the PRN medication administered. Assistant Wellness Director provided education to licensed nurses regarding checking in medications and how to enter them in to the computer to identify triggers for required behavior management documentation. The Wellness Nurse Orientation Checklist was revised to include detail for behavior management and checking in medications and entering them in to the computer system. Education provided will be to all current licensed staff now, to newly hired licensed staff with orientation, and annually. The process will be evaluated in 3 months to determine if additional education on behavior management and the documentation required including effectiveness of PRN medications is needed; individuals identified will be provided additional education. **D.** E2 or designee will conduct monthly audits for residents receiving PRN anti-anxiety medication given for behaviors. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	
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.**	3225.8.3.5 **A.** PRN medication for SS2 was disposed on 6/19/17. **B.** Residents with medications stored in facility administration containers have the potential	September 1, 2017

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	Based on observation, record review and interview it was determined that one subsampled resident (SS2) received an expired oral medication on one occasion. Findings include: 6/19/17 (9:20 AM) – Medication storage review on Reflections 2 (memory care unit on second floor) found a bottle of the laxative Milk of Magnesia with an expiration date of 2/2017 belonging to SS2. The pharmacy label documented this medication was dispensed 9/3/16 and would expire 9/3/17, one year after dispensing. The lid of the bottle contained a hand-written date of 12/2018, which did not match the expiration date on the bottle from the manufacturer. E5 (LPN) immediately confirmed the expired medication. During an interview with E1 (NHA) on 6/19/17 around 2:00 PM E1 stated that SS2 received one dose of the expired medication (April 11, 2017) when providing copies of the medication administration records to the surveyor. This finding was reviewed with E1 and E2 (DON) on 6/26/17 at 1:10 PM.	to be impacted by this practice. Medication storage areas were inspected by the licensed nurse to identify any storage of expired medications; no further expired medications were found. **C.** Pharmacy consultant will audit all medication storage areas for expired medications. Contracted pharmacy will implement label revisions concurrent with recommendation of consultant pharmacist based upon industry best practices. E2 or designee will provide education to all licensed nurses now and with new hire orientation to interpret pharmacy labels expiration dates. Wellness Nurse Orientation Checklist revised to include pharmacy label interpretation and storage of medications. **D.** E2 or designee will conduct monthly audits to identify expired medications. Consultant Pharmacist will conduct quarterly inspections to identify expired medications and provide findings to E2. E2 will include Consultant Pharmacist findings with monthly audits. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	
3225.8.6	**Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of**	3225.8.6 **A.** Self-medication assessment was completed for R7.	September 1, 2017

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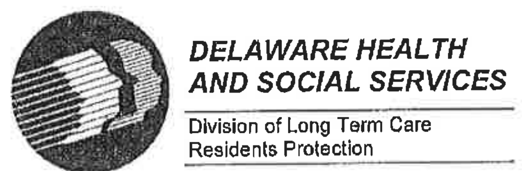

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	the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication. Based on record review and interview it was determined that the facility failed to complete a self-medication review concurrent with an annual Uniform Assessment Instrument (UAI) for two (R7 and R8) out of 9 sampled residents. Findings include: March 2001 - Facility policy entitled Medication Self Administration (last revised 8/2012) included that a resident who wants to administer their own medications and has physician approval will be assessed by a registered nurse for the ability to self-administer medications. 1. Review of R7's clinical record revealed: 3/14/17 – Admitted to assisted living facility. 4/10/17 – Annual UAI assessing R7's status and needs was completed without changes from initial UAI dated 3/7/17. R7's self-medication reviews in the record were dated 3/15/16 and 11/22/16. There was no evidence that a self-medication review was completed at the time of the April 2017 annual UAI. 2. Review of R8's clinical record revealed:	**B.** Residents who self-medicate have the potential to be affected by this practice. Records review for all residents that self-medicate was conducted to confirm they were completed concurrent with the UAI. Any self-medication assessment identified as not concurrent with the UAI has had a self-medication assessment completed concurrent with the UAI. **C.** All registered nurses will be educated now and with newly hired registered nurses with orientation regarding self-medication administration review completion concurrent with UAI. Medication Self-Administration –DE policy revised(SEE ATTACHMENT THREE) By Chief Clinical Officer to include reviews completed concurrent with the UAI. Wellness Nurse Orientation Checklist revised by E2 to include detail of Self-Administration-DE policy. **D.** Monthly audits will be conducted by E2 or designee to confirm self-medication reviews are completed concurrent with the UAI. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committeewith re-evaluation for two quarters. **A.** Self-medication assessment was completed for R8. **B.** Residents who self-medicate	

