**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

**STATE SURVEY REPORT**



**NAME OF FACILITY: Ivy Gables Assisted Living** **DATE SURVEY COMPLETED: February 17, 2023**

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLE-TION DATE |
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| | **REVISED REPORT**<br>**Deficiency 3225.9.8.2.1 Requirements for Specific Requirements for COVID-19: Prior to their start date, all new staff, vendors and volunteers must be tested in accordance with the Delaware Division of Public Health guidance was removed due to the CDC and State testing guidelines 3/22/23 being updated.**<br><br>An unannounced Annual and Complaint Survey was conducted at this facility from February 15, 2023 through February 17, 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 thirty-two (32). The survey sample totaled five (5) residents.<br><br>Abbreviations/definitions used in this state report are as follows:<br><br>Alzheimer's - a gradually progressive brain disorder that causes problems with memory, thinking and behavior;<br><br>Atrial Fibrillation - a disease of the heart characterized by irregular and often faster heartbeat;<br><br>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;<br><br>DON - Director of Nursing;<br><br>ED - Executive Director;<br><br>Resident Assessment – evaluation of a resident's physical, medical, and psychosocial | **The following is the Plan of Correction for Ivy Gables LLC regarding the Statement of Deficiencies dated 3/06/2023 for Annual Survey ending 02/17/2023. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.** | |

Provider's Signature Steven Yohay LNHA Title Executive Director Date 3/22/2023

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| | status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse;<br><br>Service Agreement - allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services;<br><br>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 resident on both an initial and ongoing basis in accordance with these regulations. | | |
| 3225.7.0 | **Specialized Care for Memory Impairment** | | |
| 3225. 7.1 | **Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations herein.** | | |
| 3225.7.2 | **Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.** | | |
| 3225.7.3 | **The information disclosed shall explain the additional care that is provided in each of the following areas:** | | |
| 3225.7.3.1 | **Philosophy: a written statement of the agency's overall philosophy and mission** | | |

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| | which reflects the needs of residents affected by memory impairment; | | |
| 3225.7.3.2 | Resident Population: a description of the resident population to be served; the service agreement and its implementation; | | |
| 3225.7.3.3 | Pre-Admission, Admission & Discharge: the process and criteria for placement, transfer or discharge from this specialized care; | | |
| 3225.7.3.4 | Assessment, Care Planning & Implementation: the process used for assessment and establishing and updating the service agreement and its implementation, | | |
| 3225.7.3.5 | Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care; | | |
| 3225.7.3.6 | Physical Environment: the physical environment and design features, including security systems, appropriate to support the functioning of adults with memory impairment; | | |
| 3225.7.3.7 | Resident Activities: the frequency and types of resident activities; | | |
| 3225.7.3.8 | Family Role in Care: the family involvement and family support programs; | | |
| 3225.7.3.9 | Psychosocial Services: the process for addressing the mental health, behavior management, and social functioning needs of the resident; | | |
| 3225.7.3.10 | Nutrition/Hydration: the frequency and types of nutrition and hydration services provided; and | | |
| 3225.7.3.11 | Program Costs: the cost of care and any additional fees. | | |

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| | This requirement was not met as evidenced by:<br><br>Based on policy review, interview and review of other facility documentation, it was determined that the facility lacked a specific Memory Care policy and procedures pursuant to the Memory Impaired resident. Findings include:<br><br>2/17/23 at 9:30 AM - Ivy Gables Policy and Procedure manuals and Resident Agreement packets were reviewed. There was no evidence of specific Memory Care Information.<br><br>2/17/23 at 10:30 AM - Per interview with E1 (ED), E1 confirmed there was not specific Memory Program information. E1 stated the Assisted Living Resident Agreement packet was utilized for resident admissions in Memory Care.<br><br>2/17/23 - Findings were reviewed with E1, E3 (Director of Community Relations), E4 (Director of Activities) and E5 (Director of Dining Services) at the exit conference, beginning at approximately 11:00 AM. | **3225.7.0-3225.7.3.11**<br>1. Facility created and implemented into its Policy and Procedure manual, P&Ps to address topics pursuant to regulation 3225.7.0, providing specialized care for memory impairment (see attached).<br>2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined below in #3.<br>3. Facility leadership was provided education and review (in-service attached) of policy and procedures specific to the operations and provision of care to the Memory Impaired Resident.<br>4. The Executive Director will review all facility policy and procedures, as needed and minimally on an annual basis to ensure facility operations are 100% compliant with state regulations 3225-Assisted Living Facilities. | 3/14/2023 |
| 3225.10.0 | **Contracts** | | |
| 3225. 10.10 | **No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.**<br><br>This requirement was not met as evidenced by: | **3225.10.10**<br>1. For Resident R4, no corrective action can be taken on the service agreement being completed after the facility contract was signed.<br>2. All residents have the potential to be affected by the deficient practice. All residents will be protected by taking corrective action(s) outlined below in #3.<br>3. The Director of Nursing and Director of Community Relations (Admissions) was provided an in service related to regulation 3225.10.10 by the Executive Director (see attached). The Director of Nursing/Designee will review all resident medical records to ensure that the UAI is | 3/14/2023 |

