DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from November 28, 2022 through December 12, 2022. The deficiencies contained in this report are based on interviews, record reviews and review of other documentation as indicated. The facility census on the first day of the survey was eighty-eight (88); thirty-one (31) of which were in the "COVE" memory care unit and fifty-seven (57) in the AL. The survey sample totaled seventeen (17) residents. Abbreviations/definitions used in this State Report are as follows: Activities of daily living (ADLs) – tasks needed for daily living (dressing, hygiene, eating, toileting, bathing); Alzheimer's - a progressive brain disorder with memory loss, poor judgement, personality changes and disorientation; AL – Assisted Living; Antipsychotic – medication used to treat psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; AWSAM (Assistance with Self-Administration of Medication) – assistance with medication provided by facility personnel who are not nurses or		

Provider's Signature [signature] Title Executive Director Date 5/19/23

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	nurse practitioners but who have successfully completed a Board of Nursing-approved medication training program in accordance with the Delaware Nurse Practice Act, 24 Del.C. Ch. 19, and applicable rules and regulations. Assistance with medication includes holding the container, opening the container, and assisting the resident in taking the medication, other than by injection, following the directions of the original container, and documenting in the medication log that each medication has been taken by the residents; Coccyx - a small, triangular bone resembling a shortened tail located at the bottom of the spine; COVE - facility name for the memory care unit; Delusions – a false belief; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; DHIN (Delaware Health Information Network) – statewide health information exchange accessible by Medical Practitioners; DRC - Director of Resident Care; DoS – Director of Sales; ED - Executive Director; Elopement - a form of unsupervised wandering that leads to the resident leaving the facility;		

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	ER – emergency room; Eschar - dead tissue that is tan, brown or black and tissue damage that is more severe than slough in the wound bed; Gluteal fold - a prominent fold that marks the upper limit of the thigh from the lower limit of the buttock; Hallucinations – an experience in which you see, hear, feel, or smell something that does not exist; LPN - Licensed Practical Nurse; Managed/Negotiated Risk Agreement – a signed document between the resident and the facility, and any other involved party, which describes mutually agreeable action balancing resident choice and independence with the health and safety of the resident or others; MAR - Medication Administration Record – a written document in which licensed personnel and unlicensed personnel who have completed AWSAM training record administration/assistance with the resident's medications. The log shall list the resident's name; date of birth; allergies; reason the medication is given; special instructions; and the dosage, route(s), and time(s), for all medications received/taken with staff administration or assistance. The log is signed/initialed by a staff member after each resident has received/taken the appropriate medication, or when the		

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	medication was not taken/given as prescribed; Medication Management by an Adult Family Member/Support Person – Any help with prescription or non-prescription medication provided by an adult family member/support person, as identified in the resident's contract and service agreement; NP - Nurse Practitioner; Paranoia – intense, irrational, persistent instinct or thought process of fearful feelings and thoughts; POA (Power of Attorney) – authority to act on behalf of another person; Psychiatry – medical specialty that diagnoses and treats mental illness; RN - Registered Nurse; Reportable Incident – an occurrence or event which must be reported immediately to the Division and for which there is reasonable cause to believe that a resident has been abused, neglected, mistreated, or subjected to financial exploitation as per the regulations as those terms are defined in 16 **Del.C.** §1131. Reportable incident also includes an occurrence or event listed in Sections 19.6 and 19.7 of these regulations. (Also see Incident, 19.5); Resident Assistant – any unlicensed direct caregiver who, under the supervision of the Assisted Living Director or Director of Health Services, assists the resident with personal needs		

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	and monitors the activities of the resident while on the premises to ensure his/her health, safety, and well-being; Sacrum – large triangular bone at base of spine; Senile – loss of cognitive abilities; Service Agreement – a written document developed with each resident that describes what services will be provided, who will provide the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome; Significant Change – a major deterioration or improvement in a resident's health status or ability to perform activities of daily living (toileting, bathing, eating); a major alteration in behavior or mood resulting in ongoing problematic behavior or the elimination of that behavior on a sustained basis. Significant change does not include ordinary, day to day fluctuations in health status, functioning, and behavior, or a short-term illness such as a cold, unless these fluctuations continue to recur, nor does it include deterioration that will normally resolve with further intervention; Slough - dead skin tissue that may have a yellow or white appearance in the wound bed; Social Services – services provided to assist residents in maintaining or		

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	improving their ability to manage their everyday physical, mental, and psychosocial needs; Stages of a pressure ulcer (PU) - categorization system used to describe the severity of the ulcer; Stage III ulcers - sores that have broken completely through the top two layers of the skin and into the fatty tissue below; Stage IV ulcers - full thickness skin loss with extensive destruction, tissue death, or damage to muscle, bone, or supporting structures; Subdural Hematoma – collection of blood between the brain and its outermost covering; Third Party Provider – a party, including a family member, other than the assisted living facility that furnishes services/supplies to a resident; Ulcer- an open sore on an internal or external surface of the body; Unstageable pressure ulcer - tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar; 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 by a		

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	Registered Nurse. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and an ongoing basis in accordance with these regulations; Urine Analysis - urine test to determine the presence of an infection; UTI (urinary tract infection) – bacteria in the urine; Vendor – any individual who is not employed by the facility, but provides direct services to one or more facility residents.		
3225 3225.0 3225.5.3	**Assisted Living Facilities** **General Requirements** **The assisted living facility shall adopt internal written policies and procedures pursuant to these regulations. No policies shall be adopted by the assisted living facility which are in conflict with these regulations.** This requirement was not met as evidenced by: Based on review of the facility's policies and procedures provided to the Surveyors, it was determined that the Falls Standard and Missing Resident Standard policies failed to include the specific requirements pursuant to the State of Delaware's 3225 Assisted Living regulations. Findings include: 1. The facility's Standard 4.10: Falls Standard, last reviewed on 10/2/17,	1. No individual was cited related to this practice. Residents were not affected by this practice. 2. All residents have the potential to be affected by this practice. The policy and procedures for missing residents was reviewed with HRA regional resident care director with DRC and NHA. It was clarified these events are reportable. 3. It was determined that the HRA policy for a resident missing was in conflict was Delaware code. The director of resident care or designee will in-service all professional nursing staff of the requirements for reporting missing residents per state regulations. In addition each resident that requires to be sent out for assessment related to falls will be reported to DHSS within the eight required time frame. The DRC or designee will monitor the effected resident for 48hours and	5/16/2023

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	lacked evidence of specific State of Delaware requirements as outlined under 3225 Assisted Living regulations, including: - the reporting timeframe within 8 hours of the occurrence and the specific fall incidents that are reportable to the State Agency; - the required documentation for all fall incidents to be retained in facility files (including non-reportables); and - the falls that require periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours. 2. Cross refer Neglect § 1131, example 1 The facility's Standard R1.07: Missing Resident, last revised on 10/2/17, lacked evidence of the specific State of Delaware requirements as outlined under 3225 Assisted Living regulations, including, the required documentation, reporting timeframe and specific incidents reportable to the State Agency as listed below: Resident elopement. Any circumstance in which a resident's whereabouts are unknown to staff and the resident suffers harm. Any circumstance in which a cognitively impaired resident, whose whereabouts are unknown to staff, exits the facility.	document accordingly. Policy and procedures have been reviewed for elopements. The policy and procedures for missing residents have been revised to coincide with Delaware regulations in that if resident leaves the community and the community is unaware of the resident's location the resident is considered an elopement and must be reported to DHCO within 8hours. Fall policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Director of resident care or designee will review all incident reports related to elopement ensuring elopement procedures are followed related to reportable compliance per Delaware regulations. All incident reports will audit for compliance weekly times 3 weeks then monthly till 100% precent compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	Any circumstance in which a resident cannot be found inside or outside a facility and the police are summoned. The facility's Missing Resident Standard stated, "... Missing resident definitions: -An Assisted Living resident has the right to come and go at will, but when there is cause for concern regarding the whereabouts of a resident, he or she is considered to be **unaccounted for.** This is not an elopement... -When there is cause for concern regarding the whereabouts of a Memory Care Resident residing in a secure Memory Care Community and it is determined he or she has gotten outside of the secured environment unaccompanied by an associate or responsible party, it is an **elopement**...". Despite the facility's definitions above, the State of Delaware's Assisted Living elopement regulations do not separate Assisted Living and Memory Care residents by elopement versus unaccounted for. 12/12/22 at 4:15 PM – Findings were reviewed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN).		
3225.5.9 3225.5.9.5	**An assisted living facility shall not admit, provide services to, or permit the provision of services to individuals who, as established by the resident assessment:** **Have developed stage three or four skin ulcers.**	1. No resident was affected by the lack of a waiver. R10 and R11 were treated accordingly. R11 was healed at the time of the survey and R 10 has healed as of 1/24/23. Waivers were obtained as needed. 2. Residents with a wound have the potential to be affected by this practice. A waiver was obtained for one	5/16/23

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	This requirement was not met as evidenced by: Based on observations, interviews, and review of clinical records and other facility documentation as indicated, it was determined that for two (R10 and R11) out of two residents sampled for wound management, both residents were treated for unstageable pressure ulcers (PUs). Findings include: Cross refer 6.1 1. 6/28/19 - R10 was admitted to AL with a diagnosis of hypertension. On 10/17/22, R10 was transferred into the COVE (memory care unit). The Surveyor was unable to identify through facility documentation the reason for the move to memory care or when R10's PU was identified. Per interview on 11/29/22 at 1:33 PM, E2 (DRC) confirmed a wound care order was not found in R10's chart. On 11/30/22 at 2:00 PM, E2 provided the Surveyor with a doctor's order for wound care signed on 11/21/22 by V3 (NP) via verbal order written by E7 (LPN). The NP's assessment, dated 11/30/22, noted, "new patient to practice", the deep tissue injury (PU) needed wound care management and there was currently an outside agency providing this. The NP noted the wound (PU) was located on the gluteal fold and was unstageable. A consult was made to an outside nursing agency, but the order was not in the resident's record or provided by the facility. Per the notes from the evaluation dated 11/28/22 by the outside agency, the coccyx wound (PU) was	other resident with a wound as of 12/30/22 3. The DRC, nurses, and other managers have been in-serviced by the NHA on the need to apply for and obtain a waiver for the facility to serve a current resident who temporarily requires care otherwise excluded in section 5.9. Wounds and other excluded services will be discussed at the weekly "At Risk"(or Interdisciplinary team) meeting and the need for waivers will be discussed and requested as needed weekly x 4 weeks and monthly x 2. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit the weekly At Risk meeting minutes for identified wound notes weekly times 3 then monthly till 100% precent compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	assessed and was deemed to be full thickness and unstageable due to slough. 11/29/22 at 10:40 AM - The Surveyor observed wound care being provided by E7 (LPN). The PU was noted to be located to the left of the sacrum, measured 1.5 cms by 5 cms and depth was not determined due to slough. Wound care was provided per the Doctor order. Per interview with E7 on 11/29/22 at 10:40 AM, the outside agency provided wound care two times a week and the facility staff provided wound care on the remaining days of the week. Per interview with E2 (DRC) on 11/30/22 at 11 AM, the order was obtained on 11/21/22, but she was unable to provide the wound origination date. E2 stated that no waiver was requested as she was unaware of the regulation and in how to request a waiver per the State regulations. 2. 9/24/21 - R11 was admitted to the COVE (memory care unit) with a diagnosis of Alzheimer's. Per record documentation on 8/29/22, a reddened sacral area was identified and an order for care was obtained. On 9/22/22, the record notes the area was now a 2 cm x 1 cm gluteal wound (PU) and V3 (NP) was notified. New wound care orders were obtained for daily wound care and were started on 9/29/22. An outside vendor was consulted, but no order for this was in the resident's record.		

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	10/18/22 - The nursing agency's evaluation of R11's wound was a full thickness mid-rectal location and unstageable due to 76-100% slough. Per interview with E7 (LPN) on 11/29/22 at 11:10 AM, the outside agency provided wound care two times a week and the facility provided wound care on the remaining days of the week. 11/29/22 at 11:10 AM – The Surveyor observed wound care being provided by E7 (LPN). The wound was noted to be located at the sacrum and appeared to be healed. During wound care, E7 stated she would contact V3 (NP) and obtain revised care orders since the wound was now healed. E7 stated the outside agency discontinued their care on 11/27/22 due to the wound being healed which the Surveyor confirmed by the outside agency documentation. During an interview on 11/30/22 at 11 AM, E2 (DRC) stated no waiver was requested as she was unaware of the regulation and how to request a waiver. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).		
3225.6.0	**Resident Waivers**		
3225.6.1	**An assisted living facility may request a resident-specific waiver so that it may serve a current resident who temporarily requires care otherwise excluded in section 5.9. A waiver request shall con-**	1. No resident was affected by the lack of a waiver. R10 and R11 were treated accordingly. R11 was healed at the time of the survey and R 10 has healed as of 1/24/23. 2. Residents with wounds have the potential to be affected by this	5/16/23

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	tain documentation by a physician stating that the resident's condition is expected to improve within 90 days. This requirement was not met as evidenced by: Based on interview and review of clinical records, it was determined that for two (R10 and R11) out of two sampled residents reviewed for wound management, the facility failed to request resident-specific waivers when R10 and R11 were identified with unstageable pressure ulcers of the coccyx and the gluteal fold. Findings include: Cross refer 5.9 1. 11/30/22 – For R10, V3 (NP) noted the PU was located on the gluteal fold and was unstageable due to 76-100% slough. 2. 10/18/22 – For R11, the nursing agency's evaluation of the PU for R11 was a full thickness mid-rectal location and unstageable due to 76-100% slough. During an interview on 11/29/22 at 2 PM, E2 (DRC) stated that she was unaware of the regulation and how to request a waiver. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	practice. Another resident lacked a waiver however was granted for wound care, by the State as of 12/30/22 3. The NHA in-serviced the DRC, nurses, and other managers on the need to apply for and obtain a waiver for the facility to serve a current resident who temporarily requires care otherwise excluded in section 5.9. Wounds and other excluded services will be discussed at the weekly "At Risk"(or Interdisciplinary team) meeting and the need for waivers will be discussed and requested as needed weekly x 4 weeks and monthly x 2. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will review weekly at-Risk minutes for wounds and other excluded services weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	
3225.8.0	**Medication Management**		

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3225.8.1 3225.8.1.4	**An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:** **Administration of medication, self-administration of medication, assistance with self-administration of medication, and medication management by an adult family member/support person.** This requirement was not met as evidenced by: Based on interview and review of the facility's policies and procedures provided, it was determined that the facility failed to establish a written medication policy and procedure that addressed medication management by an adult family member/support person. Findings include: Cross refer 8.8, example 2 Review of the various policies and procedures received by the Surveyor during and following the survey, the facility lacked evidence of a policy and procedure that addressed medication management by an adult family member/support person. 12/12/22 at 4:15 PM – Finding was discussed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN), with specific reference to R15's (husband) medication administration to his wife, R2.	1. Nothing can be done to correct the documentation. 2. All residents have the potential to be affected by this practice. 3. The DRC /designee will in-serviceNurses and Med Tech have been in serviced on proper documentation of medications administered, missed, held, or PRN medications. An audit will be conducted daily by DRC or designee for improper medication documentation and corrected within 24 hours x 4 weeks then monthly x 2. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit 20% of medication documentation will audit for compliance weekly times 3 weeks then monthly till 100% precent compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes. 1. The RN conducted an audit to determine who was responsible for their own medication management, their ability to manage their own medications, the storage of their medications, and if they had a physician order to self admin., including insulin. Residents R6, and R8 no longer reside in the community, so no immediate action could be taken. R12, was re-assisted for self-medication management. Service plans were updated and signed by appropriate par-	5/16/23 5/16/23

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3225.8.1.5 **3225.8.1.5.3**	**Provision for a quarterly pharmacy review conducted by a pharmacist which shall include:** **Review of each resident's medication regimen with written reports noting any identified irregularities or areas of concern.** This requirement was not met as evidenced by: Based on record reviews and interview, it was determined that for two (R2 and R15) out of nine residents sampled for pharmacy review, each resident only had one quarterly pharmacy review conducted for their medication regimens from 6/2/22 through 11/3/22. Findings include: 1. R2's clinical record revealed: 6/2/22 – R2 was admitted to the facility. 10/5/22 – R2's medication regimen review was conducted by the pharmacist. 12/5/22 at 10:40 AM – During an interview, E2 (DRC) provided the Surveyor with only one quarterly pharmacy review despite the resident being admitted to the facility on 6/2/22. There was no evidence that a July 2022 pharmacy review was conducted for R2. 2. R15's clinical record revealed: 6/2/22 – R15 was admitted to the facility.	ties. R13, were reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. R14 was reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. R15 was reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. and R17 was reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents signed their service plan. were reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. The Harbor Chase Medication Management Assessment was completed on everyone, and physician orders were obtained if needed. 2. No other residents manage their own medications. Residents or responsible party who desires to manage their own medications will be assessed by the RN within 30days of admission for the ability to do so and added to the medication management tickler file to be re-assessed quarterly for continued ability to manage their own medication. 3. RNs and LPNs have been in-serviced by the DRC/designee on the need for assessment to ensure that a resident can manage their own medications per regulation/policy. A tickler file has been set up in Outlook to notify DRC, ED, and	