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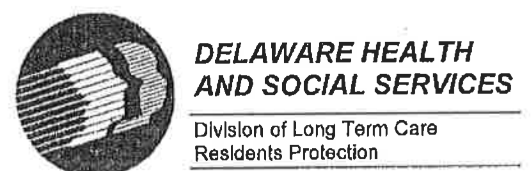

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	8/22/15 – Admitted to assisted living facility with spouse. Admission physicians' orders included that spouse (SS1) was ordered to medicate R8. 2/1/16 – Significant change UAI completed. There was no evidence in the record that a self-medication review was done at the time of the significant change UAI. 4/5/16 – Self-medication review completed for SS1, who administers R8's medications. 2/1/17 – Annual UAI completed. There was no evidence in the record that a self-medication review was done at the time of the annual UAI. During an interview with E2 (DON) on 6/26/17 around 9:45 AM to review R7 and R8's missing self-medication reviews E2 stated that she would look into the matter. Later the same day at 11:50 AM E2 informed the surveyor s/he had "not found anything" and confirmed the self-medication reviews were not completed concurrently with the UAIs. These findings were reviewed with E1 (NHA) and E2 on 6/26/17 at 1:10 PM.	have the potential to be affected by this practice. Records review for all residents that self-medicate was conducted to confirm they were completed concurrent with the UAI. Any self-medication assessment identified as not concurrent with the UAI has had a self-medication assessment completed concurrent with the UAI. C. All registered nurses will be educated now and with newly hired registered nurses with orientation regarding self-medication administration review completion concurrent with UAI. Medication Self-Administration –DE policy (SEE ATTACHMENT THREE) revised by Chief Clinical Officer to include reviews completed concurrent with the UAI. Wellness Nurse Orientation Checklist revised by E2 to include detail of Self-Administration-DE policy. D. Monthly audits will be conducted by E2 or designee to confirm self-medication reviews are completed concurrent with the UAI. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	
3225.9.0 3225.9.5.1	**Infection Control** **The facility shall have on file the results of tuberculin testing performed on all newly placed residents.**	3225.9.1 A. R1, R2, R7, R8, and R9 are asymptomatic for Tuberculosis. R6 no longer resides at this facility.	September 1, 2017

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	Based on record review and interview it was determined that the facility failed to administer tuberculin (TB) skin testing on admission in accordance with The Centers for Disease Control and Prevention (CDC) TB testing guidelines for six (R1, R2, R6, R7, R8 and R9) out of 9 sampled residents. For R1 and R9, the facility performed a 1-step tuberculin skin test (TST) on admission. For R7 the 1-step TST was done one week after admission. For R8 the 2-step results from the transferring facility was not obtained upon admission. Findings include: CDC report entitled Screening for Tuberculosis and Tuberculosis Infection in High-Risk Populations (9/8/95) documented for residents and employees of nursing homes or facilities for the elderly documented that residents should be screened for TB infection on admission by use of the two-step skin-testing method. Screening with chest radiographs alone is insufficient. https://www.cdc.gov/mmwr/preview/mmwrhtml/00038873.htm 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 TB infection but 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	**B.** Residents without two step TB skin test results have the potential to be affected by this practice. Facility census reviewed to identify residents with symptoms of tuberculosis; none identified. **C.** Immunization Records Resident policy was revised (SEE ATTACHMENT FOUR) to include two-step skin testing on all newly placed residents. All licensed nurses and preadmission personnel will be educated regarding the Immunization Record Resident policy revisions. The Wellness Nurse Orientation Checklist revised by E2 to include resident immunization requirements. **D.** E2 or designee will audit records monthly for newly placed residents to confirm appropriate tuberculin testing was conducted and residents are free from Tuberculosis. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	