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| | Based on record review and review of other facility documentation, it was determined that for one (R4) out of five residents sampled, the facility obtained a signed contract prior to the service agreement being executed. Findings include:<br><br>6/21/21 - R4 was admitted with a diagnosis of Atrial Fibrillation. The initial UAI was completed on 6/16/21. The service agreement was completed, but no date or signature was in evidence. The service agreement was entered into the EMR on 6/21/21. The contract was signed on 6/17/21, before the service agreement was executed.<br><br>2/17/23 - Findings were reviewed with E1 (ED), E3 (Director of Community Relations), E4 (Director of Activities) and E5 (Director of Dining Services) at the exit conference, beginning at approximately 11:00 AM. | completed in its entirety and service agreement executed prior to the Director of Community Relations/Designee initiating a contract.<br>4. The Executive Director will audit all potential resident assessments and service agreements on a continuous basis to ensure 100% compliance regarding completion prior to contract initiation. Based on audit findings, the Executive Director will be responsible for directing corrective actions which will include re-training and progressive discipline to ensure ongoing compliance. | |
| 3225. 11.0 | **Resident Assessment** | | |
| 3225. 11.3 | **Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review and review of other facility documentation, it was determined that for two (R1 and R2) out of five sampled residents, the facility failed to provide evidence that a Physician's medical evaluation was completed within 30 days prior to admission. Findings include:<br><br>1. 10/4/21 - R1 was admitted with a diagnosis of Alzheimer's. The Physician's evaluation indicated the exam was completed on 8/20/21 although the signature date was | **3225.11.3**<br>1. For Resident R1, no corrective action can be taken for the Physician's evaluation being completed on 8/20/2021 and signed on 9/21/2021 with resident admission on 10/4/2021. Resident R1 no longer resides in the community. For Resident, R2, no corrective action can be taken for the physician's evaluation not being dated. Resident R2 no longer resides in the community.<br>2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined below in #3.<br>3. The Director of Nursing and Director of Community Relations (Admissions) were provided an in service related to regulation 3225.11.3 by the Executive Director (see attached). The Director of Community Relations and the Director of Nursing will review all physician evaluations to ensure that any potential admission has a completed physician evaluation conducted | 3/14/2023 |

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| | 9/21/21. The physical exam was beyond the 30 days prior to admission on 10/4/21.<br><br>2. 12/29/21 – R2 was admitted with a diagnosis of dementia. The Physician's evaluation was not dated as to the exam date.<br><br>2/17/23 - Findings were reviewed with E1 (ED), E3 (Director of Community Relations), E4 (Director of Activities) and E5 (Director of Dining Services) at the exit conference, beginning at approximately 11:00 AM. | within the proper 30-day timeframe, prior to admission and that the evaluation is signed and dated in its entirety.<br>4. The Executive Director will audit all potential admission documentation to ensure that 100% of all physician evaluations are conducted within the appropriate time frame, (within 30 days prior to admission) and are signed and dated in its entirety. Based on audit findings, the Executive Director will be responsible for directing corrective actions which will include re-training and progressive discipline to ensure ongoing compliance. | |
| **3225. 11.4** | **The resident assessment shall be completed in conjunction with the resident.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review and review of other facility documentation, it was determined that for five (R1, R2, R3, R4 and R5) out of five sampled residents, the facility failed to provide evidence that UAI assessments were completed in conjunction with the resident. Findings include:<br><br>1. 10/4/21 - R1 was admitted with a diagnosis of Alzheimer's. The UAI was completed on 9/10/21 but it was not signed by either the resident or family member.<br><br>2. 12/29/21 – R2 was admitted with a diagnosis of dementia. The UAI was completed on 12/8/21 but it was not signed by either the resident or family member.<br><br>3. 2/9/23 - R3 was admitted with a diagnosis of high blood pressure. The UAI was completed on 1/18/23 but it was not signed by either the resident or family member. | **3225.11.4**<br>1. For Resident R1, no corrective action can be taken for the UAI completed on 9/10/21 that was not signed by either resident/resident representative. Resident R1 no longer resides in the community. For Resident R2, no corrective action can be taken for the UAI completed on 12/8/21 that was not signed by either resident/resident representative. Resident R2 no longer resides in the community. For Resident R5, no corrective action can be taken for the UAI completed on 5/14/21 that was not signed by either resident/resident representative. Resident R5 no longer resides in the community. Residents R3 and R4 have had their UAI's reviewed and signed by their representatives on 3/11/2023 and 2/27/2023 respectively (see attached).<br>2.) All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined below in #3.<br>3.) The Executive Director and the Director of Nursing conducted an in service to review regulation 3225.11.4 (see attached). The Director of Nursing will review all resident medical records to ensure that all UAIs have been signed and dated by either the resident or resident representative as well as the registered nurse who administered the UAI.<br>4. The Director of Nursing/Designee will be responsible for completing audits of all new admissions as well as conducting quarterly audits | 3/14/2023 |