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	10/5/22 – R15's medication regimen review was conducted by the pharmacist. 12/5/22 at 10:40 AM – During an interview, E2 (DRC) provided the Surveyor with only one quarterly pharmacy review despite the resident being admitted to the facility on 6/2/22. There was no evidence that a July 2022 pharmacy review was conducted for R15. 12/12/22 at 4:15 PM – Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	nursing staff of quarterly assessments due for medication management. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Executive Director or designee will audit current residents, that manage their medications, to ensure the regulatory required quarterly assessment is completed in a timely manner weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	
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 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.** This requirement was not met as evidenced by: Based on interviews and review of clinical records and other facility documentation as indicated, it was determined that for seven (R6, R8, R12, R13, R14, R15 and R17) out of seven sampled residents who self-administer medications, the facility failed to arrange and complete on-site medication reviews by an RN within the required timeframes pursuant to the regulation. Findings include	1. Community was unable to locate R2 and R15 missing July pharmacy recommendations. 2. All residents have the potential to be affected by this practice. All pharmacy recommendations were produced from the October 2022 pharmacy review. 3. The DRC in-serviced the Nurses and pharmacist on the requirement for quarterly pharmacy review. The pharmacist shall receive a current census upon arrival to conduct the pharmacy review. The DRC will review the quarterly report and will ensure all residents on census during the pharmacy review receives outcome review sheet. Any discrepancy will be reported to the pharmacist so he can conduct a review on any resident who was not seen on the review date. Policy	5/16/23

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	1. 7/24/19 - R6 was admitted to AL. An evaluation for the resident's cognitive and ability to self-administer medications was completed at move in on 7/24/19. No further evaluations were completed. 2. 12/27/19 - R8 was admitted to AL. Review of the record revealed an evaluation for the resident's cognitive and ability to self-administer medications was never completed. 3. 12/19/19 - R12 was admitted to AL. Review of the record revealed an evaluation for the resident's cognitive and ability to self-administer medications was completed at move in on 12/19/19. No further evaluations were completed. 4. 12/30/18 - R13 (husband) was admitted to AL. Review of the record revealed evaluations for the resident's cognitive and ability to self-administer medications were completed on 12/30/18, 4/1/19, 8/1/19, 11/1/19, and 3/16/20. No evaluation for the resident's cognitive and ability to self-administer medications was completed after 3/16/20. 5. 12/30/18 - R14 (wife) was admitted to AL. Review of the record revealed evaluations for the resident's cognitive and ability to self-administer medications were completed on 12/30/18, 4/1/19, 8/1/19, 11/1/19, and 3/16/20. No evaluation for the resident's cognitive and ability to self-administer medications was completed after 3/16/20. 6. 6/2/22 - R15 was admitted to the AL. The clinical record lacked evidence of an	and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The results of the quarterly audits will be discussed at the quarterly QAPI meeting for compliance times 2 quarters or till 100% compliance is achieved. The QAPI committee will determine frequency of the audits adjusted according to outcomes. 1.The RN conducted an audit to determine who was responsible for their own medication management, their ability to manage their own medications, the storage of their medications, and if they had a physician order to self admin., including insulin. Residents R6, and R8 no longer reside in the community, so no immediate action could be taken. R12, was re-assisted for self-medication management. Service plans were updated and signed by appropriate parties. R13, were reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. R14 was reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. R15 was reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. and R17 was reassessed immediately. The DRC updated the resident's service plans to reflect their ability to	5/16/23

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	RN evaluation of R15's cognitive and physical ability to self-administer his medications on admission and 30 days after admission. 7. 9/7/21 - R17 was admitted to AL. Review of the record revealed evaluations for the resident's cognitive and ability to self-administer medications was never completed. There is no Physician order for self-administration and R17 injects her own medication after the dose is drawn up by staff. It was confirmed by E7 (LPN) on 12/6/22 at 10:05 AM that no order for resident's self-injection or assessment of ability was in evidence. During interviews with E2 (DRC) on 12/5/22 at 11:00 AM and again on 12/12/22 at 1:30 PM, E2 confirmed that the above RN assessments have not been done. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	self-administer medication. Residents signed their service plan. were reassessed immediately. The DRC updated the resident's service plans to reflect their ability to self-administer medication. Residents sign their service plan. The Harbor Chase Medication Management Assessment was completed on everyone, and physician orders were obtained if needed. 2. No other residents manage their own medications. Residents on admission who desire to manage their own medications will be assessed by the RN within 30days of admission for the ability to do so and added to the medication management tickler file to be re-assessed quarterly for continued ability to manage their own medication. 3. RNs have been in-serviced on the need for assessment to ensure that a resident can manage their own medications per regulation/policy. A tickler file has been set up in Outlook to notify DRC, ED, and nursing staff of quarterly assessments due for medication management. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Executive Director or designee will audit current residents, that manage their medications, to ensure the regulatory required quarterly assessment is completed in a timely manner weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations.	
3225.8.8	**Concurrently with all UAI-based assessments, the assisted living facility shall arrange for an on-site medication review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication, to ensure that:**		
3225.8.8.2	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;** This requirement was not met as evidenced by:		

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	Based on record reviews and interviews, it was determined that for eight (R1, R2, R3, R4, R8, R10, R16 and R17) out of eight sampled residents who required assistance with medication administration, the facility failed to arrange for on-site medication reviews by an RN with all UAI-based assessments to ensure each resident received the medications prescribed as ordered. Findings include: 1. 2/21/22 – R1's clinical record lacked evidence of on-site RN evaluations of the staff medication administration 30-days after admission with her required UAI-based assessment and after the significant change UAI-based assessment dated 11/19/22. 2. 6/2/22 – R2's clinical record revealed that an on-site RN evaluation for a resident who required assistance with self-administration of medications to be done concurrently with her UAI-based assessment 30-days after admission was never arranged and completed. R2's husband (R15) was administering her medications from admission on 6/2/22 until 11/3/22. 3. 10/1/22 - 10/31/22 - R3 was to receive the following medications: -On 10/1/22 Hydralazine (for high blood pressure) at 4:00 PM and 8:00 PM, Melatonin (for sleep) at 8:00 PM, Acetaminophen (for pain) at 8:00 PM, Quetiapine Fumarate (for mood disorder) at 8:00 PM and Divalproex (for seizures) at 8:00 PM.	The frequency of the audits adjusted according to outcomes. 1. R1, R2, R3, R4, R10, R16, and R17 had medications reviewed onsite by RN with each UAI assessment including admissions, significant changes, and annual reviews. It is included under Page 9 of the UAI and are either handwritten or a copy of the reviewed POS attached. R2 is no longer in the facility and her husband is not administering her medications. Insulin orders for residents without parameters have been added as to when to hold the insulin. The resident who self-administers her own insulin after dialed up by the medication assistance has had to show nurse insulin pen dialed dose prior to giving to resident to administer to her MAR. 2. All residents have an onsite medication review by the RN with the conduction of UAI assessments including admissions, significant changes, and annual reviews. It is included under Page 9 of the UAI and either handwritten or a copy of the reviewed POS attached. No other residents have outside assistance with medications. All residents have the potential to have failed document for administered medications on the Medication administration records and that cannot be altered for these residents. Audit for residents with Insulin orders without parameters have been added as to when to hold the insulin. No other residents self-administer insulin.	5/16/23

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	-On 10/26/22 at 9:00 AM, Hydralazine, Multivitamin, Acetaminophen and Vitamin B12 (supplement) and at 8:00 PM Quetiapine Fumarate and Divalproex. These medications were shown as missed on the MAR without a reason as to why, and there was no documented evidence of notification of the Nurse or Physician. 4. 8/1/22 - 8/31/22 - R4 was to receive the following medications: -On 8/7/22 at 9:00 AM Omeprazole (for acid reflux) and Venlafaxine HCL ER (for depression/anxiety); at 10:00 AM Pulmicort Flexhaler (for asthma), Meclizine (for nausea/dizziness), and Lisinopril (for high blood pressure). -On 8/29/22 at 8:00 AM Senokot (for constipation) and Omeprazole and Venlafaxine HCL ER at 9:00 AM. These medications were shown as missed on the MAR without reason as to why, and there was no documented evidence of notification of the Nurse or Physician. 5. 10/1/22-10/31/22 - R8 was to receive Baza Protect to the buttock area for a sacral wound twice daily. The MAR indicated this was administered only two times at 5:00 PM on 10/1/22 and 10/2/22. No reason was indicated as to why the remaining doses were missed. 11/1/22 – 11/9/22, Baza Protect was again not administered and on 11/4/22, B Complex tab (supplement) at 9:00 AM was missed without a reason why, and there was no	3. It was determined that Nurses/ Med tech didn't understand the importance of documentation for medication administration. Nurses and Med Tech have been in serviced on proper documentation of medications administered, missed, held, or PRN medications, and on residents who use an insulin pen for self-administration of insulin dose after it is checked by the nurse. An audit will be conducted daily by DRC or designee for improper medication documentation and correction.in-servicing daily x 1 week and then twice a week x 1 month until 100% compliance is achieved. Any person assisting a resident with medication administration will have the self-administration of medication assessment completed as outline in self-administration policy within 30-days of admission. 4. The NHA will conduct an audit of 20% of the current medication administration records for completeness, improper medication documentation, and correction weekly times 3 weeks then monthly until 100 compliance is achieved. Outcome will be reported to the QAPI committee. The QAPI committee will determined the frequency of the audits..	

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: December 12, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	documented evidence of notification of the Nurse or Physician. 6. 9/1/22-9/30/22 - R10 on 9/9/22 had an order for Cholestyramine 4 Gm packet mixed in 8 ounces of water daily for 14 days. Per the MAR this was only administered 12 days. The record does not indicate the reason why the last two doses were not given. 10/1/22-10/31/22 - On 10/18/22 and 10/19/22, Cranberry (supplement) tab twice a day at 9:00 AM and 6:00 PM and on 10/28/22 at 6:00 PM Atorvastatin (for high Cholesterol) and Cranberry were marked as missed without reason why, and there was no documented evidence of notification of the Nurse or Physician. 7. 12/4/22 at 0800 - R16 was to receive Insulin (Novolog Flexpen) 50 units subcutaneously before breakfast. The MAR did not show that the blood glucose reading was recorded or that the Insulin was administered. Per interview on 12/6/22 at 7:40 AM, E13 (LPN) confirmed the reason was not indicated and there was no documented evidence of notification of the Nurse or Physician. E13 confirmed there was no order for blood glucose parameters as it would be on the MAR if ordered. Interview with E7 (LPN) on 12/6/22 at 9:19 AM confirmed there were no parameters ordered by the Physician and stated she would contact the Physician to obtain blood glucose parameters. 8. 12/4/22 at 11:00 AM - R17 was to receive Insulin (Novolog Flexpen) 10 units subcutaneously before lunch and Xuttophy Flexpen 35 units subcutaneously		

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	daily before bed. The MAR did not show that either of these Insulin doses was administered and the reason why was not noted and there was no documented evidence of notification of the Nurse or Physician. On 11/10/22, 11/15/22, 11/19/22, 11/22/22, 11/23/22, 11/27/22, 11/28/22, and 11/29/22 the MAR indicated that Insulin (Novolog Flexpen) 10 units subcutaneously before lunch was not administered with no notation as to the reason why the med was not administered and no documented evidence of notification of the Nurse or Physician. On 11/10/22, 11/18/22, 11/19/22, 11/25/22, 11/26/22 and 11/27/22 Xuttophy Flexpen 35 units subcutaneously daily before bed was not administered with no notation as to the reason why the med was not administered and there was no documented evidence of notification of the Nurse or Physician. In review of the record, there was no order for blood glucose parameters. Per interview with E19 (AL Medication Assistant) on 12/6/22 at 7:40 AM, E19 stated she dials in the dose on the Flexpen then hands it to the resident to self-administer. Per interview with E13 (LPN) on 12/6/22 at 7:42 AM, E13 confirmed the reason for the missed doses was not listed or documented. E13 confirmed there was no order for blood glucose parameters as it would be on the MAR if ordered. E13 also confirmed that the Nurse should check the dosing on the pen if "dialed in" dose was performed by the Medication Assistant. Interview with E7 (LPN) on 12/6/22 at 10:05 AM confirmed there were no parameters ordered by the Physician or an order for the resident to self-administer		

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	the insulin once drawn. E7 stated the Nurse should dial in the insulin dose or check the insulin dosing if drawn up by the Medication Assistant. E7 stated she would contact the Physician to obtain blood glucose parameters and an order to allow the resident to self-administer her insulin. During an interview with E5 (Medication Assistant) on 11/29/22 at 8:10 AM, E5 stated that when a medication is not given for whatever reason, the employee will circle their initial at the time the medication is missed, will make a notation as to the reason medications are not given on the back of the MAR and alert the Nurse of the missed dose. This procedure was confirmed by E13 on 12/6/22 at 7:38 AM. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN).		5/16/23
3225.9.0 3225.9.5 3225.9.5.1	**Infection Control** **Requirements for tuberculosis and immunizations:** **The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** This requirement was not met as evidenced by: Based on record reviews, interview and review of other facility documentation, it was determined that for three (R3, R12 and R17) out of fourteen (14) sampled resident records, tuberculin testing was	1. .All sited residents receive a TD test prior to admission. R 3 received an TB test on 9-26-20. R12 received a TB test on 12-13-19 . R17 received a TB test on 6-28-23 All TB tests on these residents were negative. 2. All residents on admission have the potential to not have a TB test done within 30days prior to admission. An audit will be conducted by the DRC/designee to ensure all current residents have received a TB test prior to admission. No residents were found not to have a TB test completed. 3. Executive director in-serviced the Admissions staff and DRC on the requirement for a resident to have received a TB test within 30days prior to admission and place on their record when admitted. An "Admission Tracking Form" has been developed to track TB testing on admission. On admission, the tracking form will be completed by admission personnel.	