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	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 6/1/2007 – Facility policy entitled Immunization Records Resident documented that if the tuberculin test was not documented on the history and physical on admission, the resident will be requested to have one done by the nurse in the facility. A tuberculin test done within the twelve months prior to admission or a chest x-ray showing no evidence of active tuberculosis shall satisfy this requirement for asymptomatic individuals. The facility policy did not follow CDC recommendations as it did not require a two-step TB skin test. Additionally chest x-ray results should only be used in the presence of a positive TB skin test. Review of R1, R2, R6 and R9's clinical records revealed the residents received a one-step TST prior to admission and test results were negative: 1. R1: admitted 7/12/16. 1. R2: admitted 10/20/16. 3. R6: admitted 11/2/16. 4. R9: admitted 4/9/14. 5. Review of R7's clinical record revealed: 3/14/16 – Admission to facility		

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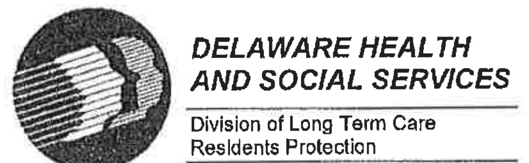

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	3/23/16 – one-step TST completed one week after admission (result negative). 6. Review of R8's clinical record revealed: 8/22/15 - Transfer from a nursing home. There was no evidence in the record of the results of the two-step skin test performed at the nursing home or that the facility tried to obtain them. January, 2016 – one-step TST performed five months after admission (result negative). During an interview with E1 (NHA) on 6/21/17 at 8:50 AM to discuss the CDC recommendation for 2-step TST for newly admitted residents, E1 confirmed the facility did not perform a 2-step skin test on residents. 6/23/17 – E3 (LPN) provided the surveyor with R8's negative 2-step results from the nursing home completed on June 16 and 25, 2015. These findings were reviewed with E1 and E2 (DON) on 6/26/17 at 1:10 PM.		
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically**	3225.9.7 A. R1, R3, and R6 have been offered the pneumococcal pneumonia vaccine and documentation included in the resident record. B. All residents have the potential to be affected by this practice. Audit conducted by Assistant Wellness Director and LPN to confirm residents were offered the pneumococcal pneumonia	September 1, 2017

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	contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record. Based on record review and interview it was determined that the facility failed to ensure evidence of a pneumonia vaccination (Pneumovax) or reason for refusal for three (R1, R3 and R6) out of 9 sampled residents. Findings include: 6/27/00 – Facility policy entitled Influenza / Pneumovax Vaccines (last revised August 2011) included the Pneumovax vaccine: - will be offered to residents who are over age 65, non-ambulatory or with a debilitating disease as per physician's order. - A physician's order is obtained for the Pneumovax vaccine for residents over 65 years of age: if not previously vaccinated; if the first dose received at age ≥ 65 and more than five years have passed since the dose, then revaccination is indicated. - Upon admission, residents will be screened for immunization status and documentation will be maintained in the resident record. Review of clinical records (including, but not limited to, history and physical, vaccine section of the UAI) revealed with no evidence of any type of pneumonia vaccine or refusal for the following: residents over age 65 years. 1. R1 admitted 7/12/16. 2. R3 admitted 4/5/17.	vaccine and documentation provided in resident records accordingly. **C.** Influenza/Pneumovax Vaccines policy revised (SEE ATTACHMENTFIVE) by the Chief Clinical Officer to include the need for documentation for resident's vaccination consent or refusal and the health risks associated if refused. All licensed nurses and preadmission personnel will be provided education now and newly hired staff during orientation regarding revised pneumococcal pneumonia vaccine protocols including necessary documentation. Wellness Nurse Orientation Checklist revised by E2 to include Influenza/Pneumovax Vaccine protocols. **D.** Monthly audits will be conducted by E2 or designee for newly placed residents and at the time of the annual vaccination event. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	