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| | 4. 6/21/21 - R4 was admitted to Independent Living with a diagnosis of atrial fibrillation. The initial UAI was completed on 6/16/21 but it was not signed by either the resident or family member.<br><br>On 1/20/23 the resident was transferred to Assisted Living with an added diagnosis of dementia. A significant change in condition UAI was completed on 1/20/23, but it was not signed by either the resident or the family member.<br><br>5. 6/14/21 - R5 was admitted with a diagnosis of Alzheimer's depression. The UAI was completed on 5/14/21, but it was not signed by either the resident or family member.<br><br>6/16/21 but it was not signed by either the resident or family member.<br>On 1/20/23 the resident was transferred to Assisted Living with an added diagnosis of dementia. A significant change in condition UAI was completed on 1/20/23, but it was not signed by either the resident or the family member.<br><br>5. 6/14/21 - R5 was admitted with a diagnosis of Alzheimer's depression. The UAI was completed on 5/14/21, but it was not signed by either the resident or family member.<br><br>2/17/23 - Findings were reviewed with E1 (ED), E3 (Director of Community Relations), E4 (Director of Activities) and E5 (Director of Dining Services) at the exit conference, beginning at approximately 11:00 AM. | to verify 100% ongoing compliance. Results of these audits will be provided to the Executive Director for review. Based on audit findings, the Executive Director will be responsible for directing additional corrective actions which will include re-training and progressive discipline of staff that did not properly administer and complete the UAI to ensure ongoing compliance. | |
| **3225. 13.0** | **Service Agreements** | | |
| **3225. 13.1** | **A service agreement based on the needs identified in the UAI shall be completed** | **3225.13.1**<br>1. For Resident R1, no corrective action can be taken for the service agreement completed on | 3/14/2023 |

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| | **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 agreement must be able to comprehend and perform their obligations under the agreement.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review and review of other facility documentation, it was determined that for five (R1, R2, R3, R4 and R5) out of five sampled residents, the facility failed to provide evidence that the service agreement was signed by the resident or a family member. Findings include:<br>1. 10/4/21 - R1 was admitted with a diagnosis of Alzheimer's. The Service Agreement was completed on 9/10/21, but it was not signed by either the resident or family member.<br><br>2. 12/29/21 – R2 was admitted with a diagnosis of dementia. The Service Agreement was completed on 12/8/21, but it was not signed by either the resident or family member.<br><br>3. 2/9/23 - R3 was admitted with a diagnosis of high blood pressure. The Service Agreement was completed on 1/18/23, but it was not signed by either the resident or family member.<br><br>4. 6/21/21 - R4 was admitted with a diagnosis of atrial fibrillation. The Service Agreement lacked a date or signature of completion and it was not signed by either the resident or family member. | 9/10/21 that was not signed by resident/resident representative. Resident R1 no longer resides in the community. For Resident R2, no corrective action can be taken for the service agreement completed on 12/8/21. Resident R2 no longer resides in the community. For Resident R5, no corrective action can be taken for the service agreement completed on 5/14/21 that was not signed by resident/resident representative. Resident R5 no longer resides in the community. Residents R3 and R4 have had their service agreements reviewed and signed by their representatives on 3/11/2023 and 2/27/2023 respectively (see attached).<br>2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined below in #3.<br>3. The Executive Director and the Director of Nursing conducted an in service to review regulation 3225.13.1 (see attached). The Director of Nursing will review all resident medical records to ensure that all service agreements have been reviewed, signed, and dated by either the resident or resident representative.<br>4. The Director of Nursing/Designee will be responsible for completing audits of all new admissions as well as conducting quarterly audits to verify 100% ongoing compliance. Results of these audits will be provided to the Executive Director for review. Based on audit findings, the Executive Director will be responsible for directing additional corrective actions which will include re-training and progressive discipline of staff to ensure ongoing compliance. | |