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	not in evidence or administered upon admission. Findings include: 1. 9/28/20 - R3 was admitted to AL. The facility lacked evidence of tuberculin testing upon admission. 2. 12/19/19 - R12 was admitted to AL. The facility lacked evidence of tuberculin testing upon admission. 3. 9/7/21 - R17 was admitted to AL. The facility lacked evidence of tuberculin testing upon admission. During an interview on 12/6/22 at 1:00 PM, E2 (DRC) confirmed there was no evidence of tuberculin testing upon admission for these residents. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	The ED or designee will audit the sheet weekly x 4 weeks then monthly times two to assure TB information is present. 4. The ED or designee will audit all new resident files to ensure that a TB test has been complete per regulatory requirements weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	5/16/23
3225.9.5.2	**Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.**	1. The community has administered a two-step TB test for all current employees. 2. No residents were affected by this practice. All residents could be affected by this practice. 3. It was determined that the director of human services (HR) was following an outdated directive issue by DHSS stating that there was a temporary order to only administer a one-step TB test till further notice. The director of HR has completed an audit of all current employees to identified employees that did not receive a two-step PPD prior to employment. The identified employees from the audit will be completed the two step PPD test. All employees currently have completed the two step TB test and the evidence has been placed in their employee file. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Director of Human resources or designee will audit all new employee files to ensure that their two step TB	

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	This requirement was not met as evidenced by: Based on interview and review of facility provided documentation, it was determined that for four (E3, E4, E8 and E9) out of eight employees sampled for pre-employment two step tuberculin skin test, there was no evidence that the second step was given. Findings include: 2/28/21 - E3 (Director of Memory Care) hire date. The first step Tuberculin testing was done on 8/26/20, however, no testing was done closer to the hire date, nor was there evidence of a second step Tuberculin test performed. 3/7/22 - E4 (LPN) hire date. Tuberculin testing was done on 4/22/22 after the hire date, however, there was no evidence of a second step Tuberculin test performed. 9/26/22 - E8 (Life Enrichment Coordinator) hire date. Tuberculin testing was done on 9/28/22 after the hire date; there was no evidence of a second step Tuberculin test performed. 6/15/22 - E9 (wait staff) hire date. Tuberculin testing was done on 6/17/22 after the hire date; there was no evidence of a second step Tuberculin test performed. During interview on 12/6/22 at 1:00 PM, E1 (ED) confirmed the second step testing was not completed. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN).	test have been complete per regulatory requirements weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes. 1. Residents R9 (has expired), R 10 had flu vaccine on 10-06-22, and R 13 flu vac on 10-04-22. All residents have had two or more vaccinations. They facility also has their flu vaccination records	5/16/23

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3225.9.6	**The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza 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.** This requirement was not met as evidenced by: Based on interview, review of medical records and facility provided documentation, it was determined that for three (R9, R10 and R13) out of fourteen residents sampled for an annual vaccination against influenza, the annual vaccine was not given and there was no record of the vaccine being offered to the resident and declined. Findings include: 1. 11/14/22 - R9 was admitted to AL. R9's record lacked evidence of the Influenza vaccine being given or offered at admission. 2. 6/28/19 - R10 was admitted to AL. R10's record lacked evidence of the Influenza vaccine being given or offered annually. 3. 12/30/18 - R13 was admitted to AL. R13's record lacked evidence of the	from the last clinic and the Delvax forms. 2. An audit was conducted and all residents at Harbor Chase relating to covid and flu vaccinations. All have at least two covid vaccinations, in an annual flu clinic is offered by a local pharmacy in the fall for those residents wishing to have the flu vaccine. A flu vaccine will be offered again in the fall 3. It was determined that the communities password was not updated and the community was waiting to receive the new password from Delvac. Delvac access has been obtained by the DRC. Admission staff, the DRC, and nurses were in service on the requirement for a resident to have on record proof of an annual flu vaccine being offered. If a resident refuses the vaccine at the time of the annual flu clinic, a declination form will be offered, signed, and placed on record. An "Admission Tracking Form" has been developed to track Flu vaccine on admission. A form will also be included in the admission package, listing local pharmacies offering the flu vaccine for residents to obtain the vaccine if they desire. If not, they will be asked to sign a declination form. Harbor Chase would also be available to take residents for the vaccine if desired. The tracking form will be completed by admission personnel. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will review the audit sheets for flu vaccine	

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	Influenza vaccine being given or offered for the year 2022. During an interview on 12/12/22 at 3 PM, E2 (DRC) confirmed the findings. E2 stated that she has no access to the DelVax site to check immunization status'. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	compliance weekly x 3 and then monthly times two till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	
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 contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully in-formed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** This requirement was not met as evidenced by: Based on interview, review of clinical records and other facility documentation, it was determined that for six (R3, R9, R10, R12, R13 and R17) out of fourteen residents sampled for pneumococcal pneumonia vaccines, the facility lacked evidence that residents'	1. R3, R9, R10, R12, R13 and R17 were offered the pneumococcal vaccine at the a pneumococcal clinic which was held on February 17, 2023 by the DRC or designees.. . 2. An audit was conducted on all residents, using Delvax information and/or family interview to determine pneumococcal vaccine status, and those who did not have a record for the pneumococcal vaccine were offered the vaccine via a vaccine clinic on February 17. Those not wanting the vaccine were asked to sign a declination form, or the family verbally confirmed they did not want the vaccine administered to the resident. 3. Delvax access has been obtained by the DRC. Admission staff, and nurses were in service on the requirement for a resident to have on record proof of a Pneumococcal vaccine. If the resident does not have proof of pneumococcal vaccine, they will be offered it at our annual flu clinic. If a resident does not have a record of receiving the vaccine	5/16/23

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	pneumococcal pneumonia vaccines were offered. Findings include: 1. 9/28/20 - R3 was admitted to AL. The facility records lacked evidence of the pneumococcal pneumonia vaccine in R3's history and that the vaccine was offered to the resident and declined. 2. 11/14/22 - R9 was admitted to AL. The facility records lacked evidence of the pneumococcal pneumonia vaccine in R9's history and that the vaccine was offered to the resident and declined. 3. 6/28/19 - R10 was admitted to AL. The facility records lacked evidence of the pneumococcal pneumonia vaccine in R10's history and that the vaccine was offered to the resident and declined. 4. 12/19/19 - R12 was admitted to AL. The facility records lacked evidence of the pneumococcal pneumonia vaccine in R12's history and that the vaccine was offered to the resident and declined. 5. 12/30/18 - R13 was admitted to AL. The facility records lacked evidence of the pneumococcal pneumonia vaccine in R13's history and that the vaccine was offered to the resident and declined. 6. 9/7/21 - R17 was admitted to AL. The facility records lacked evidence of the pneumococcal pneumonia vaccine in R17's history and that the vaccine was offered to the resident and declined. During an interview on 12/12/22 at 3:10 PM, E2 (DRC) confirmed the records lacked evidence pneumonia vaccines	and refuses the vaccine at the time of the annual flu clinic, a declination form will be offered, signed, and placed on record. A form will be placed in the admission paperwork recommending residents receive the pneumococcal vaccine and a list of local pharmacies that provide the vaccine will be included if a resident would like the vaccine before the next clinic. Harbor Chase would transport to the pharmacy if needed. The DRC will track who has not received that vaccine so it can be offered at the next clinic. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The DRC will review new resident pneumococcal vaccine status at the monthly QAPI meetings indicating prior administration, refusal, or if seeking outside pharmacy for administration. Monthly x 3 months.	

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	were not offered. E2 stated she has no access to DelVax site to check immunization status'. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	1. No staff was tested prior to employment. No venders were tested prior to entering the building. There are no volunteers working at HCW. Vendors were tested by their employers. All staff that is currently working in the community. If vendors had not received a test prior to entering HCW they were not permitted to enter the community. 2. All residents had the potential to be affected by this practice. No residents were identified to have been affected by this practice. 3. Human Resources was unaware of the need to Covid test staff prior to or on their start date. The director of human resources has been in-service to ensure new staff is tested for covid 19 on or before start date. New vendors will be given a covid test when filling out credentialing forms. The business office manager or designee will Inservice concierges on testing new vendor prior to entering community. 4. The ED or designee will audit new hire paperwork for covid testing of new staff members prior to start date times 3weeks then monthly till 100% compliance has been reached. All findings will be reported to QAPI committee. Qapi committee will determine frequency of audits.	5/16/23
3225.9.8 **3225.9.8.2** **3225.9.8.1**	**Specific Requirements for COVID-19:** **Staff, vendors and volunteers** **Prior to their start date, all new staff, vendors and volunteers must be tested in accordance with the Delaware Division of Public Health guidance.** This requirement was not met as evidenced by: Based on interview and review of facility provided documentation, it was determined that new hires, vendors, and volunteers were not tested for COVID prior to entering the facility. Findings include: During an interview on 11/29/22 at 1:35 PM, E2 (DRC) confirmed that pre-hire COVID testing was not done, but the facility requires vaccination records prior to hire. On 12/5/22 at 11:10 AM per interview with E12 (Business Office Manager/HR), E12 stated that COVID testing was not. performed on prospective applicants prior to hire. E12 stated that all staff are to be vaccinated and there were no vaccination exemptions.		

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	1. All residents including the original four were negative at week two testing, and no one had any further signs or symptoms of Covid.	5/16/2023
3225.9.8.2.1	**All other resident testing should be consistent with Division of Public Health guidance for the duration of the public health emergency.** This requirement was not met as evidenced by: Per COVID outbreak tracking records provided by E2 (DRC), the facility's last outbreak was early November 2022 (11/3/22 was the first positive). Outbreak testing began the week of 11/3/22 and testing was done during the week of 11/8/22 with all negative results. Outbreak testing was not provided for the additional week required by CDC and State COVID guidelines to obtain two weeks (14 days) of negative test results. During an interview on 12/5/22 at 11:08 AM, E2 confirmed that only one week of negative testing was performed instead of the recommended 14 days of negative results. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).	2. All residents have the potential to be affected by this practice. No residents were affected by the lack of a second week of Covid testing. All residents including the original four were negative at week two testing, and no one had any further signs or symptoms of Covid. 3. Root Cause Analysis: It was determined that the meaning of two negative tests was not clearly understood by the nursing staff. Managers and nurses were in service by the DRC on the two negative testing recommendations when in an outbreak. During a Covid outbreak, the DRC or designee will audit for two weeks (or current guidelines) after the original testing, for negative testing before declaring the outbreak is over. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit for two negative weekly testing results for compliance weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	
3225.10.4	**The resident shall sign a contract within 3 business days after admission that:**		

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.10.4.1	**Is a clear and complete reflection of commitments agreed to by the parties and the actual practices that will occur in the assisted living program.** This requirement was not met as evidenced by: Based on review of the admission and clinical records, it was determined that for three (R1, R2 and R15) out of three residents reviewed for contracts, the facility failed to ensure that each resident signed a contract within 3 business days after admission that was a clear and complete reflection of commitments agreed to by the parties and the actual practices that will occur in the AL. Findings include: Cross refer 10.10, examples 1, 2, 3 1. R1's admission and clinical records revealed: 2/15/22 - F2 (R1's POA) signed the contract on behalf of R1 prior to admission to the AL on 2/21/22 and lacked a signed service agreement. Although R1's admission was delayed from 2/17/22 to 2/21/22, the contract was signed prior to admission without a signed service agreement. The facility failed to ensure that R1's contract was signed within 3 days after admission. 2. R2's admission and clinical records revealed:	1. R1, R2 and R15 or POAs have signed their latest contracts and service agreements or the afore mentioned documents have been sent via email to the responsibly party for their review showing they are matching exhibit 1 of the signed contract. 2. All residents have the potential to be affected by this practice. An audit was conducted and all Residents or POAs have signed the latest contracts and service agreements or the afore mentioned documents have been sent via email to the responsibly party for their review showing they are matching exhibit 1 of the signed contract. 3. It was determined the admissions personal did not utilizes the admissions check off sheet to ensure all document were signed prior to admission's. Admissions, and managers were in-serviced by the DRC on proper processes and time frames for documentation related to the admission process to include signed UAI, service plans, and contracts. An audit form has been developed to track assessments, UAI completion prior to admission and Service Plan process and dates to assure they are signed within 3 days of admission. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance.	5/16/23

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	5/31/22 – R2 signed the contract prior to admission to the AL on 6/2/22 and lacked a signed service agreement. R2's contract was signed three days prior to admission without a signed service agreement. 3. R15's admission and clinical records revealed: 5/31/22 – R15 signed the contract prior to admission to the AL on 6/2/22 and lacked a signed service agreement. R15's contract was signed three days prior to admission without a signed service agreement. 12/12/22 at 4:15 PM – Findings were reviewed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN). The facility failed to ensure that R1, R2 and R15s' contracts were signed within three days after admission.	4. The ED or designee conducted an audit of the new assessments, UAI, and service plans weekly x 3 weeks then monthly till a 100% compliance. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes. 1. Residents or POAs have signed their latest contracts and service agreements, or the mentioned documents have been sent via email to the responsibly party for their review showing they are matching the Exhibit 1 contract signed agreement. 2. All residents have the potential to be affected by this practice. An audit was conducted by the DRC or designee and all Residents or POAs have signed the latest contracts and service agreements, or the mentioned documents have been sent via email to the responsibly party for their review showing they are matching the Exhibit 1 contract signed agreement. 3. The DRC in serviced RN's, Admissions, and managers on proper processes and time frames for documentation related to the admission process to include signed UAI, service plans, and contracts. An audit form has been developed to track assessments, UAI completion prior to admission and Service Plan process and	5/16/23
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.** This requirement was not met as evidenced by:		

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	Cross refer to 10.4, #1, 2, 3 Based on review of the clinical records and interview, it was determined that for three (R1, R2 and R15) out of three sampled residents reviewed for contracts, the facility failed to execute (signed) service agreements prior to signing each Residency Agreement (contract). Findings include: 1. R1's admission and clinical records revealed: 2/14/22 – The UAI was completed and signed by E2 (DRC). However, the UAI was not signed by F2 (R1's POA). 2/15/22 – F2 signed the contract on behalf of R1. 2/21/22 – R1 was admitted to the facility. 2/21/22 – Six days after the contract was signed, R1's service plan was completed. In addition, the service plan was never signed by both F2 and E2 as required. 2. R2's admission and clinical records revealed: 5/31/22 – The contract was signed by R2. 6/2/22 – R2 moved into the facility.	dates to assure they are signed and reviewed within 3 days of admission. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee conduct an audit of the new admissions, UAI, and service plans weekly x 3 weeks then monthly till a 100% compliance. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	6/6/22 – Four days after R2 moved into the facility, the service agreement was completed by E2 (DRC), however, the service agreement was not signed by both R2 and E2 (DRC) as required. 3. R15's admission and clinical records revealed: 5/31/22 – The contract was signed by R15. 6/2/22 – R15 moved into the facility. 6/6/22 – Four days after R15 moved into the facility, the service agreement was completed by E2 (DRC), however, the service agreement was not signed by both R15 and E2 (DRC) as required. 12/12/22 at 1:00 PM – During an interview, timely completion of service agreements for R1, R2 and R15 were reviewed with E2 (DRC). 12/12/22 at 4:15 PM – Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DRC) and E12 (Division RN).	**1.** R2, R3, R8, R13, R14 and R15 assessment dates cannot be changed. **2.** All residents have the potential to be affected by this practice. Nothing can be done to change the assessment dates for any admitted residents. 3. It was determined that the assessment dates completed in a timely manner due to a tracking system was not in place. RNs, Admissions, and managers were in-serviced on proper processes and time frames for documentation related to pre- admission UAI by the DRC.A tracking form has been developed to track pre and post admission assessment dates to assure pre-admission UAIs are completed within 30-days of admissions and reviewed a 30-days post admission for changes.. The audits will be	5/16/23
3225.11.0	**Resident Assessment**		
3225.11.2	**A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed**		

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	prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area. This requirement was not met as evidenced by: Based on record review, interview and other documentation, it was determined that for six (R2, R3, R8, R13, R14 and R15) out of seventeen residents sampled for pre-admission UAI based assessments were not completed prior to admission to the facility or completed more than 30 days prior to admission. Findings include: 1. 6/2/22 - R2 was admitted to AL. The initial UAI assessment was dated 5/2/22, which was completed 31 days prior to admission. 2. 9/29/20 - R3 was admitted to AL COVE (Memory Care). The initial UAI-based assessment was dated the day of admission on 9/29/20. 3. 12/27/19 - R8 was admitted to AL. The facility lacked evidence of the initial UAI-based assessment being completed.	conducted prior to the admission date by the admission coordinator. and by the ED or designee for the 30 days post admission review of a new admission to assure compliance weekly x's two months. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee conduct audits as listed above for pre-and post-admission assessment dates x 3 weeks then monthly till a 100% compliance. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	4. 12/30/18 - R13 was admitted to AL. The initial UAI-based assessment was dated the day of admission on 12/30/18. 5. 12/30/18 - R14 was admitted to AL. The initial UAI-based assessment was dated the day of admission on 12/30/18. 6. 6/2/22 - R15 was admitted to AL. The initial UAI was dated 5/2/22, which was completed 31 days prior to admission. During a combined interview on 12/12/22 at 3:30 PM, E1 (ED) and E2 (DRC) stated that assessments are done prior to admission on all residents, but lacked evidence of the assessments listed above to have been completed prior to admission. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1, E2 and E14 (Division RN).		
3225.11.3	**Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.** This requirement was not met as evidenced by: Based on interview and record reviews, it was determined that for seven (R1, R5, R8, R10, R12, R13 and R14) out of seventeen residents sampled for pre-admission medical evaluations, the	1. R1, R5, R8, R10, R12, R13 and R14 cannot have the medical evaluation dates changed.	5/16/23

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	facility failed to ensure that pre-admission medical evaluations were completed within the regulation timeframe. Findings include: 1. 2/21/22 - R1 was admitted to AL. R1's Physician medical evaluation visit was dated 1/10/22, which was 42 days prior to admission to the facility. 2. 9/27/19 - R5 was admitted to AL. The medical evaluation visit was dated 8/12/19 and signed on 9/6/19. This medical examination was beyond the 30 days prior to admission. 3. 12/27/19 - R8 was admitted to AL. The medical evaluation visit was dated 8/16/19 and signed on 12/23/19. This medical examination was beyond the 30 days prior to admission. 4. 6/28/19 - R10 was admitted to AL. The medical evaluation visit was dated 2/20/19 and signed on 6/28/19. This medical examination was beyond the 30 days prior to admission. 5. 12/19/19 - R12 was admitted to AL. The facility failed to provide evidence that a pre-admission medical evaluation was completed. 6. 12/30/18 - R13 was admitted to AL. The medical evaluation visit was dated 10/10/18 and signed on 12/27/18. This medical examination was beyond the 30 days prior to admission.	2. Nothing can be done to change the medical evaluation dates for any admitted residents. All residents could be affected by this practice. 3. It was determined that the assessment dates completed in a timely manner due to a tracking system was not in place. RNs, Admissions, and managers were in-serviced by the DRC on proper processes and time frames for documentation related to the admission process including 30-day medical evaluation. A tracking form has been developed to track 30-day medical evaluation to assure compliance with regulations. An audit will be conducted within 3 days of a new admission by the Ed or designee to assure compliance weekly x's 2 months. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee conduct an audit of the new admissions for the 30day time frame for signing medical evaluations for compliance weekly x 3 weeks then monthly till a 100% compliance. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