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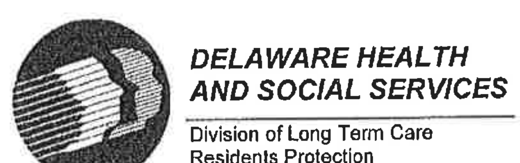

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	3. R6 admitted 11/2/16. During an interview with E1 (NHA) on 6/21/17 at 8:50 AM to review the timing of pneumonia vaccines and the immunization status of R1 and R3, E1 indicated she would have the pneumonia vaccination verified by nursing. During an interview with E4 (LPN) on 6/22/17 around 1:10 PM to determine the administration or offering of a pneumonia vaccination, E4 confirmed all three residents did not receive (or refuse) a pneumonia vaccination. These findings were reviewed with E1 and E2 (DON) on 6/26/17 at 1:10 PM.		
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**	3225.12.1.3 **A.** The commercial can opener was cleaned immediately and acknowledged by surveyor. The stainless steel steam table pans were removed from the ready to use rack, cleaned, and stored to air dry immediately and acknowledged by the surveyor. The two missing dinner meal temperatures were not able to be conducted. The trash cans hindering access to the eye wash station were moved immediately and acknowledged by the surveyor. The missing hand wash signage identified on	September 1, 2017
3225.12.1.3	**Food service complies with the Delaware Food Code; and** Based on observation and interview it was determined that the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of food-borne illness. Findings include: 6/23/17 (8:30 AM – 9:00 AM) – A brief kitchen tour revealed: 1. **4-602.13** Nonfood-**Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a**		

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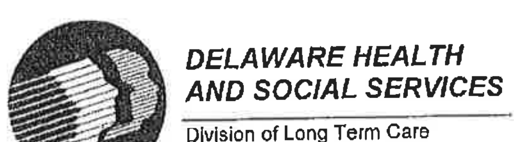

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	frequency necessary to preclude accumulation of soil residues. The commercial can opener had dried debris on the blade, increasing the change of contamination when opening canned foods. 2. **4-903.11Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.** (B)(1) **Clean EQUIPMENT and UTENSILS shall be stored as specified under ¶ (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and** - There were 8 wet stainless steel steam table pans stored in the ready to use rack. They were not stored under sanitary conditions. 3. **3.202.11Temperature.** **(D)TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked to a temperature and for a time specified under §§ 3-401.11 -3-401.13 and received hot shall be at a temperature of 57oC (135oF) or above. P** - Steam table food temperatures for two dinner meals were missing so determining if hot foods were at least 135 degrees was not possible. 4. **5-201.11Approved System and Cleanable Fixtures.** (A)**A PLUMBING SYSTEM shall be designed, constructed, and installed according to LAW.** -A sink with the eye wash station next to the 3-compartment sink was blocked by unused, stacked trash cans and a wheeled large round trash can in use, making the sink not accessible for handwashing.	6/26/17 was corrected immediately. **B.** All residents have the potential to be affected by this practice. **C.** Daily kitchen closing assignments will be revised to include cleaning of the can opener, proper storage for steam table pans after washing, uninhibited access to eye wash station and daily documentation of steam table temperature readings. E6 or Designee will provide education to ensure cleaning assignments are executed effectively, equipment is stored safely, hand washing directives are posted and followed, and steam table temperatures are documented now and with orientation for all newly hired employees. **D.** E6 or designee will audit closing assignments weekly to ensure accuracy and consistency. Data will be aggregated and analyzed by E6 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	

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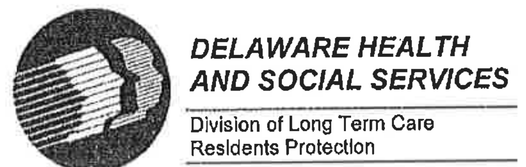