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| | 5. 6/14/21 - R5 was admitted with a diagnosis of Alzheimer's depression. The Service Agreement was completed on 5/14/21, but it was not signed by either the resident or family member.<br><br>2/17/23 - Findings were reviewed with E1 (ED), E3 (Director of Community Relations), E4 (Director of Activities) and E5 (Director of Dining Services) at the exit conference, beginning at approximately 11:00 AM. | | |
| 3225. 13.6 | **The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.**<br>This requirement was not met as evidenced by:<br><br>Based on record review and review of other facility documentation, it was determined that for one (R4) out of five sampled residents, the facility failed to provide evidence that the service agreement was completed with a significant change in condition UAI. Findings include:<br><br>1/20/23 - R4 was transitioned into AL with an added diagnosis of dementia. A significant change in condition UAI was completed on 1/20/23. A Service Agreement was not in evidence with this UAI completion.<br><br>2/17/23 - Findings were reviewed with E1 (ED), E3 (Director of Community Relations), E4 (Director of Activities) and E5 (Director of Dining Services) at the exit conference, beginning at approximately 11:00 AM. | **3225.13.6**<br>1. For Resident R4, a service agreement has been executed, dated, and signed by the Director of Nursing and resident responsible party on 2/27/2023 (see attached).<br>2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined below in #3.<br>3. The Executive Director and the Director of Nursing conducted an in service to review regulation 3225.13.6 (see attached). The Director of Nursing will review all resident medical records to ensure that all service agreements have been reviewed, signed, and dated by either the resident or resident representative when the needs of the resident have changed and, minimally, in conjunction with each UAI if indicated, within the 10-day timeframe.<br>4. The Director of Nursing/Designee will be responsible for completing an audit of resident medical records as well as conducting quarterly audits to verify 100% ongoing compliance. Results of these audits will be provided to the Executive Director for review. Based on audit findings, the Executive Director will be responsible for directing additional corrective actions which will include re-training and progressive discipline of staff to ensure compliance. | 3/14/2023 |

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| 3225. 19.0<br><br>3225.19.6<br><br><br><br><br>3225. 19.7<br><br>3225. 19.7.7<br><br>3225. 19.7.7.2 | **Records and Reports**<br><br>**Records and Reports 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.**<br><br>**Reportable incidents include:**<br><br>**Significant injuries.**<br><br>**Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review, interview and review of other facility documentation, it was determined that for two (R1 and R2) out of five sampled residents, the facility failed to report falls leading to an emergency room evaluation. Findings include:<br><br>1. 10/4/21 - R1 was admitted with a diagnosis of Alzheimer's. The Emergency Room discharge record on 12/9/21 indicated that an evaluation was completed after the resident fell in the Assisted Living facility which resulted in right hip bruising. The facility failed to report the incident to the State.<br><br>2. 12/29/21 – R2 was admitted with a diagnosis of dementia. On 3/4/22, the resident fell to floor resulting in transport to the Emergency Room for evaluation.<br><br>Per the medical record on 4/24/22 at 10:15 PM, the resident "slipped out of bed and hit | **3225.19.7.7.2**<br>1. For Resident R1, no corrective action can be taken for facility failure to report an incident to the State regarding resident fall on 12/9/21, which resulted in a transfer to an acute care facility for treatment/evaluation. Resident R1 no longer resides in the community. For Resident R2, no corrective action can be taken for facility failure to report an incident to the State regarding resident fall on 3/4/21, which resulted in a transfer to an acute care facility for treatment/evaluation. Resident R2 no longer resides in the community.<br>2. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined below in #3.<br>3. The Executive Director and the Director of Nursing conducted an in service to review regulation 3225.19.7.7.2 (see attached). The Director of Nursing will review all resident incident reports and report all incidents under the jurisdiction of regulation 3225.19.7.7 to the Division.<br>4. The Executive Director will audit all facility incident reports on a continuous basis to ensure 100% compliance with reportable incidents. Based on audit findings, the Executive Director will be responsible for directing corrective actions which will include re-training and progressive discipline to ensure compliance. | 3/14/2023 |

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| | her head." The facility sent the resident to the Emergency Room for evaluation. The facility failed to report these incidents to the State.<br><br>2/16/23 at 10:40 AM – Per an interview with E1 (ED), E1 confirmed they did not report these falls resulting in Emergency Room evaluations to the State.<br><br>2/17/23 - Findings were reviewed with E1, E3 (Director of Community Relations), E4 (Director of Activities) and E5 (Director of Dining Services) at the exit conference, beginning at approximately 11:00 AM. | | |

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