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	7. 12/30/18 - R14 was admitted to AL. The medical evaluation visit was dated 10/10/18 and signed on 12/27/18. This medical examination was beyond the 30 days prior to admission. During an interview with E1 (ED) and E2 (DRC) on 12/12/22 at 3:45 PM, E2 stated that Physicians complete a pre-admission evaluation prior to admission on all residents and confirmed they lacked evidence of the medical examinations listed above to be done within 30 days prior to admission. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1, E2 and E14 (Division RN).		
3225.11.4	**The resident assessment shall be completed in conjunction with the resident.** This requirement was not met as evidenced by: Based on clinical record reviews and interview, it was determined that for six (R1, R3, R6, R8, R10 and R11) out of seventeen residents sampled for UAI assessments, the facility failed to ensure that the UAI assessments were completed in conjunction with the resident by not obtaining signed and dated assessments by the resident, POA or family member pursuant to the State of Delaware requirements. Findings include:	1. R1, R3, R6, R8, R10 and R11 or POAs have signed their latest contracts, UAI, or the mentioned documents have been sent via email to the responsibly party for their review.	5/16/23

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	The State of Delaware's form entitled Uniform Assessment Instrument for Assisted Living Facilities stated, "The purpose of the Uniform Assessment Instrument (UAI) is to collect information regarding an assisted living applicant/resident's physical condition, medical status and psychosocial needs. The information is to be used to: (1) determine if an applicant meets eligibility for entrance or retention in an assisted living facility; (2) if admitted, determine the appropriate level of care for the resident and develop a service agreement; and (3) update service needs and the service agreement... The applicant/resident represents that all oral and/or written information made or furnished by, or on behalf of, the applicant for completion of the UAI are true and accurate to the best of his/her knowledge and belief. The applicant understands and acknowledges that providing this information does not represent a commitment for, or guarantee of, service or admission to an Assisted Living Facility and is provided solely for the purpose of evaluation." On the last page and below this statement, there is a signature page for the applicant/resident, legal representative (if applicable) and the Registered Nurse (RN) to sign and date. 1. Review of R1's clinical record revealed: 2/14/22 – The initial UAI assessment was signed and dated by E2 (DRC),	2. An audit was conducted by DRC and designees and all residents that did not have a signed UAI have signed (or POA has signed the latest UAI, or the mentioned documents have been sent via email to the responsibly party for their review . All residents have the potential to be affected by this practice. 3. It was determined the admissions personal did not utilizes the admissions check off sheet to ensure all document were signed prior to admission's, RN's, Admissions, and managers were in-serviced by the DRC on proper processes and time frames for documentation related to the admission process and the signed UAI, An audit form has been developed to trac UAI completion prior to admission process and dates to assure are signed and reviewed within 3 days of admission. The audits will be conducted within 3days of a new admission by the Ed or designee to assure compliance weekly x's 2 months. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will conduct an audit of new UAI weekly x 3 weeks then monthly till a 100% compliance. Findings will be reported during the monthly QAPI meeting for review and recommendations.	

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	however, F2 (R1's POA) never signed and dated the initial UAI as required. 11/19/22 – R1's UAI was reviewed and revised after her second elopement from the facility and was signed by E2. F2 never signed the 11/19/22 revised UAI assessment as required. 12/12/22 at 1:00 PM – During an interview, E2 confirmed that R1's UAI assessments were not signed by F2. 2. 5/12/22 R3's annual UAI assessment was completed, signed and dated by E2. It was not signed or dated by the resident, POA or family member. 3. 10/28/20 R6's annual UAI assessment was completed, signed and dated by an RN. It was not signed or dated by the resident, POA or family member. 4. 4/6/22 R8's annual UAI assessment was completed, signed and dated by E2. It was not signed or dated by the resident, POA or family member. 5. 3/15/21 R10's annual UAI assessment was completed, signed and dated by E2. It was not signed or dated by the resident, POA or family member. 9/8/21 R11's initial UAI assessment was completed, signed and dated by E2. It was not signed or dated by the resident, POA or family member.	The frequency of the audits adjusted according to outcomes.	

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	12/12/22 at 2:30 PM – During an interview, E2 confirmed that not all of the UAI assessments were signed by the resident, POA or family member. 12/12/22 at 4:15 PM – Finding was reviewed during the Exit Conference with E1 (ED), E2 and E12 (Division RN). The facility failed to ensure that R1's UAI assessments were completed and signed by F2, her legal representative.		
3225.11.5	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular update must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** This requirement was not met as evidenced by: Based on interviews and review of clinical records and other documentation as indicated, it was determined that for fourteen (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R14 and R15) out of seventeen residents sampled for at a minimum, regular updates of UAI assessments, the facility failed to ensure the UAI assessments were completed, specifically 30 days after admission, annually and when there was a significant change in condition. Findings include: 1. R1's clinical record revealed:	1. R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R14 and R15 assessment dates can't be changed. 2. Nothing can be done to change passed assessment dates for residents. All residents have the potential to be affected by this practice. 3. It was determined that the nursing staff miss counted the number days for completing on some UAIs in the 30 day requirement. The DRC was in serviced by the regional nurse and then the DRC in serviced nurses, and other managers on the UAI assessment on the required update at 30 days (not 31 days) after admission, yearly, and with a significant change in status and what a significant change in status is. Residents with a significant change in class will be discussed at the weekly "At Risk"	5/16/23

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	8/27/22 – According to hospital records, R1 was evaluated in the hospital after running away from the facility and was noted to be wandering on Shipley Road. R1's discharge diagnoses were Dementia, Senile with Delusions. 8/29/22 – R1 was seen and evaluated in the facility by V3 (NP) for a status post hospitalization visit for an acute change in mental status, paranoia, hallucinations and threatening to kill herself. V3 increased R1's antipsychotic medication due to increased behaviors not related to the UTI (urinary tract infection) treatment. The facility lacked evidence that R1's UAI was reviewed and revised to reflect the significant change in her condition. 2. R2's clinical record revealed: 5/2/22 – R2's UAI was completed and signed by E2 (DRC). 6/1/22 – R2's 30-day UAI was reviewed and signed by E2 (DRC) despite R2 not having been admitted to the facility yet on this date. 6/2/22 – R2 was admitted to the facility. R2's UAI was never reviewed and updated 30 days after admission as required. 3. 9/29/20 - R3 was admitted to AL COVE (Memory Care) with a diagnosis of	meeting to determine if a new assessment is needed. ED or designee will monitor the discussion to ensure the review is completed promptly. This audit will occur weekly times four and monthly times two. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit 10 percent of UAI assessments to ensure compliance with state regulations weekly times 3 weeks and then monthly till 100% compliance is achieved. Findings will be reported to the QAPI committee for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Dementia. The initial UAI was dated 9/29/20. The 30 day post admission review of the UAI and the 2021 annual UAI assessments were not found. 4. 2/28/20 - R4 was admitted to the facility. The 30 day UAI assessment was completed on 3/7/20 prior to 30 days after admission. 5. 9/27/19 - R5 was admitted to the facility. The 30 day UAI assessment was completed on 10/10/19 prior to 30 days after admission. 6. 7/24/19 - R6 was admitted to AL and moved into the COVE (Memory Care) with a diagnosis of Dementia on 4/19/21. Resident exhibited increasing aggressive behaviors to both staff and other residents and sustained multiple falls. The facility failed to complete an annual UAI for the year 2020, when she moved into the COVE on 4/19/21, or when R6 sustained multiple falls, had wandering behavior with a documented exit from the facility, increased confusion and hallucinations, or with increasing aggressive behavior issues that were documented in the resident's record in June and July of 2021. 7. 5/29/19 - R7 was admitted to the COVE (Memory Care) with a diagnosis of Dementia. The 30 day UAI assessment was completed on 7/14/19, more than 30 days after admission. The annual UAI assessment due in July of 2020 was not in evidence.		

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	8. 12/27/19 - R8 was admitted to the AL. The facility lacked evidence of the initial or 30 day UAI assessments being completed. 9. 11/12/22 - R9 was admitted to the AL. There is no evidence that a 30 day post admission UAI was completed. 10. 6/28/19 - R10 was admitted to the AL. On 10/17/22, R10 was transferred into the COVE (Memory Care). The 30 day UAI assessment was completed on 8/1/19, more than 30 days after admission. There was no evidence of an annual UAI assessment for the years 2020 or 2021 and no evidence of a significant change in condition UAI when R10 was transferred into the COVE on 10/17/22 or when a PU was identified and the resident's needs increased. 11. 9/24/21 - R11 was admitted to the AL Cove (Memory Care) with a diagnosis of Alzheimer's. The 30 day UAI assessment was completed on 10/3/21 prior to the 30 days after admission. There was no evidence of an annual UAI assessment for the year 2020 or a significant change in condition UAI when the PU was identified and the resident's needs increased. 12. 12/19/19 - R12 was admitted to the AL. The 30 day UAI assessment was completed on 1/8/20 prior to the 30		

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	days after admission and the annual UAI assessment due in 2021 was not found. 13. 12/30/18 - R14 was admitted to the AL. The facility lacked evidence of the annual UAI assessment due in December of 2020. 14. R15's clinical record revealed: 8/22/22 through 8/26/22 – R15 returned to the facility after being hospitalized for heart failure (disease that affects the pumping action of heart muscles), acute kidney injury (abrupt reduction in kidney's ability to filter waste products), difficulty breathing, and high blood pressure. R15 came back on multiple medications and supplemental oxygen as needed. 8/29/22 through 8/30/22 – R15 was subsequently hospitalized again and returned to the facility on hospice services. The facility lacked evidence that a significant change UAI was completed after the two hospitalizations and admission to hospice services. During a combined interview on 12/12/22 at 3:30 PM, E1 (ED) and E2 (DRC) stated that significant UAI assessments are completed when two or more changes in resident's needs occur, and they were not completed on the above listed residents. E2 confirmed the 30 day and annual UAIs were not in		

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3225.12.1.3	evidence on the above listed residents and was not sure if they were completed. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1, E2 and E14 (Division RN). **Food service complies with the Delaware Food Code.** Based on observations and interviews it was determined that the facility did not ensure that food safety practices was fully observed. Findings include: Cross refer to 2019 edition of Delaware Food Code: 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, P (b) Cooked READY-TO-EAT FOOD, P and (c) Fruits and vegetables before they are washed; P	1. The cookie dough was removed by the director of hospitality from the counteroffer/bistro grab and go restaurant reach in refrigerator when identified by the surveyor. No residents were effect by this practice. 2. The Director of Hospitality immediately in-serviced the counteroffer attendant on the proper way to store items in refrigerators. The Hospitality Director audited the community's refrigerators to ensure food items are being properly stored. All residents could have been affected by this practice, however, not any were identified. 3. It was determined the counteroffer attended inadvertently misplaced the food item. The hospitality management team has completed training in proper food handling techniques and are certified by Serve Safe training. The Director of Hospitality or designee will in-service all food service employees on proper food handling. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Director of Hospitality will audit all refrigerators for proper storage per Delaware's food code weekly times 3 weeks then monthly till 100% precent compliance is achieved. Findings will be reported during the	5/16/23

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(d) Frozen, commercially processed and packaged raw animal FOOD may be stored or displayed with or above frozen, commercially processed and packaged, ready-to-eat food. The following were observed during the initial kitchen tour on 11/29/22 at approximately 11:00 AM: -The bistro walk-in refrigerator had raw cookie dough stored on top of the ready to eat desserts and cheeses. Raw cookie dough is classified as potentially hazardous food due to the raw content and has significant water activity to encourage microbial growth. Finding was reviewed and confirmed by E18 (Food Services Director) on 11/29/22 at approximately 11:30 AM.	monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	
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 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.**	1. R1, R2, R3, R5, R7, R10, R13, R14, R15 and R17s have signed their service agreements have been sent via email to the responsibly party for their review showing they match exhibit 1. 2. An audit was conducted and all Residents or POAs have signed the latest service agreements have	5/16/23

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	This requirement was not met as evidenced by: Based on record reviews and interview, it was determined that for ten (R1, R2, R3, R5, R7, R10, R13, R14, R15 and R17) out of sixteen residents sampled for service agreements, the facility failed to ensure that service agreements were completed timely and signed by both resident/legal representative and facility designee. Findings include: 1. 2/21/22 - R1 was admitted to AL. R1's service agreement was completed on the day of admission, however, it was never signed by F2 (R1's POA) and E2 (DRC) as required. 2. 6/2/22 – R2 was admitted to AL. R2's service agreement was completed four days after her admission to the facility on 6/6/22. In addition, R2's service agreement was never signed by R2 and E2 as required. 3. 9/28/20 - R3 was admitted to the AL Memory Care. The initial service agreement was dated 9/29/20, the day after admission. The service agreement dated 5/3/22 was not signed by the resident or the POA. 4. 9/27/19 - R5 was admitted to the AL. The service agreement dated 9/27/19 was not signed by the resident or the POA.	been sent via email to the responsibly party for their review showing it matches exhibit 1. 3. It was determined that there was no tracking system in place. RN's, Admissions, and managers were in-serviced by the DRC on proper processes and time frames for documentation related to the admission process to include signed service plans,. An audit form has been developed to track assessments, UAI completion prior to admission and Service Plan process and dates to assure they are signed and reviewed within 3 days of admission. The audits will be conducted within 4 days of a new admission by the Ed or designee to assure compliance weekly x's 2 months. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit 10 percent of service plans, to ensure they are signed by the resident or responsible party weekly times 3 weeks and then monthly till 100% compliance is achieved. Findings will be reported to the QAPI committee for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	5. 5/29/19 - R7 was admitted to the COVE (Memory Care). The service agreement was completed the day after admission on 5/30/19. 6. 6/28/19 - R10 was admitted to the AL. The service agreement dated 7/1/19 was completed three days after the resident's admission. Additionally, the service agreement dated 3/15/21 was not signed by the resident or the POA. 7. 12/30/18 - R13 was admitted to the AL. The service agreements dated 2/1/19, 12/30/19, 1/21/21 and 12/21/21 were not signed by the resident or the POA. 8. 12/30/18 - R14 was admitted to the AL. The service agreements dated 2/1/19, 12/30/19 and 12/21/21 were not signed by the resident or the POA. 9. 6/2/22 – R15 was admitted to AL. R15's service agreement was completed four days after admission to the facility on 6/6/22. R15's service agreement was never signed by R15 and E2 as required. 10. 9/7/21 - R17 was admitted to the AL. The service agreement dated 3/7/22 were not signed by the resident or the POA. 12/2/22 at 2:34 PM – During an interview, E2 (DRC) confirmed there are unsigned service agreements on these residents.		