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(302) 577-6661

NAME OF FACILITY: Brandywine Senior Living at Fenwick

DATE SURVEY COMPLETED: June 26, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	E9 (Cook) immediately placed the can opener in the dishwasher and removed the stainless trays from service by placing them in the dirty dish area. E6 (Director of Dining Services) confirmed the missing temperatures and removed the objects from in front of the sink. 5. On 6/26/17 (10:07 AM and 11:30 AM) tours of the kitchen revealed: 6-301.14 – No signage at 3 out of 3 handwashing sinks notifying employees to wash their hands. During an interview with E6 on 6/26/17 at 11:30 AM, this finding was confirmed. These findings were reviewed with E1 (NHA) and E2 (DON) on 6/26/17 at 1:10 PM.		
3225.13.0 3225.13.6	**Service Agreements** **Banking, record keeping, and personal spending services;** Based on record review and interview it was determined that the facility failed to ensure a service agreement for one (R8) out of 9 sampled residents was reviewed with, and signed by, the POA. Findings include: 6/1/07 - Facility policy entitled Resident Service Plan (last revised August, 2009) documented that the resident and the Wellness Director or Executive Director will	3225.13.6 *(Note: The Statement of Deficiencies specified Section 3225.13.6 as 'banking, record keeping, and personal spending services;' however, the context provided is indicative of the service agreement regulation. This plan of correction was developed in accordance with the Section 3225.13.6 written in Title 16 as noted.)* **A.** The service agreement dated 2/1/17 was signed by the resident's responsible party on 6/20/17 and provided to the surveyor on 6/21/17. **B.** All residents have the potential to be affected by this practice. Audit conducted by	September 1, 2017

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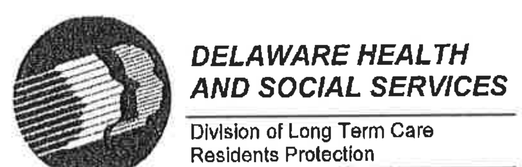

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	sign the agreement and the resident will receive a copy. Review of R8's clinical record revealed: 2/1/17 – Annual UAI and service agreement completed and contained the signature of E2 (DON) but was missing the signature of the POA (spouse who resided in the facility with R8). During an interview with E1 (NHA) on 6/20/17 around 4:00 PM the above finding was reviewed. On 6/21/17 around 9:00 AM, E1 showed the surveyor that R8's POA signed the 2/1/17 service agreement and said it was signed last night. This finding was reviewed with E1 (NHA) and E2 (DON) on 6/26/17 at 1:10 PM.	E2 to identify service agreements were acknowledged by signature within 10 days of UAI completion. Any findings were immediately corrected. **C.** E2 or designee will provide education to all licensed nurses regarding service agreement review and signature acknowledgement by resident within 10 days of UAI completion now and during orientation for all newly hired nurses. E2 revised the Wellness Nurse Orientation Checklist to include service agreement resident signature acknowledgement. **D.** Monthly audits for responsible party acknowledgement of the service agreement will be conducted by E2or designee. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	
3225.17.0	**Environment and Physical Plant**		
3225.17.8	**Hot water at resident bathing and hand-washing facilities shall not exceed 120 degrees Fahrenheit.** Based on observation it was determined that the facility failed to ensure handwashing and bathing water temperature on both dementia units (Reflections 1 and Reflections 2) was not over 120 F. Findings include: 6/19/17 (8:08 AM – 8:50 AM) - During the initial tour the water temperature in the common bathroom near the activity room on both memory care units felt hot to the touch.	3225.17.8 **A.** Boiler temperatures were immediately adjusted byE7 to reduce the temperature of the water at the sinks effectively. **B.** Residents using the common area sink near the activity rooms had the potential to be affected by the water temperature. Alternate areas for hand washing were encouraged pending the temperature adjustment. **C.** Water temperature logs were prepared (SEE	September 1, 2017

