DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
Cambridge Building
263 Chapman Road Suite 200
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: September 28, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced complaint visit was conducted at this facility on August 11, 2023, with a subsequent visit on September 20, 2023 through September 28, 2023. The deficiencies contained in this report are based on interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 79. The survey sample totaled 1 resident. Abbreviations/definitions used in this state report are as follows: Division – Division of Health Care Quality (DHCQ); ED - Executive Director; ER – Extended Release; Incident – an occurrence or event; Laceration – cut/tear in skin; LLAM - Limited Lay Administration of Medications staff; MAR – Medication Administration Record; MG - Milligrams – unit of weight, 1 mg equals 0.0035 ounce; PD MC – Program Director, Memory Care; RCD – Resident Care Director; RN – Registered Nurse; Service Agreement - allows both parties involved (the resident and the assisted living	On Monday, August 7, 2023, at approximately 6:30pm, Rockland Place was affected by a New Castle County-wide power outage, due to a major storm. The Executive Director immediately notified Delmarva Power and the facility's DP representative, to both report the outage and place the facility on the restoration priority list. On Tuesday, August 8, 2023, the facility remained without power. At approximately 1:30pm, the facility contacted its generator company to order additional generators to restore power to 100%. Later that evening, at approximately 6:00pm, the generator company arrived to install two (2) additional generators for full restoration. By 12:00pm Wednesday, 8/9/2023, power was fully restored, prior to the DP representative, notiying the ED a few hours later, indicating that DP has corrected the problem and requested that the facility remove the two (2) generators, as the power had been fully restored. **Assisted Living Facilities** **Medication Management** **A. Individual/Resident Impacted** R1 was impacted by this deficient practice which was unable to be corrected. The Resident Care Director will educate the identified employees, (E2) and (E3) on "Alternative Documentation on the Medication Administration Record and Signing off on Medication Given or Refused, when the Electronic Medication Administration Record is Unavailable."	11/27/2023

Provider's Signature [signature] NHA Title Executive Director Date October 18, 2023

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	facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services; UAI (Uniform Assessment Instrument) - a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.	**B. Identification of other residents/employees with the potential to be affected** All residents have the potential to be affected by this deficient practice. The Resident Care Director will conduct a weekly audit on all Alternative Medication Administration Records (MARs), when the electronic MAR is unavailable, to ensure residents medication administration is properly documented and signed-off as either given or refused. All Nurses/LLAM staff will be educated on "How to Properly Document and Sign-Off on Medication Administration Records, as well as "Understanding the Process for Back-up EMAR Records," when the EMAR system is not available. All Nurses/LLAM staff will be educated on "Understanding the Importance of Providing Physical Assistance to Residents who Need Assistance Consuming their Medications." **C. System Changes** The facility's root cause analysis revealed that the power outage was responsible for the absence of the documentation due to the level of responsibility associated with managing the outage. Although R1 was asleep during her scheduled medication dose, the nurse felt	
3225.0	**Assisted Living Facilities**		
3225.8.0	**Medication Management**		
3225.88	**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:**		
3225.88.2	**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: Review of R1's record revealed: 6/13/23 – A physician's order was written for carbidopa-levodopa 25-250 mg, give one tablet by mouth four times a day for Parkinson's Disease.		

Provider's Signature *[signature]* NHA Title *Executive Director* Date *October 18, 2023*

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	7/22/23 – A physician's order was written for acetaminophen ER 650 mg, give 1 tablet by mouth four times a day for pain. 9/20/23 – A review of R1's Medication Administration Record (MAR) revealed that R1's acetaminophen ER 650 mg and carbidopa-levodopa 25-250 mg medications that were scheduled to be given at 11:59 PM on 8/8/23 were not signed off as having been given to R1. 9/21/23 8:15 AM – During an interview, E2 (RN, RCD) confirmed that the 8/8/23 11:59 PM acetaminophen ER 650 mg and carbidopa-levodopa 25-250 mg medications were not signed off as given to R1 on the MAR. 9/22/23 10:35 AM – During an interview, E3 (RN) stated that she was the nurse caring for R1 on 8/8/23 during the 11:00 PM – 7:00 AM shift. E3 confirmed that she did not give R1 the scheduled 11:59 acetaminophen ER 650 mg and carbidopa-levodopa 25-250 mg medications. 9/26/23 – A review of R1's Facility Service Agreement revealed that R1 required physical assistance by a Nurse/LLAM or facility staff to consume her prescribed medications.	obligated to respect R1's rights to respect and dignity, during such time R1 was in a deep sleep and should not be interrupted. The Resident Care Director/designee, will educate all Nurses/LLAM staff on "How to Access the MAR System During a Power Outage." The Resident Care Director, will conduct monthly audits to ensure all Nurses/LLAM staff understand how to access the MAR system during a power outage. The Resident Care Director will ensure all Nurses print the EMAR records at the beginning of each month and ensure the paper MAR reflects all updated medications as a backup, in the event the facility loses power or has a system failure that limits access to the EMAR system. **D. Success Evaluation** The Resident Care Director will monitor all Nurses/LLAM staff training, weekly, times four weeks, then monthly, until 100% compliance and then reviewed during Quality Assurance meetings.	
3225.19.0	**Records and Reports**	**Records and Reports**	11/27/2023
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division.**	**A. Individual/Resident Impacted** No resident(s) were affected by this deficient practice.	

Provider's Signature *Virginia C. Gray NHA* Title *Executive Director* Date *October 18, 2023*

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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.** This requirement was not met as evidenced by: Review of R1's record revealed: 8/11/2023 – A review of an 8/9/23 Facility Incident Report described that R1 had a fall with an injury and that she was found by facility staff on 8/9/23 at 6:30 AM. R1 was transported to a hospital by ambulance because R1 had a forehead laceration and swelling to her right arm as a result of the fall. 8/11/2023 7:12 PM – An electronic incident report for R1's 8/9/23 6:30 AM fall was submitted to the Division, which was more than 48 hours after R1's fall with injury happened. 9/2/23 at 3:00 PM - Findings were reviewed during the Exit Conference with E1 (ED), E2 (RN, RCD) and E6 (PD, MC).	**B. Identification of other residents/employees with the potential to be affected** All residents have the potential to be affected by this deficient practice. The Resident Care Director/ designee, will educate all Nurses on "Timely Reporting of Resident Incidents," regardless as to whether or not there is a power outage. The Resident Care Director will conduct a weekly audit on all resident incident reports to ensure all resident reportable incidents are timely reported. **C. System Changes** The facility lacked evidence to ensure resident reportable incidents were timely reported. The Resident Care Director will educate all Nurses on "Various Methods of Reporting Resident Incidents within 8-Hours During any hour of the day," to include the Division's toll-free number." The Resident Care Director will conduct monthly audits to ensure all resident reportable incidents have been timely reported. **D. Success Evaluation** The Resident Care Director will	

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		monitor all Nurses training, weekly, times four weeks, then monthly, until 100% compliance and then reviewed during Quality Assurance meetings.	

Provider's Signature [signature] NHA Title Executive Director Date October 18, 2023