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	12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).		
3225.13.2	**The service agreement or contract shall address the physical, medical, and psychosocial services that the resident requires as follows:**		
3225.13.2.9	**Notification procedures when an incident occurs or there is a change in the health status of the resident.** This requirement was not met as evidenced by: Based on clinical record review and interview, it was determined that for three (R1, R2 and R15) out of seventeen residents sampled, the facility's service agreements failed to address notification procedures when an incident occurs or there was a change in the residents' health status. Findings include: Cross refer 13.3, examples 1, 2, 15 1. R1's clinical record revealed: 2/14/22 – The initial service agreement lacked evidence of notification procedures when an incident occurred or there was a change in the health status of R1. 2. R2's clinical record revealed:	1. The notification for R1, R2 and R15 cannot be changed. 2. An audit was conducted for the previous 30-day period of all incidents that occurred for notification. If notification was not documented, then the appropriate notification was made. All residents had the potential to be affected by this practice. 3. It was determined that a nursing professional did not notify a family member and physician of an incident related to R1 and R2. The nursing supervisor failed to document that they notified R15's physician that they had a change of condition. The DRC or designee will in-service managers and Nursing Staff on physician and family notification of all incidents. The DRC audits the incident reports daily to assure proper notifications have been made and will correct if notification was not made. Residents are reviewed	5/16/23

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: December 12, 2022

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	6/2/22 – R2 was admitted to the facility and retained her personal physician, V1. 6/6/22 – R2's initial and only service agreement lacked evidence of notification procedures when an incident occurred or there was a change in her health status. 11/1/22 at 4:30 PM – According to the facility's incident report, R2 fell in her room and was initially assessed with no injury by E4 (LPN). The facility's incident report lacked evidence of Physician notification. 11/1/22 at 11:25 PM – A nurse's note by E4 documented that V1 (R2's Physician) "... would be contacted and informed of fall...". There was no further evidence in R2's clinical record of V1's notification. 11/29/22 at 4:20 PM - During an interview, E4 was asked if R2 was on an anticoagulant (blood thinning) medication. E4 responded that R2 was on an Aspirin. The Surveyor responded that R2 was on Eliquis. When asked how R2's Physician was notified of the fall, E4 stated that she sent a fax to V1 about R2's fall. When the Surveyor asked to see the fax, E4 could not locate the faxed documentation. The facility's service agreement for R2 lacked specific notification procedures when an incident occurred. 3. R15's clinical record revealed:	at the weekly "AT Risk" meeting for potential changes in health conditions and the need for changes in status assessment updates that need to be needed weekly times four and monthly times two to ensure proper notification of events that occurred. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Executive Director or designee will audit 10% of current incident reports for regulatory compliance related family member and physician notification by the community weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	6/2/22 – R15 was admitted to the facility and retained his personal physician, V1. 6/6/22 – R15's initial and only service agreement lacked evidence of notification procedures when an incident occurred or there was a change in his health status. 12/12/22 at 4:15 PM – Findings were reviewed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN).		
3225.13.3	**The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for seventeen (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R13, R14, R15, R16 and R17) out of seventeen residents sampled, the facility failed to identify each residents' personal attending physician(s) and contact information in their service agreements. Findings include: Cross refer to 13.2.9, examples 1, 2 and 3. 1. 2/21/22 and 11/19/22 – R1's service agreements did not identify her	1. The DRC or designee indicated the physician's name, address, and phone number was added on R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R13, R14, R15, R16 and R17) service plans 2. All residents had the potential to be affected by this practice. A notation has been made on the current service plans of all residents, indicating the resident's attending physician's name, address, and phone number by DRC designee. 3. It was determined nursing staff was not following the regulation related to listing the physician's contact information. The DRC was in serviced by the regional nurse and the DRC in serviced nurses on the policy to include the physician's name, address, and phone number on the resident's service plan. The DRC or designee will	5/16/23

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	Physician's name and contact information as required. 2. 6/6/22 – R2's service agreement did not identify her Physician's name and contact information as required. 3. 9/28/20 - R3 was admitted to the facility COVE (Memory Care). The service agreements dated 9/29/20, 11/17/20, 1/21/21, 11/12/21 and 5/3/22 did not contain the Attending Physician's name, address, and telephone number. 4. 2/28/20 - R4 was admitted to the AL. The service agreements dated 2/27/20, 3/7/20, 3/20/20, 10/28/20, 3/11/21, 12/8/21, 3/7/22 and 10/13/22 did not contain the Attending Physician's name, address, and telephone number. 5. 9/27/19 - R5 was admitted to the AL. The service agreements dated 9/27/19, 10/27/19 and 3/26/20 did not contain the Attending Physician's name, address, and telephone number. 6. 7/24/19 - R6 was admitted to AL and later moved to the COVE (Memory Care). The service agreements dated 7/24/19, 8/23/19, 11/1/19, 1/24/20, 10/28/20 and 5/5/21 did not contain the Attending Physician's name, address, and telephone number. 7. 5/29/19 - R7 was admitted to the COVE (Memory Care). The service agreements dated 5/30/19, 6/14/19	complete an admitting check off form that includes checking that the physician's name, address, and phone number are on the services plan during the admitting process. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The DRC or designee will audit the newly admitted resident check off form to ensure the attending physicians contact information is accurate weekly x 3 weeks and then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	and 7/16/20 did not contain the Attending Physician's name, address, and telephone number. 8. 12/30/19 - R8 was admitted to the AL. The service agreements dated 12/30/19, 1/29/20, 8/13/21 and 4/28/22 did not contain the Attending Physician's name, address, and telephone number. 9. 11/12/22 - R9 was admitted to the AL. The service agreement dated 11/15/22 did not contain the Attending Physician's name, address, and telephone number. 10. 6/28/19 - R10 was admitted to the AL. The service agreements dated 3/17/19, 1/19/20, 11/5/20, 5/5/21, and 3/16/22 did not contain the Attending Physician's name, address, and telephone number. 11. 9/24/21 - R11 was admitted to the AL Memory Care. The service agreements dated 9/16/21 and 4/29/22 did not contain the Attending Physician's name, address, and telephone number. 12. 12/19/19 - R12 was admitted to the AL. The service agreements dated 12/19/19, 1/19/20, 11/5/20, 5/5/21, and 3/16/22 did not contain the Attending Physician's name, address, and telephone number.		

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	13. 12/30/18 - R13 was admitted to the AL. The service agreements dated 12/30/18, 2/1/19, 6/30/19, 12/30/19, 1/30/20, 6/30/20, 1/21/21, 12/9/21 and 12/21/21 did not contain the Attending Physician's name, address, and telephone number. 14. 12/24/18 - R14 was admitted to the AL. The service agreements dated 12/30/18, 2/1/19, 6/30/19, 12/30/19, 1/30/20, 6/30/20, 8/25/20, 11/30/20, 1/21/21 and 12/21/21 did not contain the Attending Physician's name, address, and telephone number. 15. 6/6/22 – R15's service agreement did not identify his Physician's name and contact information. 16. 2/28/20 - R16 was admitted to the AL. The service agreements dated 2/27/20, 3/28/20, 12/8/20, and 3/17/22 did not contain the Attending Physician's name, address, and telephone number. 17. 9/7/21 - R17 was admitted to the AL. The service agreements dated 9/21/21, 3/7/22 and 5/24/22 did not contain the Attending Physician's name, address, and telephone number. 12/12/22 at 3:00 PM – During an interview, E2 (DRC) confirmed this information was not on any of the facility service agreements for residents.		

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	12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).		
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.** This requirement was not met as evidenced by: Based on interviews and review of clinical records and other documentation as indicated, it was determined that four (R1, R5, R15 and R16) out of seventeen residents sampled for service agreement completion when a resident's need changed or in conjunction with each UAI, the facility failed to timely complete the service agreements. Findings include: 1. R1's clinical record revealed: 8/27/22 – According to hospital records, R1 was evaluated in the hospital after running away from the facility and was noted to be wandering on Shipley Road. R1's discharge diagnoses were Dementia, Senile with Delusions. 8/29/22 – R1 was seen and evaluated in the facility by V3 (NP) for a status post	1. R1, R5, R15, and R16 service agreements cannot be changed. 2. Nothing can be done to change services agreement dates for residents. All residents could be affected by this practice. 3. It was determined the admission personal did not utilizes the admissions check off sheet to ensure all service agreements were signed prior to admission's, The DRC was in serviced by the regional nurse consultant and the DRC in-serviced nurses, and other managers on the service plan and the required update at 30 days (not 31 days) after admission, yearly, and with a significant change in status and what a significant change in status is. Residents with a significant change in class will be discussed at the weekly "At Risk" meeting to determine if a new assessment is needed. ED or designee will monitor the discussion and audit to ensure the review is completed promptly and the service plan updated within ten days of completion of the new UAI. This audit will occur weekly times four and monthly times two. Policy and procedures have	5/16/23

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	hospitalization visit for an acute change in mental status, paranoia, hallucinations and threatening to kill herself. V3 increased R1's antipsychotic medication due to increased behaviors unrelated to the UTI treatment. The facility failed to review, revise, and execute R1's service agreement in conjunction with a significant change UAI assessment when R1's needs changed. 2. 9/27/19 - R5 was admitted to the AL. The facility failed to provide evidence of a service agreement in conjunction with the UAI completed on 5/25/21. 3. R15's clinical record revealed: 8/22/22 through 8/26/22 – R15 returned to the facility after being hospitalized for heart failure, acute kidney injury, difficulty breathing, and high blood pressure. R15 came back on multiple medications and supplemental oxygen as needed. 8/29/22 through 8/30/22 – R15 was subsequently hospitalized again and returned to the facility on hospice services. The facility failed to review, revise, and execute R15's service agreement after the two hospitalizations and admission to hospice services when R15's needs changed.	been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit 10 percent of service plans to ensure compliance with the required update at 30 days (not 31 days) after admission, yearly, and with a resident's significant change weekly times 3 weeks and then monthly till 100% compliance is achieved. Findings will be reported to the QAPI committee for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	4. 2/28/20 - R16 was admitted to the AL. The facility failed to provide evidence of an annual service agreement completed for the calendar year 2021. Interview on 12/12/22 at 3:00 PM, E2 (DRC) confirmed this information was not in evidence for these residents. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).		
3225.13.7	**The service agreement shall be based on the concepts of shared responsibility and resident choice. To participate fully in shared responsibility, residents shall be provided with clear and understandable information about the possible consequences of their decision-making. If a resident's preference or decision places the resident or others at risk or is likely to lead to adverse consequences, a managed/negotiated risk agreement section may be included in the service agreement.** This requirement was not met as evidenced by: Based on clinical and admission record reviews and interview, it was determined that for two (R2 and R15, wife/husband) out of three residents sampled for contracts review, the facility failed to include a managed/negotiated	1. R 2 no longer resides at Harbor Chase and R15 is no longer administering medications to R2.. R15 assessment has been updated to reflect current status. 2. An audit was done and no other residents were identified as needing a shared risk-agreement. All residents had the potential to be affected by this practice. 3. It was determined that the nursing staff was not trained on the process to complete a resident shared risk agreements. ED and DRC were in-service by regional director of health services on shared responsibility and resident choice. The DRC in-serviced managers on shared responsibility and resident choice to participate fully in shared responsibility, residents	5/16/23

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	risk agreement section in each of their initial service agreements. Findings include: 1. R2's clinical and admission record revealed: 5/2/22 – R2's initial UAI-based assessment was completed by E2 (DRC). 5/12/22 – R2 was evaluated by V1 (personal Physician), and he completed the facility's form entitled "Report of Resident Physical Examination." For R2, V1 documented that she was: -non-ambulatory (unable to walk) by reason of mental impairment and was not capable of self-preservation without the assistance of another person; -unable to control and administer her own medications; -not appropriate for Assisted Living; and -appropriate for Secured Memory Care. 6/2/22 – R2 was admitted to the AL, sharing a room with R15. 6/6/22 – Four days after R2 was admitted, a service agreement was completed, but it was never signed by E2 (DRC) and R2 as required. R2's service agreement documented that she was independent with mobility; under the Communication section, it stated, "Husband (R15) helps"; and under the Medications section, it stated, "(R15) to assist with medications."	shall be provided with clear and understandable information about the possible consequences of their decision-making. ED and admission staff will discuss and institute a risk agreement with anyone meeting the criteria for shared risk, and the agreement will be added to the service plan. The ED or designee will maintain a list of all at-risk contracts in the community. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The Executive Director or designee will audit all duly occupied apartment contracts and service plans to ensure the shared agreement is complete as appropriate weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	Despite V1's assessment and recommendations documented in R2's pre-admission medical certification, the facility failed to include a Managed/Negotiated Risk Agreement in R2's service agreement that address the above issues, including her safety. 2. R15's clinical and admission record revealed: 5/2/22 – R15's initial UAI-based assessment was completed by E2 (DRC). 5/12/22 – R15 was evaluated by V1 (personal physician), and he completed the facility's form entitled, "Report of Resident Physical Examination." For R15, V1 documented that he was: -ambulatory; -unable to control and administer his own medications (listed only two eye drop medications); -appropriate for Assisted Living; and -"on the borderline for secured memory care." 6/2/22 – R15 was admitted to the AL, sharing a room with R2. 6/6/22 – Four days after R15 was admitted, a service agreement was completed, but it was never signed by E2 (DRC) and R15 as required. R15's service agreement documented that he was independent with mobility; able to self-administer medications and he did not have any eye drop medications; and admitted to Assisted Living.		

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	Despite V1's assessment and recommendations documented in R15's pre-admission medical certification, the facility failed to include a Managed/Negotiated Risk Agreement in R15's service agreement that addressed the above issues, including his self-administering his medications and R2's medications and his safety. 12/6/22 - During the survey, E1 (ED) was asked if the facility had an any residents with Managed/Negotiated Risk Agreements as part of their service agreement. At the time, E1 could not recall a specific resident. No further information was received by the Surveyor. Finding was determined upon further review of R2 and R15's clinical and admission records after the exit conference on 12/12/22.		
3225.16.13	**The Director of Nursing shall have overall responsibility for the coordination, supervision, and provision of the nursing department /services.** This requirement was not met as evidenced by: Based on review of the survey outcome and multiple significant findings, it was determined that the facility's Director of Resident Care (E2) failed to ensure the coordination, supervision, and provision	1. The facility was unable to correct the deficiency. 2. All residents had the potential to be affected by this practice The regional director of health services in-serviced the DRC, nurses, and managers on Delaware Event Reporting criteria, including but not limited to elopement, time frames,	5/16/23

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	of nursing services to meet the needs of the residents. Findings include: The facility's job description for the Director of Resident Care, dated 1/2015, stated, "... Essential Functions: -Ensures delivery of nursing services to residents according to professionally recognized using practices. -Monitors nursing care for compliance with federal, state, and local regulations.... Review of the survey outcome and multiple significant findings involving nursing services included, but were not limited to: -UAIs were not completed accurately, timely and lacked evidence of residents/legal representatives signatures; -Service Agreements were not completed accurately, timely and lacked evidence of residents/legal representatives signatures; -Incidents, including falls and elopements, were not reported timely to the State Agency and some incidents lacked evidence of incident reports; and -RN reviews of residents' medication regimes were not completed at all. 12/12/22 at 4:15 PM – The above findings were individually discussed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN).	injury reporting, and death after discharge reporting. They were also in-serviced on the admission process, UAIs, Service Plans and signatures, contracts, waivers, and shared responsibilities. Incidents will be reviewed at the daily stand-up meeting to ensure that notifications occur to families, physicians, and the state promptly and within regulations 3. It was determined that the professional staff had not been trained on all event reporting procedures' regional director of health services in-serviced the DRC, nurses, and managers on Delaware Event Reporting criteria, including but not limited to elopement, time frames, injury reporting, and death after discharge reporting. They were also in-serviced on the admission process, UAIs, Service Plans and signatures, contracts, waivers, and shared responsibilities. Incidents will be reviewed at the daily stand-up meeting to ensure that notifications occur to families, physicians, and the state promptly and within regulations. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit new UAIs, Service Agreements, Incidents, and RN review of resident medications.to assure regulatory requirements weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported to the QAPI committee for review and recommendations. The frequency of the audits adjusted according to outcomes.	
3225.19.5	**Incident reports, with adequate documentation, shall be completed for**		

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

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	each incident. Records of incident reports shall be retained in facility files for the following: This requirement was not met as evidenced by: Based on interview and review of clinical records and other resources as indicated, it was determined that for two (R1 and R2) out of two residents sampled, the facility failed to ensure that incident reports were completed, included adequate documentation for each incident, and retained the reports in the facility files for R1's 8/27/22 elopement and R2's 11/1/22 fall, 11/3/22 serious, life threatening injury and subsequent death on 11/6/22. Findings include: 1. R1's clinical record revealed: 8/27/22 – According to hospital records, R1 was evaluated in the hospital after running away (eloping) from the facility and was noted to be wandering on Shipley Road. R1's discharge diagnoses were Dementia, Senile with Delusions. According to the Surveyor's staff interview, E7 (LPN) stated that they were on the Shipley Road sidewalk with R1 for approximately 2 hours and 30 minutes trying to convince R1 to return to the facility. 8/29/22 – R1 was seen and evaluated in the facility by V3 (NP) for a post hospitalization visit for an acute change in mental status, paranoia,	1. The deficiency cannot be corrected forR1 & R2.. 2. Nothing can change any admitted residents' assessment dates, signatures, or incident reporting. All residents have the potential to be affected by this practice. If an AL resident went unaccounted for, it would be considered an elopement and the procedure for a eloped resident would be followed. 3. It was determined that the elopement HCW AL residents was in conflict with Delaware's regulations. The regional director in-serviced the DRC, and the DRC in-service nurses and managers on incident reporting, state reportable incidents, what an elopement is, elopement reporting, death within five days of discharge, significant change, notifying service providers, proper processes, and time frames for documentation related to compliance with regulations. Incidents and elopements will be reviewed daily at the morning stand-up meeting to ensure reportable incidents are reported to the State Event Reporting Website within 8 hours. ED or designee to ensure discussions occur at morning	5/16/23