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	- Second floor (Reflections 2) water temperature at 9:07 AM was 130.1 F. - First floor (Reflections 1) water temperature at 9:57 AM was 133.3 F. During an interview with E5 (LPN) on 6/19/17 at 10:08 AM to determine if residents on the on the Reflections units use the common bathrooms, E5 said "some of them" do use it. During an interview with E1 (NHA) on 6/19/17 at 10:25 AM E1 was informed of the extreme water temperature. When asked if there was a difference in residents between the two units, E1 stated that the residents on Reflections 1 were more impaired. E1 acknowledged that as dementia progresses with increasing impairment, the person might not be able to move away from the hot water resulting in a burn. [The higher temperature was on the unit with the more impaired residents.] The surveyor stated that this must be immediately addressed for resident safety. On 6/19/17 around 1:05 PM E1 gave the surveyor a temperature log showing water temperatures taken between 12:34 PM – 12:56 PM by E7 (Environmental Director) throughout the building, with the highest of 119 F. On 6/19/17 the surveyor observed the temperatures in the common bathroom on each dementia unit to be under 120 F: - First floor (3:31 PM): 105.9 F	ATTACHMENT SIX)to include temperatures leaving the hot water tank, leaving the mixing valve, returning after the cycle and at 8 variably identified sites for use. E7 or designee will conduct water temperature audits twice weekly and findings will be immediately addressed. E7 or designee will provide education regarding water temperatures and urgent reporting for waters identified as 'hot to the touch' now and during orientation for all newly hired staff. **D.** E7 or Designee will audit temperature logs weekly. Data will be aggregated and analyzed by E7 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	

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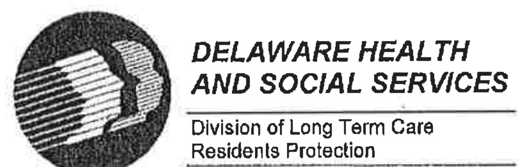

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care Residents Protection

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	- Second Floor (3:40 PM): 106.2 F During an interview with E7 on 6/20/17 at 12:15 PM E7 stated a new mixing valve was ordered and that the water temperature was adjusted by reducing the boiler temperature. E7 confirmed the kitchen was on a separate boiler, so hot water used for washing dishes would not be affected. These findings were reviewed with E1 (NHA) and E2 (DON) on 6/26/17 at 1:10 PM. **Records and Reports**		
3225.19.0 3225.19.1	**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.** Based on record review and interview it was determined that the facility failed to ensure assessments were dated for two (R2 and R6) out of 9 sampled residents. Findings include: Facility policy entitled Neurological Checks (last revised August, 2011) documented that residents with potential head trauma will have neuro checks (neurological assessment) completed and defined a potential head trauma as: 1) When a resident or witness reports that they have either hit, bumped or had an external object hit or bump their head. No evidence of visual trauma is observed. 2) When a resident is found on the floor or	3225.19.1 **A.** Neurological assessment logs for R2 and R6 were reviewed and resident conditions were within normal limits and unchanged by the omission of the date. **B.** Residents with need for neurological checks to be documented have the potential to be affected by this deficient practice. Audit conducted on incident reports to confirm that identified incidents incorporated neurological assessments as part of the treatment plan and documentation completed accordingly. **C.** E2 or designee will provide education to all licensed nurses regarding incidents or occasions which require neurological assessment as per policy (SEE ATTACHMENT SEVEN) and the documentation to be completed accordingly.	September 1, 2017

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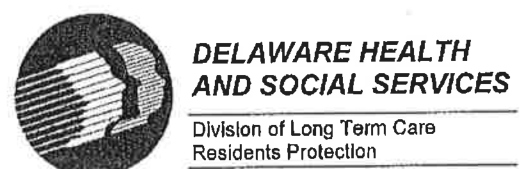