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	hallucinations and threatening to kill herself. V3 increased R1's antipsychotic medication due to increased behaviors unrelated to the UTI treatment. 2. R2's clinical record revealed: 11/1/22 at 2:30 PM – According to hospice records, R2 was admitted to hospice services and, in response, V1 would no longer be R2's Attending Physician. 11/1/22 at 4:30 PM – The facility's incident report documented that R15 (R2's husband) informed the nurse that R2 had a fall in her room where she slid off of her chair and landed on her buttocks. R2 could not say exactly what happened as she was very anxious. E4's (LPN) initial assessment of R2 revealed no injury. However, the facility's incident report lacked evidence of hospice notification and follow-up assessments with a specific concern that R2 was on Eliquis, an anticoagulant (blood thinning) medication. 11/1/22 at 11:25 PM – A nurse's note by E4 documented that V1 (R2's Physician) "... would be contacted and informed of fall...". R2's clinical record lacked evidence that her new hospice provider was notified of her fall for follow-up evaluation. 11/29/22 at 4:20 PM - During an interview, E4 was asked if R2 was on anticoagulant medication. E4 responded	meetings. Policy and procedures have been reviewed and changes were made only to the elopement policy to achieve regulatory compliance. 4. The ED or designee will audit 100% of incident reports to ensure the community is reporting according to the regulatory time requirements for elopement, resident death within five days of being transferred, significant change, notifying service providers, proper processes, and time frames for documentation related for compliance with regulations weekly times 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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	that she was on an aspirin. The Surveyor stated that R2 was on Eliquis, which was not documented as a concern on R2's incident report. When asked how R2's Physician was notified of her fall, E4 stated that she sent a fax to V1 about R2's fall. When asked to see the fax, E4 could not provide this documentation to the Surveyor. The Surveyor was made aware through hospice records and after E4's interview that R2 was admitted to hospice services just prior to the fall on 11/1/22. 12/12/22 at 1:00 PM – During an interview, E2 (DRC) stated that she expected licensed nursing staff to monitor residents for 3 days after a fall and document any changes. 11/3/22 at 12:54 PM – A nurse's note documented that "Care partners called for help to Room (number), nursing found resident (R2) laying on her bed on (sic) saturated urine and BM (bowel movement). Resident cleaned out (sic) and assisted putting her clothes on. This nurse called hospice (name) but no answer, nursing (sic) immediately (sic) called 911 for the ambulance for resident to go out for further evaluation since resident wasn't on (sic) her baseline. Resident was very weak, unable to talk, very lethargic and her BP (blood pressure) would not read. Paramedics came in and resident transferred to (name) hospital. Tried calling (name) hospice and went		

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	through talked to triage nurse. POA… was called and made aware…". 11/3/22 at 5:56 PM – A nurse's note documented that the hospital was called for an update. R2 was admitted with a "large subdural hematoma… non-responsive… on comfort measures." 11/6/22 at 7:04 PM – A nurse's note documented that R2 passed away at 2:30 PM today, which was three days after she was transferred to the hospital. 11/29/22 – The Surveyor asked for all incident reports involving R2. For the 11/3/22 incident, E2 (DRC) only provided the Surveyor with a copy of two pages of handwritten phone interviews of staff working on the two prior shifts (evening and night) and an interview with R15 (R2's husband). The facility failed to complete an incident report with complete documentation. The facility failed to complete an incident report with adequate documentation of R2's death within five (5) days of transfer to an acute care facility. 12/12/22 at 4:15 PM – Findings were reviewed during the Exit Conference with E1 (ED), E2, and E14 (Division RN).		
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**		

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	reporting shall be as directed by the Division.		
3225.19.7	**Reportable incidents include:** **These requirements were not met as evidenced by:**		
3225.19.7.5	**Resident elopement.**	1. Nothing can change the assessment dates, signatures, or incident reporting for R1,R2, R3, R4, R5, R6, R7, R12. Management team were in-service immediately on reportable events, signatures, assessment dates, and elopement criteria for the state of Delaware and reporting criteria. All residents have the potential to be affected by this practice. Nothing can change any admitted residents' assessment dates, signatures, or incident reporting.	5/16/23
3225.19.7.5.2	**Any circumstance in which a cognitively impaired resident, whose whereabouts are unknown to staff, exits the facility.**		
3225.19.7.5.3	**Any circumstance in which a resident cannot be found inside or outside a facility and the police are summoned.**		
3225.19.7.6	**Death of a resident in a facility or within 5 days of transfer to an acute care facility.**	2. All residents have the potential to be affected by this practice. Nothing can change any admitted residents' assessment dates, signatures, or incident reporting. All residents have the potential to be affected by this practice.	
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 reassessment of the resident's clinical status by facility professional staff for up to 48 hours.**	3. It was determined that the policy for elopements was in conflict with Delaware regulations. DRC, nurses, and managers were in-serviced meetings by regional nurse consultant or DRC.on incident reporting, state reportable incidents, what an elopement is, elopement reporting, death within five days of discharge, significant change, notifying service providers, proper processes, and time frames for documentation re-	
3225.19.7.7.10	**Serious unusual and/or life-threatening injury.** These requirements were not met as evidenced by: Based on interviews and reviews of clinical records and the State Agency's Incident Reporting System, it was determined that for eight (R1, R2, R3, R4, R5, R6, R7 and R12) out of		

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	seventeen residents reviewed, the facility failed to report three elopements, multiple residents' falls with injury requiring transfer to an acute care facility or requiring periodic reassessment for up to 48 hours, a serious and life-threatening injury, and death within 5 days of transfer to an acute care facility to the State Agency within 8 hours as required. Findings include: 1a. R1's clinical record revealed: 8/27/22 – R1 was reported to be walking alone in the bike lane on Shipley Road towards Silverside Road and away from the facility. R1 refused to return to the facility when staff caught up to her. R1 was transferred to the hospital for evaluation before returning to the facility. The facility failed to report R1's 8/27/22 elopement to the State Agency. 1b. R1's clinical record and facility surveillance video revealed: 11/9/22 through 11/10/22 – At 8:23 PM, R1 left the facility through an unalarmed fire exit door without staff knowledge wearing pajamas, a robe, and slippers. R1 was found the next morning at approximately 7:30 AM wandering the halls by a Church staff member. The Church is over 1 mile away from the facility. The Police responded along with facility staff to the Church.	lated to compliance with regulations. Incidents and elopements will be reviewed daily at the morning stand-up meeting to ensure reportable incidents are reported to the State Event Reporting Website within 8 hours. ED or designee to ensure discussions occur at morning meeting. Policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. 4. The ED or designee will audit 100% of incident reports to ensure the community is reporting according to regulatory compliance for incident reporting, state reportable incidents, what an elopement is, elopement reporting, death within five days of discharge, significant change, notifying service providers, proper processes, and time frames for documentation weekly time 3 then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations.	

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	R1 refused to return to the facility with nursing staff. R1 was then transported to the Emergency Room for evaluation before returning to the facility. 11/18/22 at 4:44 PM – Eight days later, the facility reported R1's elopement only after the State Agency contacted the facility directly to inquire about R1's elopement after receiving an anonymous complaint. 2. R2's clinical record and hospital documentation revealed: 11/3/22 at 8:05 AM – R2 was emergently transferred to the hospital after being found in bed incontinent and unresponsive. R2 had a fall on 11/1/22 on the 3-11 PM shift and had no visible injury. 11/3/22 at 5:56 PM – A nurse's note documented a hospital update that R2 was admitted with a large subdural hematoma, unresponsive and on comfort measures. The facility failed to report R2's serious and life-threatening injury to the State Agency within 8 hours as required. 11/6/22 at 2:20 PM – Three days later, R2 was pronounced in the hospital. The facility failed to report R2's death within 5 days of transfer to an acute care facility to the State Agency within 8 hours as required.		

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

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	3. 9/29/20 - R3 was admitted to AL COVE (Memory Care) with Dementia. On 11/17/22, the resident sustained a fall and was transferred to the ER for evaluation. This reportable fall was not reported to the Division. The resident experienced multiple and frequent falls. Facility staff failed to document that the periodic reassessments of the resident's clinical status were completed after the 9/13/22, 9/14/22, 10/1/22, 11/3/22, and 11/17/22 falls when the resident returned to the facility and to make changes in the care plan for resident safety. 4. 2/28/20 - R4 was admitted to the AL. The resident experienced multiple and frequent falls. Facility staff failed to document that the periodic reassessments of the resident's clinical status were completed after the 6/20/21, 6/23/21, 8/10/21 and 8/13/21 falls when the resident returned to the facility and to make changes in the care plan for resident safety. 5. 9/27/19 - R5 was admitted to the AL. R5 sustained a fall on 12/23/19, was evaluated and treated in the Emergency Room for a hand laceration. This reportable fall was not reported to the Division. The resident experienced multiple falls. Facility staff failed to document that the periodic reassessments of the resident's clinical status were completed after the 12/23/19, 3/24/21, 6/16/21 and 7/6/21 falls when the resident returned to the		

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	facility and to make changes in the care plan for resident safety. 6a. 7/24/19 - R6 was admitted to AL and moved into the COVE (Memory Care) with a diagnosis of Dementia on 4/19/21. Per the resident record, R6 was exhibiting aggressive behaviors towards other residents and staff. Staff later found the resident trying to get in from outside of the facility through the Bistro doors. R6 was assisted back into the facility; the DRC, the Physician and the family were notified per employee notation. R6 appeared without injury. This elopement was not reported to the Division. Per interview on 12/12/22 at 3:35 PM, E1 (ED) stated that residents either learn the code to exit memory care or they closely follow out the COVEs opened door when someone enters or exits. E1 stated staff should be attentive to this possibility. 6b. 7/24/19 - R6 sustained falls on 7/28/20 and 7/21/21 resulting in a transfer to the Emergency Room for evaluation. These two reportable falls were not reported to the Division. R6 experienced multiple falls. Facility staff failed to document that the periodic reassessments of the resident's clinical status were completed after the 6/19/21, 7/21/21 and 78/28/21 falls when the resident returned to the facility and to make changes in the care plan for resident safety.		

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	7. 5/29/19 - R7 was admitted to the COVE (Memory Care) with a diagnosis of Dementia. The resident sustained falls on 8/8/19, 9/23/19, 11/27/19, 6/5/20, 6/12/20, 8/1/20, 2/24/21 and 3/12/21 resulting in transfers to the Emergency Room for evaluation. These reportable falls were not reported to the Division. The resident experienced multiple and frequent falls. Facility staff failed to document that the periodic reassessments of the resident's clinical status were completed after the 8/8/19, 9/23/19, 11/27/19, 6/5/20, 6/12/20, 8/1/20, 1/21/21, 2/2/21, 2/17/21, 2/24/21, 3/12/21 and 3/30/21 falls when the resident returned to the facility and to make changes in the care plan for resident safety. 8. 12/19/19 - R12 was admitted to the AL and sustained a fall on 5/26/21 resulting in a transfer to the Emergency Room for evaluation. The facility staff failed to document that the periodic reassessments of the resident's clinical status were completed after the 5/6/21 fall when the resident returned to the facility and to make changes in the care plan for resident safety. Per interview on 12/12/22 at 3:45 PM, E2 (DRC) was unclear why these reportable falls were not reported to the State Agency. E2 confirmed the documentation by staff was not always completed.		

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	12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN).		
16 Delaware Code, Chapter 11, Subchap-ter, III	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents.** **(81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)** **(12) "Neglect" means the failure to provide good and services necessary to avoid physical, harm, mental anguish, or mental illness. Neglect includes all of the following: a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** This requirement was not met as evidenced by: Based on interviews and review of the clinical records, facility documentation and other resources as indicated, it was determined that nine (R1, R3, R4, R5, R6, R7, R8, R10 and R12) out of seventeen sampled residents experienced neglect while residing in the facility. The neglect included a lack of attention to the physical needs of the residents, including safety. Findings include: The facility policy on falls, undated, directed staff to "After a fall, review the situation and determine if emergency services are needed. Observe the resident for signs of injury and check	1. a) R1 resides in the community and currently lives in the secure part of the community. b) Nothing can be done related to falls for R3, R4,R5, R6, R7 R8,,R10,R12. c) Nothing can be done to correct the MARs for following resi-dent's.R12,R3, R4, R8, R10, R1. 2. All residents have the potential to be affected by this practices. A) The policy and procedures for missing residents was reviewed with HRA re-gional resident care director with DRC and NHA. It was clarified these events are reportable. B) The DRC will be reviewing all falls at the resi-dent At Risk meeting weekly to dis-cuss interventions. C) Supervising LPN will monitor medication admin-istration records randomly daily to ensure accuracy. 3. A) and B): It was determined that the HRA policy for a resident missing was in conflict was Delaware code. The director of resident care or de-signee will in-service all professional nursing staff on the requirements for reporting missing residents per state	5/16/23

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	the following: vital signs, consciousness, evidence of injury, body parts obviously out of proper position/alignment, broken skin, swelling, pain, inability to move, bleeding, open wounds. Provide immediate first aid and calm the resident. Immobilize the resident if injury noted; otherwise assist to bed or chair. Notify physician and if needed emergency services. Notify the residents family and or legal representative. Document the fall in the resident's record. Communicate any resident care changes." The facility's Assisted Living Levels of Care (I-IV) brochure documented that: Level of Care I: (included but not limited to) -Routine night check (once per evening). 1. R1's admission and clinical record revealed: 1/11/22 to 1/13/22 – The facility received an email inquiry from an outside referral agency for a private female bed in memory care. Emails were going back and forth between E16 (DoS) and the outside agency about availability, cost, and setting up a tour of the facility. E16 stated they had a private memory care bed available. The outside party provided E16 with R1's name and arranged a tour with R1's other family members, not F2 (R1's POA).	regulations. In addition each resident that requires to be sent out for assessment related to falls will be reported to DHSS within the eight hours required time frame. The DRC or designee will monitor the effected resident for 48hours and document accordingly. Policy and procedures have been reviewed for elopements. The policy and procedures for missing residents have been revised to coincide with Delaware regulations in that if resident leaves the community and the community is unaware of the resident's location the resident is considered an elopement and must be reported to DHCO within 8hours. Fall policy and procedures have been reviewed and no changes were necessary to achieve regulatory compliance. C) Nurses and Med Tech have been in serviced on proper documentation of medications administered, missed, held, or PRN medications, and on residents who use an insulin pen for self-administration of insulin dose after it is checked by the nurse. An audit will be conducted daily by DRC or designee for improper medication documentation and correction.in-servicing daily x 1 week and then twice a week x 1 month until 100% compliance is achieved. Any person assisting a resident with medication administration will have the self-administration of medication assessment completed as outline in self-administration policy within 30-days of admission. 4. The Executive Director or designee will audit current residents incident reports related to elope-	

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	On the last email, dated 1/13/22, the following information was handwritten by E16 (DoS): Names of R1's family members ... "dementia, went to (name of a locked dementia facility located nearby), some days good, worse at night, paranoia, ind w/ ADLs (independent with activities of daily living), currently at (name) independent living facility, wanders, needs med mgmt (medication management) ...". 2/4/22 – The facility received the Physician medical certification. The physician checked that R1 was appropriate for Assisted Living; unable to control and administer her own medications; and was prescribed Seroquel, an antipsychotic medication for a diagnosis of Dementia and Zoloft, a medication used for Anxiety. It was unclear in the Physician medical certification as to what specific behaviors were being treated with Seroquel. R1's Physician documented that the last physical exam of R1 was on 1/10/22, which exceeded the State requirement of 30 days prior to her planned admission on 2/17/22. 2/14/22 – The initial UAI was completed by E2 (DRC). The UAI documented that the source of information obtained was by R1 and family. R1 was independent for all ADLs, but required assistance with medication management and supervision for emergency response (fire, evacuation). Under the sleep patterns section, R1 was noted to be	ment, falls, and medication administration for compliance weekly times 3 weeks then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits adjusted according to outcomes.	