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	other position that suggest an injury may have occurred. Neither the resident nor a witness is able to confirm or deny that head trauma occurred. No actual injury is visible. 1. Review of R2's clinical record revealed: 10/26/16 – 6/19/17 Progress Notes – Resident with multiple unwitnessed falls when the facility completed neuro checks. Review of R2's neuro check assessments found 6 forms were undated. 2. Review of R6's record revealed 1 neuro check assessment was undated. Review of progress notes revealed the resident fell once on 3/1/17. These findings were reviewed with E1 (NHA) and E2 (DON) on 6/26/17 at 1:10 PM.	Wellness Nurse Orientation Checklist revised by E2 to include indicators for conducting a neurological assessment and documentation necessary to support those assessments. "Neuro Check Log" revised to promote completion of the date of the "neuro check." **D.** E2 or designee will conduct monthly audits for accurate and consistent completion of the "Neurological Check Log." Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters.	
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 immediately report two (SS3 and SS4) out of four investigative files reviewed. Findings include: 1. On 10/22/16 (10:30 PM) SS3 received a 2.5 cm by 2.14 cm skin tear while being transferred into bed by two CNAs. Injury	3225.19.6 **A.** SS3 incident was reported beyond the 8 hour notification to the Division on 10/24/17. SS3 no longer resides at this facility. **B.** All residents have the potential to be affected by this practice. Incident report audit conducted by Assistant Wellness Director to identify reportable incidents were reported within 8 hours of the occurrence to the Division. Incidents which require reporting will be confirmed for timely reporting; instances when reportable notification	September 1, 2017

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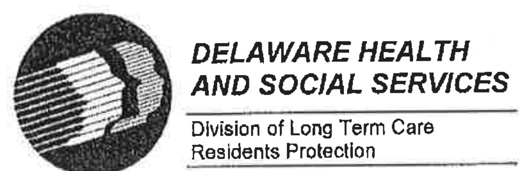

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	sustained by a resident dependent on staff for toileting, mobility, transfer and/or bathing is reportable to the State Agency. This injury was reported to the State Agency on 10/24/17 at 1:52 PM. 2. On 1/23/17 while preparing SS4 for a shower, E11 (LPN) found bruising to left chest wall and shoulder. E11 wrote that review of the record discovered a nursing note dated 1/19/17 (9:50 AM) describing when a care manager (aide) notified the nurse of bruising on SS4's left shoulder and left upper chest. This injury was not immediately reported to the State Agency. Investigation found the resident said the bruising was from falling out of bed (and returned to bed unassisted). On 1/24/17 when evaluated in the ER for an unrelated issue, a broken shoulder bone was discovered. The injury was reported to the State Agency on 1/26/17 at 11:32 AM. During an interview with E2 (DON) on 6/26/17 around 11:10 AM E2 stated that for SS3 the injury from Saturday night was not reported until s/he discovered the incident on Monday morning. E2 added that nursing is not consistent with remembering that injury to a dependent resident is reportable. E2 explained that an incident report was not completed when SS4's bruising was discovered on 1/19/17. These findings were reviewed with E1 (NHA) and E2 on 6/26/17 at 1:10 PM.	within 8 hours of the occurrence were delinquent will be reported immediately upon identification. C. E2 will provide education to all licensed nurses regarding timely notification of incidents within 8 hours of the occurrence to the Division. E1 will provide education to all managers regarding identification of incident reports that require a timely notification to the Division. E2 revised the Wellness Nurse Orientation Checklist to include timely notification of reportable incidents to the Division. D. Monthly audits of all incidents will be done by E2 or designee to identify timely notification of reportable incidents to the Division. Data will be aggregated and analyzed by E2 and reported quarterly to the Quality Improvement Committee with re-evaluation for two quarters. A. SS4 incident was reported beyond the 8 hour notification to the Division on 1/26/17. B. All residents have the potential to be affected by this practice. Incident report audit conducted by Assistant Wellness Director to identify reportable incidents were reported within 8 hours of the occurrence to the Division. Incidents which require reporting will be confirmed for timely reporting; instances when reportable notification	

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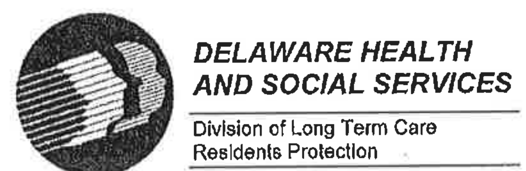

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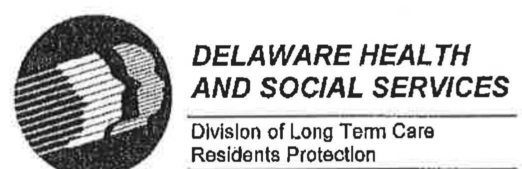

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