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STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington **DATE SURVEY COMPLETED: December 12, 2022**

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	both a sound sleeper and has difficulty sleeping at night. There was no further information documented about R1's sleep patterns despite the contradiction. There was no answer to the question if the resident was agitated at night. In addition, night checks were changed from yes to no. Under the Psychological section, R1 was documented as having problems making herself understood and she had no history of wandering. R1 was prescribed an antipsychotic medication, Seroquel, for Dementia. There was no further information in the UAI that specified the behaviors that were being treated with the use of Seroquel. This assessment was never signed by F2 (R1's POA) as required. Despite the information collected by E16 (DofS) during the pre-admission process that R1 had a history of paranoia, wandering, and good during the day/worse at night, this information was not addressed in R1's initial UAI assessment. 2/21/22 at 1:00 PM – R1 was admitted to the facility's Assisted Living side in a private room and not in the COVE (Memory Care Unit). 2/21/22 – R1's service agreement was completed by E2 (DRC). The service agreement documented that R1: -was not receiving a night check and was a sound sleeper; -had no behaviors and no wandering.		

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	The service plan lacked evidence of addressing that R1 had difficulty sleeping at night; specific behaviors that were being treated with the use of antipsychotic medication; and E16's (DoS) knowledge during the pre-admission process of R1's history of wandering, paranoia and good during day/worse at night and R1's history of being in a locked Dementia facility as documented on her COVID vaccination card. 2/23/22 – R1 was seen by V3 (NP) as a new patient to the practice. R1 was tearful and expressed transitional issues related to the move. V3 recommended behavioral health and R1 declined the intervention stating that the Zoloft medication was enough for now. Under the assessment and plan, V3 documented: -R1 will remain on Zoloft for anxiety and will require ongoing reassessment due to transition to the facility. -Under Dementia, "Staff reports the patient having experienced previous hallucinations and will continue to require Seroquel for management for now. Pt (patient) does not have any behaviors or hallucinations currently." 6/20/22 – V3 (NP) evaluated and documented that R1 had a depressed mood and continued Seroquel for management of symptoms; R1 denied being homicidal/suicidal at time of the visit; and V3 recommended completion of PHQ9 (Mini mental status		

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	examination) at the next visit. Follow up in one month. R1's clinical record lacked evidence of a physician/NP follow-up visit in one month. 8/2/22 at 2:43 PM – A nurse's note documented that R1 went on a leave of absence from the facility with family. R1 returned to the facility on 8/20/22. 8/27/22 – A Late Entry nurse's note written seven days later on 9/3/22 at 7:42 PM documented, "Resident decided she wanted to go outside for a walk today. It was noticed by another resident that she was off the premise's and seen walking down Shipley Rd. (road) heading to Silverside Rd. Per (other) resident she (R1) was not walking on the sidewalk, she was walking in the bike lane. Staff immediately went to get (sic) resident. When care partners arrived to walk her back (R1) stated that she was not going back there. Nurse was called to see if she could talk (R1) into going back. This nurse tried to talk to resident. She was very calm and cooperative. Asked her where she was going and she said, 'to Concord Pike.' She was asked where on Concord Pike she was going and she did not know. Asked her if she knew how to get back to Harbor Chase and she said that she would use landmarks to find the building. As soon as it was mentioned to get in the car and she would be driven back she refused to go		

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	back. This nurse tried to get her into the car, and she refused. When asked why she didn't want to go back she stated that her things were being stolen (Dentures, Clothes and her daughter's ashes). As this nurse and staff tried talking to the resident, the residence we were in front of came out of the house yelling for us to stop yelling at her. It was explained to the women the (sic) we were from where she lives and that I was her nurse taking care of her. The woman became more disruptive, and this nurse called the police for assistance. The DRC (E2) was called and informed of the situation. This nurse was able to obtain (R1) son's phone number and the Police Officer arrived shortly after and tried speaking to the resident and she explained what she was doing that she was not going back. (Name) Ambulance was driving by and stopped to see if all was okay and the officer asked them to stay because she needed to go to the hospital. Resident was cooperative and asked if she would get in the ambulance to (sic) they could get her vital signs to make sure she was okay. She stepped onto the first step looked inside the ambulance and backed out and said that she wasn't going in there and if this is how her life is going to be she was going to kill herself. Eventually resident did get in the ambulance and was taken to (Name) ER for further assessment. Resident returned early morning of the next day. On the Monday after V3 (NP) was looking at her records in DNH		

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	(DHIN) and it was that resident was positive for a UTI (urinary tract infection). In the hospital paperwork that she came back with stated she was negative for a UTI. Orders were received from V3 (NP) to start Keflex (antibiotic) … for 7 days." 8/27/22 at 4:04 PM – The Prehospital Care Report by the Paramedics documented the ambulance was enroute to another facility but was flagged down by a Police Officer. "Upon arrival the patient was found standing on the sidewalk with a … officer and several … nurses… When asked what happened the patient stated she was going for a walk. The … staff endorsed this and stated that the patient had wandered off and now did not want to go home. The patient endorsed fear towards going back to…. She stated that several of her things were missing, and that someone was trying to hurt her. The staff endorsed a history of Dementia. The patient was able to respond appropriately to the crew's questions, however, was obviously demented as demonstrated through distracted thinking and repetitive questioning. Eventually everyone was able to convince the patient to go to the hospital… En route the patient was continuously reassessed for changes in condition. Due to her mental state and increased distress when asked, vital signs were unable to be obtained…".		

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	8/27/22 at 4:32 PM – R1 arrived at the Emergency Room (ER). The hospital record documented, "… PMH (past medical history) of dementia … anxiety… who presents after she escaped from Harbor Chase. She ran out of Harbor Chase today, the staff chased her down and brought her with the paramedics. She reportedly has a history of paranoid dementia, when they caught her, she said the staff there were going to hurt her and she no longer wants to live. She tells me that she is afraid to go back and wants to be locked up to protect herself. Staff from Harbor Chase reported she is at her baseline… and has had progressive paranoia recently… also has a history of sundowning (period of heightened confusion and agitation that occurs in dementia residents around sunset) … alert and oriented x (times) 2 not to date … Assessment and Plan: …presenting after she made suicidal (sic) after run (sic) away from Harbor Chase… Doubt infectious etiology, urinalysis reviewed by me unremarkable with contaminant. She also has no symptoms from this. As she is at her baseline mental status and has a history of paranoid dementia, we will discharge her back. Final Impression/Disposition: Dementia, senile with delusions." An ED nurse documented at 12:39 AM on 8/28/22 that "(R1) concerned about going back to nursing home. Sitter at bedside." 8/27/22 at 4:54 PM – The responding Police Officer completed a State of		

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	Delaware Division of Substance Abuse and Mental Health form entitled "Request for 24-Hour Emergency Detention of an Adult." The State form defined "Dangerous to self" to mean that by reason of mental condition there is a substantial likelihood that the person will imminently sustain serious bodily harm to oneself. This determination shall take into account a person's history, recent behavior, and any recent act or threat. The Police Officer documented that R1 met the requirement for dangerousness to self and "(R1) is a resident at Harbor Chase nursing home. Today, she left/walked out of Harbor Chase without notifying staff and was found wandering on Shipley Rd (Road). (R1) refused to respond back to the nursing home and then made statements that she was going to kill herself. (R1) reportedly suffers from dementia and other mental health illness." 8/28/22 at 5:12 AM – A nurse's note documented that R1 returned to the facility at 3:30 AM from the hospital ED and "... When the transport guys were leaving, they reported that resident was making some off statements. She begged them not to bring her back to this facility, because the staff was trying to kill her. They were concern (sic) that the hospital sent someone is (sic) this condition back to the facility. The report from the hospital was that resident was negative for UTI, and she showed no suicidal behaviors. Resident is in her		

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	room and staff is monitoring her for behaviors." 8/29/22 – R1 was seen by V3 (NP) for a follow-up ED visit for "acute change in mental status and threatening to kill herself as reported by the staff… We are asked to see the patient for new reports of paranoia and hallucinations being reported by the staff… Staff reports new behaviors to include paranoia, hallucinations and the patient is convinced that the 'staff are out to get me and trying to poison me.' Pt alleges that someone stole her clothing, stole her daughter's ashes, and alleges that she cannot eat the food because someone is trying to poison her. Pt (patient) is anxious, requires constant redirection with prompting constantly. Pt has returned to HarborChase from being out with family for the last week and stayed at her sister's home. Pt has now returned and having paranoia and anxiety. Staff reports that the patient was threatening to end her life on Sunday, 8/28, and was sent to the ED for further evaluation and was released back to HC (HarborChase) without any new medications. Pt was not considered a candidate for psychiatric admission to (two names of local psychiatric facilities). Pt was evaluated for UTI on 8/27 and culture came back on 8/29 with greater than 100,000 colony count … and started on oral abx (antibiotic) for management of symptoms. Pt complaint of urinary frequency and urgency without painful urination…		

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	Physical Exam... Psychiatric: Behavior paranoid – Thought Content: inappropriate at times and paranoid... Assessment and Plan... Will consult psychiatry for further evaluation... Pt with depressed mood and continues on (Seroquel) for management of symptoms and patient denies being homicidal suicidal at time of visit. Will increase (Seroquel) for management of new behaviors of paranoia and hallucination... Physician Orders: Seroquel x 1 NOW for behaviors; Increase Seroquel to 50 mg (milligrams) by mouth TID (three times a day) for mood disorder; Start (Keflex) ... for 7 days for UTI (urinary tract infection); Follow up in one month." The facility failed to recognize and complete a significant change UAI assessment after R1's 8/27/22 elopement from the facility, hospital visit and continued paranoid behaviors. R1's service agreement was never reviewed and updated to meet R1's needs, especially with regard to her safety. R1 remained in the same room in Assisted Living and no further interventions were implemented besides increasing her antipsychotic medication. V3 (NP) was consulting with a psychiatric doctor by phone. There was no evidence that R1 was seen by the psychiatric doctor. 9/26/22 – R1 was seen by V3 (NP) for acute visit for "follow up per staff request for increased paranoia with		

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	increased confusion and states she believes 'everyone is out to get me'… (R1) continues to remain fearful… Assessment and Plan… Continues to be followed by psychiatry for symptoms of paranoia and increased confusion… presents today with increased behaviors including paranoia and anxiety… Physician Orders: follow up with psychiatry for further recommendations if paranoia continues despite treatment for UTI. Follow up in one month and prn (as needed)." There was no evidence in the clinical record that psychiatry had seen and evaluated R1. 10/5/22 – R1 was seen by V4 (Physician) for "paranoia… (checked) the patient has severe cognitive impairment and cannot care for themselves… Paranoid delusions regarding people stealing from her. D/W (discussed with) (R1's POA) has been ongoing for 18 months approximately… MMSE (Mini-Mental State Examination) 24/30… Assessment and Plan… Dementia c (with) paranoia – will increase Seroquel to 75mg TID (three times a day) and re-assess in 1 month." The facility failed to complete a significant change UAI assessment and revise her service agreement to address R1's safety needs. 10/12/22 at 4:15 PM – A nurse's note documented that V3 (NP) was made aware that over the weekend R1 refused her afternoon Seroquel.		

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	10/12/22 – R1 was seen by V3 (NP) for an "acute visit for onset of paranoid and delusional thoughts and behaviors. Staff reporting that the patient is refusing medications, refusing mealtimes (at times), and refusing care for fear that 'they are trying to poison me'… Pt (Patient) remains independently ambulatory. Pt with recent episodes as reported by staff to have crying spells, refusing of medications, refusing care and paranoid that the staff and others are trying to poison her… Staff reports new behaviors to include paranoia, hallucinations … Pt refused to have bloodwork drawn today and does not wish to have it done. Pt is anxious, requires constant redirection with prompting constantly… Assessment and Plan… Anxiety disorder… Will increase (Zoloft) from 50mg to 100mg by mouth once daily in the am and discussed this case with V4 (Physician) today… Pt denies being homicidal or suicidal during visit today. Continues to be followed by psychiatry for symptoms of paranoia and increased confusion… presents today with increased behaviors including paranoia and anxiety… Follow up in one month and prn." The clinical record lacked evidence that R1 was being seen and followed by psychiatry. The facility failed to complete a significant change UAI assessment and revise her service agreement to address R1's safety needs.		

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	11/9/22 at 8:32 PM – R1 was recorded on the facility surveillance video outside of the unalarmed Bistro fire exit doors wearing her pajamas, robe and socks and slippers walking in the dark across the grass toward the side parking lot where there were two pathways. The inside pathway goes around the inside perimeter of the facility grounds. The outside pathway extends outside of the facility grounds starting from Shipley Road past the community pool and ends at Alders Drive, a neighborhood street, which is directly behind the facility. 11/9/22 - Review of the historical weather forecast overnight revealed that around the time R1 was walking outside of the facility it was approximately 47 degrees Fahrenheit. Overnight, the temperature dropped to 40 degrees Fahrenheit. 11/9/22 at 9:20 PM – Almost one hour later, R1 was captured on a surveillance video attempting to open a locked door to a Church. R1 was captured entering the Church through an unlocked door. The Church's surveillance videos for over 10 hours captured R1 drinking a beverage, turning on lights, wandering the hallways, pacing back and forth from an inside door to the outside exit door then looking out the window towards the strip mall and parking lot. R1 was observed readjusting her robe numerous times throughout the night to keep it closed and attempted to cover her head at one point without success.		

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	R1 found, carried, and placed a chair next to the outside exit door and sat down for approximately 15 minutes. Then she moved the chair again to around the corner and never used it again. R1 continued to pace back and forth from the inside door to the outside exit door looking outside, readjusting her robe until 7:30 AM when a staff member entered the Church. Surveillance video captured the staff member checking the outside exit door, which was found partially open and likely exposed R1 to the outside temperature overnight. 11/10/22 at 9:21 AM – The hospital record documented, "...history of dementia, senile with delusions... and sundowning presents after being found wandering in church... Discussed case with patient's (family member, F1). He states the patient has been found wandering in the past... patient has had increased paranoia...Urinalysis sent... Will cover... with Keflex (antibiotic)...". The final urine culture report was negative for a UTI. 11/10/22 at 5:10 PM – A nurse's note documented, "Resident left facility early this morning in her pajamas, robe, and slippers. Facility received phone call from the State Police that resident was found at a local church on Rte. 202. Someone from the church called 911. Nurse and care partner went to the church to get resident to come back and she declined. Son was called to inform		

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	him of the situation. A number was given to him to call the nurse that was with (R1) at the present time. Nurse with resident was having difficult time with resident trying to get her to go with them. Having Paranoid suspicious behavior. It was then decided to send resident to the ER for further assessment and (F1) was notified and will meet her there. Resident returned around 2:30 PM with (F1) from the ER. UA was performed ... Resident prescribed (antibiotic) for 5 days... V3 (NP) notified that resident was back at facility." Despite knowing that R1 was found in a Church on Route 202 and that State Police were summoned, the facility failed again to immediately report R1's second elopement from the facility and her transfer/evaluation at the ED. Facility staff were not aware at t this time that R1 left the facility the evening before at 8:23 PM on 11/8/22 and was out of the building without their knowledge for over 11 hours. The overnight elopement for 11 hours had the potential for significant harm to R1, an ambulatory resident with paranoid Dementia. 11/12/22 at 8:53 AM – A nurse's note documented that "...This morning, staff reported that resident was up at the front door looking out the doors. Care partner asked resident if she needed anything and (R1) stated that she was		

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	just looking out the door then walked away…". 11/14/22 – R1 was seen by V3 (NP) for an acute visit for delusional behavior, elopement risk and paranoid behaviors per staff and family request… Pt (Patient) recently eloped from (the facility) and this is her second elopement within the last 90 days. Pt expressing not feeling 'safe here' today and as reported by the staff… We are asked to see this patient related to elopement and increased mood disorder with paranoid delusional behavior with UA negative… Pt seen and examined at the bedside today. Pt is tearful during visit and states 'I am not safe here.' She reports that they are out to get her, and she is refusing medications at times for fear they are trying to poison her. Again today states 'they are trying to get rid of me here because they took my teeth and my clothes.' Patient believes that someone stole her daughter's ashes and stole her cell phone. Placed a call to Psychiatry (name) who is involved in her care and he recommends placement at (name) for further evaluation by psychiatry… Pt… took her meds this morning with some difficulty stating they are trying to poison her with the medications. Pt is tearful during visit stating she is not welcome here at the facility and they are all out to get her. Pt is not homicidal or suicidal during visit. Pt states she is 'not safe to stay here'… Pt is not redirectable at times. Reviewed		

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	medications with the patient x 2 and patient still believes that it is too much medication and she does not need any of it... Discussed plan of care with F2 (R1's POA), E2 (DRC) and the nursing staff. Placed a call to (name of local psych facility) for admission... Psychiatric: Behavior: abnormal, paranoid delusions, anxious – Thought Content: inappropriate... Assessment and Plan...Mood Disorder: Pt on Seroquel without symptom relief. Pt is paranoid delusions and states 'I am not safe here and I cannot stay here.' Pt eloped and refused to return to facility... Pt is not in a locked unit and will require further psychiatric evaluation asap. Discussed with psychiatry and placed a call to V4 (Physician) to discuss plan for referral for psych admission." 11/17/22 – An anonymous outside complaint was filed with the State Agency's Abuse/Neglect reporting system that R1 recently eloped from the facility and was found in a Church on Route 202, a multi-lane highway. 11/18/22 at 1:19 PM - Upon receipt of this outside complaint, S1 (State Agency Triage Nurse) called the facility for more information about R1's elopement and asked what interventions they implemented after her 11/9/22 elopement to ensure R1's safety and prevent her from eloping again. It was noted that after S1 contacted the facility about R1's elopement, the facility self-reported the incident to the State		

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	Agency, well beyond the required reporting timeframe. In addition, the State Agency was not aware of R1's first elopement on 8/27/22 at this time as it was not reported to the State Agency. On 11/19/22, the facility finally completed a significant change UAI assessment along with a revised Service Agreement, with interventions implemented to ensure R1's safety as she was still located in Assisted Living and not in the Memory Care unit. 12/6/22 at 1:00 PM - During an interview, E16 (DofS) stated that R1's family member (F1), not the POA, and V2, an outside referral agent, stated they were comfortable with R1 being in Assisted Living since the room they picked was close to the nurse's station and the front door was locked at night. Although E16 stated that she was clear with families that if their loved one wanders, Assisted Living was not appropriate. It was unclear if R1's family member and V2 clearly understood that the facility's ten (10) fire exit doors on the first floor in Assisted Living were not locked from the inside, nor were they alarmed at night. When asked by the Surveyor who collects the COVID vaccination card, E16 stated that she received a copy of R1's COVID card on 2/8/22 from F1 (family member). The Surveyor showed her a copy of R1's COVID card from the year 2021 and asked if she was familiar with the facility listed. E16 said yes, it was a locked		

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	dementia facility. The Surveyor showed a copy of an email dated 1/13/22 with handwritten comments about R1's wandering, paranoia and good during day/worse at night. E16 confirmed that was her handwriting. Despite the facility being aware during the pre-admission process that R1 wandered, became paranoid and was worse at night, R1's initial UAI assessment and service agreement failed to address her safety needs. The facility's ten fire exit doors are not permitted to be locked from the inside per the State of Delaware's Fire Code. R1 was admitted to the facility's Assisted Living. R1's behaviors of paranoia and delusions increased, and she eloped twice, once during the afternoon walking in the bike lane of a busy road and the second was overnight for over 11 hours in a Church (over one mile away) located on Route 202, a busy multi-lane highway. Each elopement, R1 refused to return to the facility with nursing staff despite encouragement by the responding Police Officers and instead was transported to the Emergency Room each time for evaluation. R1 had the potential for significant injury and/or harm during the two elopements from the facility. 12/12/22 at 4:15 PM – Findings were reviewed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN). E14 asked E1 and E2 where R1 was currently located in the facility after the		

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	Surveyor reviewed R1's two elopements. E1 stated that she was relocated to the COVE (Memory Care Unit) on 12/3/22 with a physician's order to attend supervised activities during the day in Assisted Living. 2. 9/29/20 - R3 was admitted to the AL COVE (Memory Care Unit) with a diagnosis of dementia. On 11/17/22 the resident sustained a fall and was transferred to the ER for evaluation. This reportable fall was not reported by the facility to the Division. The resident experienced multiple and frequent falls. Facility staff failed to document that periodic reassessments of the resident's clinical status were completed after the 9/13/22, 9/14/22, 10/1/22, 11/3/22, and 11/17/22 falls when the resident returned to the facility. Per documentation, other falls sustained by R3 were on 9/5/22, 9/29/22, multiple falls on 9/30/22, 10/4/22, 10/6/22, multiple falls on 10/7/22, 10/13/22, 10/28/22, 10/31/22, 11/7/22 and 11/8/22. The facility failed to provide evidence of periodic reassessments of the resident's clinical status or changes in the care for R3's safety. Documentation indicated R3 was non-compliant and difficult to redirect after the 9/30/22 and the 10/13/22 falls. 3. 2/28/20 - R4 was admitted to AL with a diagnosis of high blood pressure. The resident experienced multiple and frequent falls. Facility staff failed to document that periodic reassessments		

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	of the resident's clinical status were completed after the 6/20/21, 6/23/21, 8/10/21 and 8/13/21 falls when the resident returned to the facility. Per documentation, other falls sustained by the resident were on 9/14/21 and 10/31/21. The facility failed to provide evidence of periodic reassessments of the resident's clinical status or changes in the care for R3's safety. 4. 9/27/19 - R5 was admitted to AL with a diagnosis of Atrial Fibrillation (irregular heart rhythm). R5 was relocated to the memory care unit on 2/3/20 due to Dementia. R5 sustained a fall on 12/23/19 and was evaluated and treated in the Emergency Room (ER) for a hand laceration. The Hospital record reported treatment was provided for a subdural hematoma and a hand laceration. This reportable fall was not reported to the Division. The resident experienced multiple falls. Facility staff failed to document periodic reassessments of the resident's clinical status were completed after the 12/23/19, 3/24/21, 6/16/21 and 7/6/21 falls when the resident returned to the facility. Per documentation, other falls sustained by the resident were on 10/26/20, 11/26/20, 5/25/21 and 7/5/21. The facility failed to provide evidence of periodic reassessments of the resident's clinical status or changes in the care for R5's safety. The physician noted on 11/3/20 to continue with strict fall precautions, however the record		

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	doesn't indicate what precautions were established. 5. 7/24/19 - R6 was admitted to AL and moved into the COVE (Memory Care) on 4/19/21 with a diagnosis of Dementia with progressive deterioration and a change in behaviors (wandering, aggression). The resident sustained falls on 7/28/20 and 7/21/21 resulting in transfers to the ER for evaluation. These two reportable falls were not reported to the Division. The resident experienced multiple falls. Facility staff failed to document that periodic reassessments of the resident's clinical status were completed after the 6/19/21, 7/21/21 and 78/28/21 falls when the resident returned to the facility. Per documentation, another fall not resulting in an Emergency Room evaluation was on 7/13/20. The facility failed to provide consistent evidence of periodic reassessments of the resident's clinical status or changes in the care for the resident's safety. The physician noted on 7/29/20 to place the resident on fall precautions, however the record does not indicate what precautions were established. 6. 5/29/19 - R7 was admitted to the COVE (Memory Care) with a diagnosis of dementia. The resident sustained falls on 8/8/19, 9/23/19, 11/27/19, 6/5/20, 6/12/20, 8/1/20, 2/24/21 and 3/12/21 resulting in a transfer to the ER for evaluation. These reportable falls were		

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	not reported to the Division. The resident experienced multiple and frequent falls. Facility staff failed to document that periodic reassessments of the resident's clinical status were completed after the 8/8/19, 9/23/19, 11/27/19, 6/5/20, 6/12/20, 8/1/20, 1/21/21, 2/2/21, 2/17/21, 2/24/21, 3/12/21 and 3/30/21 falls when the resident returned to the facility. Per documentation, other falls not resulting in an ER evaluation, sustained by the resident were on 8/25/19, 12/13/19, 12/19/19, 12/27/19, 3/30/20, 4/24/20, 1/6/21, 1/8/21, 1/15/21, 1/23/21, 1/24/21, 2/15/21, 2/22/21, 3/1/21, and 3/14/21. The facility failed to provide evidence of periodic reassessments of the resident's clinical status or changes in the care for the R7's safety. Documentation by staff indicated "resident moves fast", "ambulates with walker without difficulty", and on 3/1/21 to "continue to monitor for safety." An evaluation by physical therapy in March of 2021 indicated R7 required supervision and a rolling walker for gait and transfers, however, the record does not indicate this supervision was provided. 7. 12/30/19 - R8 was admitted to AL with a diagnosis of cerebral atherosclerosis (build-up of plaque in the blood vessels of the brain occurs). The resident experienced multiple falls not resulting in ER evaluations on		

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	7/8/20, 6/28/21, 9/14/21 and 6/30/22. The facility failed to provide evidence of periodic reassessments of the resident's clinical status or changes in the care for R8's safety. Physical Therapy was ordered by the Physician after the 6/30/22 fall. 8. 6/28/19 - R10 was admitted to AL with a diagnosis of high blood pressure and moved into the COVE (Memory Care) on 10/17/22. The resident returned to the facility on 10/17/22 from a rehabilitation (rehab) facility after a surgery. The rehab transfer information indicated the resident was in need of moderate to maximum assistance for transfers and assistance with a walker in mobility. The resident experienced multiple falls not resulting in ER evaluations on 6/17/22, 10/26/22 and 10/27/22. The facility failed to provide evidence of periodic reassessments of the resident's clinical status or changes in the care for R10's safety. 9. 12/19/19 - R12 was admitted to AL with a diagnosis of high blood pressure. The resident sustained a fall on 5/26/21 resulting in a transfer to the ER for evaluation. Facility staff failed to document that periodic reassessments of the resident's clinical status were completed after the 5/6/21 fall when R12 returned to the facility. Per documentation, other falls not resulting in ER evaluations sustained by the resident were on 5/17/20, 5/18/20, and		

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	11/30/22. The facility failed to provide evidence of periodic reassessments of the resident's clinical status or changes in the care for R12's safety. Per interview with E2 (DRC) on 12/12/22 at 3:45 PM, E2 confirmed the documentation by staff was not always completed. General fall findings were reviewed with E1 (ED), E2 and E14 (Division RN) at the Exit Conference on 12/12/22, beginning at approximately 4:15 PM. Discussion of the facility fall policy, staffing, and resident care plan updates may need to be reviewed and revised. **c. Failure to carry out a prescribed treatment plan for a patient or resident.** This requirement was not met as evidenced by: Based on interviews and review of clinical records, it was determined that for seven (R1, R3, R4, R8, R10, R16 and R17) out of seventeen sampled residents, the facility failed to ensure that each resident's medications were administered as ordered. Findings include: 1. R1 - Review of the November 2022 MAR revealed that the following medications were not administered to R1 as ordered: Seroquel on 11/16/22 at 9:00 AM; Seroquel on 11/19/22 at 7:00 PM; Seroquel at 11/20/22 at 7:00 PM; Zyprexa, Losartan, Atorvastatin,		

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	Omeprazole and Zoloft at 11/23/22 at 9:00 AM; and Zyprexa on 11/25/22 at 8:00 PM. 2. 10/1/22 - 10/31/22 - R3 was to receive medications: On 10/1/22 Hydralazine at 4:00 PM and 8:00 PM, Melatonin at 8:00 PM, Acetaminophen at 8:00 PM, Quetiapine Fumarate at 8:00 PM and Divalproex at 8:00 PM. On 10/26/22 at 9:00 AM, Hydralazine, Multivitamin, Acetaminophen and Vitamin B12 and at 8:00 PM Quetiapine Fumarate and Divalproex. These medications were shown as missed on the MAR, however, without reason as to why and no documentation that the Nurse or Physician were notified. 3. 8/1/22 - 8/31/22 - R4 was to receive medications: On 8/7/22 at 9:00 AM Omeprazole and Venlafaxine HCL ER; at 10:00 AM Pulmicort Flexhaler, Meclizine, and Lisinopril. On 8/29/22 at 8:00 AM Senokot and Omeprazole and Venlafaxine HCL ER at 9:00 AM. These medications were shown as missed on the MAR, however, without reason as to why and no documentation that the Nurse or Physician were notified. 4. 10/1/22-10/31/22: R8 was to receive Baza Protect to the buttock area for a sacral wound twice daily. The MAR indicates this was administered only two times at 5:00 PM on 10/1/22 and 10/2/22. No reason was indicated as to why the remaining doses were missed. 11/1/22 -11/9/22, Baza Protect was again not administered and on 11/4/22, B Complex tab at 9:00 AM was missed		

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	without a reason why and no documentation that the Nurse or Physician were notified. 5. 9/1/22-9/30/22 - R10 on 9/9/22 an order for Cholestyramine 4 Gm packet mixed in 8 ounces of water daily for 14 days. Per the MAR this was only administered 12 days. The record does not indicate reason why the last two doses were not given. 10/1/22-10/31/22: On 10/18/22 and 10/19/22, Cranberry tab twice a day at 9:00 AM and 6:00 PM. On 10/28/22 at 6:00 PM Atorvastatin and Cranberry. These medications were marked as missed without a reason why and no documentation that the Nurse or Physician were notified. 6. 12/4/22 at 8:00 AM - R16 was to receive Insulin (Novolog Flexpen) 50 units subcutaneously before breakfast. The MAR did not show that either the blood glucose reading was recorded or that the Insulin was given. Per interview with E13 (LPN) on 12/6/22 at 7:40 AM, E13 confirmed the reason was not indicated and there was no documentation that the Nurse or Physician were notified. E13 confirmed there was no order for blood glucose parameters as it would be on the MAR if ordered. During an interview with E7 (LPN) on 12/6/22 at 9:19 AM, R7 confirmed there were no parameters ordered by the Physician and E7 stated she would contact the Physician to obtain blood glucose parameters.		

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	7. 12/4/22 at 11:00 AM - R17 was to receive Insulin (Novolog Flexpen) 10 units subcutaneously before lunch and Xuttophy Flexpen 35 units subcutaneously daily before bed. The MAR did not show that either of these Insulin doses was administered and no reason why was noted. On 11/10/22, 11/15/22, 11/19/22, 11/22/22, 11/23/22, 11/27/22, 11/28/22, and 11/29/22 the MAR indicated that Insulin (Novolog Flexpen) 10 units subcutaneously before lunch was not administered with no notation as to reason why the med was not administered. On 11/10/22, 11/18/22, 11/19/22, 11/25/22, 11/26/22 and 11/27/22 Xuttophy Flexpen 35 units subcutaneously daily before bed was not administered with no notation as to why the med was not administered. In review of the record, there was no order for blood glucose parameters. Per interview with E13 (LPN) on 12/6/22 at 7:42 AM, E13 confirmed the reason for the missed doses was not indicated or documentation that the Nurse or Physician were notified. E13 confirmed there was no order for blood glucose parameters as it would be on the MAR if ordered. During an interview with E7 (LPN) on 12/6/22 at 10:05 AM, R7 confirmed there were no parameters ordered by the Physician or an order for the resident to self-administer the insulin once drawn. E7 stated she would contact the Physician to obtain blood		

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	glucose parameters and to get an order to allow R17 to self-administer her insulin. During an interview with E5 (Medication Assistant) on 11/29/22 at 8:10 AM, E5 stated that when a medication was not given for whatever reason, the employee will circle their initial at the time the medication was missed, will make a notation as to the reason medications were not given on the back of the MAR and alert the Nurse of the missed dose. This procedure was confirmed by E13 on 12/6/22 at 7:38 AM. The facility failed to provide evidence that these medications were administered and notification of the nurse, NP (Nurse Practitioner) or Physician. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 and E14 (Division RN). **Limited Lay Administration of Medications (LLAM) Course Training & Resource Manual** **Revised 8/31/18** **The "4 Routes" of giving medications:** **1. Ingestion: oral tablets, capsules or liquids, lozenges (in the mouth, not swallowed), sublingual tablets (under the tongue, not swallowed). Note: UAPs are allowed to utilize the barrel of a syringe to administer oral medications.**		

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	2. Application: skin ointments, gels, lotions, liniments, skin sprays or aerosols, throat gargles, transdermal patches, eye ointment or drops, ear drops, nose drops or nasal sprays. **3. Inhalants: inhalers, nebulizers (respiratory).** **4. Insertion: rectal suppositories, vaginal suppositories or creams.** **NOTE: The LLAM does not allow for administration of injectables with the exception of an epi-pen, which is given in life saving emergencies for severe allergic reactions.** 12/6/22 at 7:40 AM during observation of medication administration with E19 (Medication Assistant), E19 stated she dials in the dose on the Flexpen then hands it to the resident to inject the Insulin. Per interview with E13 (LPN) on 12/6/22 at 7:42 AM, E13 confirmed that the Nurse should check the dosing on the pen if a "dialed in" dose was performed by the Medication Assistant prior to having the resident inject the dose. During an interview with E7 (LPN) on 12/6/22 at 10:05 AM, E7 confirmed the Nurse should dial in the insulin dose or check the insulin dosing if drawn up by the Medication Assistant prior to administration of Insulin. 12/12/22 at 4:15 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 (DRC) and E14 (Division RN).		

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STATEMENT OF DEFICIENCIES SECTION	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE