DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Dover Place Assisted Living **DATE SURVEY COMPLETED:** November 7, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from November 1, 2023 through November 7, 2023. The deficiencies contained in this report are based on interview, record review and review of other facility and partnering services documentation as indicated. The facility census on the first day of the survey was 62 (sixty-two). The survey sample totaled nine (9) residents. Abbreviations/definitions used in this state report are as follows: Abrasion – a wound caused by skin rubbing against a rough surface; Contract – a legally binding agreement made between parties involved in a transaction for the exchange of goods or services; DSM – Dietary Services Manager; Ecchymosis - a discoloration of the skin resulting from bleeding underneath; ED - Executive Director; Hematoma - a solid swelling of clotted blood within the tissues; LEC – Life Enrichment Coordinator; LPN – Licensed Practice Nurse; MCM – Memory Care Manager; RCD – Resident Care Director; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; RCP – Resident Care Provider; RWD – Resident Wellness Director; SA (Service Agreement) - allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services;	Dover Place will be in regulatory compliance by 12/29/23. Please review attached audits, in-service, and sign-in documents.	

Provider's Signature [signature] Title Executive Director Date 12/8/23

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	UAI (Uniform Assessment Instrument) - a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.		
3225.9.0	**Infection Control**		
3225.9.5	**Requirements for tuberculosis and immunizations:**		
3225.9.5.1	**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 review, interview and review of other facility documentation, it was determined that three (R2, R3 and R7) and out of nine sampled residents, the facility failed to provide evidence of tuberculin testing performed before or at admission. Findings include: 1. 12/27/21 - R2 was admitted to the facility. The first tuberculin testing was done on 1/4/22, eight days after admission. 2. 9/29/18 – R3 was admitted to the facility. The first tuberculin testing was done on 10/1/18, three days after admission. 3. 6/3/22 – R7 was admitted to the facility. The first tuberculin testing was performed on 6/15/22, twelve days after admission.	3225.9.5.1 A) R2 was not admitted to the facility on 12/27/21. Her service agreement was signed at that time. Her tuberculin test was done 1/14/22 on admission which is meeting Assisted Living Regulations. Evidence of this was emailed to surveyor on 11/6/23. No corrective action required. R3 had first step on 9/29/18, and read on 10/1/18, also meeting regulatory compliance. R7 has completed tuberculin testing documentation on file. B) All residents have the potential to be affected by this deficient practice; RWD will audit all resident records to ensure facility is following tuberculin testing requirements. If resident has not been tested, they will immediately receive a PPD.	12/29/23

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	11/2/23 - Per interview with E2 (RWD) at approximately 4:00 PM, E2 confirmed the testing was completed either at or after admission, some of which were prior to her employment. E2 stated that her belief was that tuberculin testing could be done at the time of the admission. 11/2/23 - Findings were reviewed with E1 (ED), E2(RWD), E3 (RCD), E4 (Maintenance Director) and E5 (MCM) at the clinical exit conference, beginning at approximately 4:00 PM. The environmental exit conference was completed with E15 (DSM) on 11/7/23 at approximately 2:10 PM.	C) RCA reveals that nurses require in-service education regarding state tuberculin requirements. RWD or designee to provide education. D) An audit will be conducted by RWD or designee on new move-ins weekly for 4 weeks and then monthly for 2 months until 100% compliance is obtained. Audits will be reviewed during quarterly QI to ensure compliance is maintained.	
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.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that four (E3, E8, E9 and E11) out of seven employees sampled, the facility failed to provide evidence of the base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test)	<u>3225.9.5.2</u> A) Reviewed E3, E8, E9 and E11 employee files. Tuberculin testing was completed although outside of hiring parameters and state requirements. Not able to correct deficiency. B) All current staff will be reviewed by the BOM for tuberculin test results and will be provided with a TB test if not documented. C) RCA determined with changes in the hiring process and covid waiver, the TB test process at time of hire had been interrupted. All new employees will be presented to the nursing department upon offer/hire and must begin PPD process. Each Employee must complete both steps (or receive QuantiFERON screening) and will not be permitted to work on unit until complete.	12/29/23

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	such as QuantiFeron prior to hire. Findings include: 1. 7/11/23 - E3 was hired. The first tuberculin skin test was administered on 7/15/23, four days after hire. 2. 4/5/22 - E8 was hired. The first tuberculin skin test was administered on 4/18/22, thirteen days after hire. 3. 10/3/23 - E9 was hired. The facility provided no evidence that a tuberculin test or IGRA was completed. 4. 6/28/22 - E11 was hired. The first tuberculin skin test was administered on 6/30/22, 2 days after hire. 11/2/23 - Findings were reviewed with E1 (ED), E2(RWD), E3 (RCD), E4 (Maintenance Director) and E5 (MCM) at the clinical exit conference, beginning at approximately 4:00 PM. The environmental exit conference was completed with E15 (DSM) on 11/7/23 at approximately 2:10 PM.	D) New employee audits will be completed by ED/designee weekly x4 and then monthly x2 until 100% compliance is achieved. Audits will be reviewed at quarterly QI to ensure continued compliance.	
3225.10.0	**Contracts**		
3225.10.10	**No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.** This requirement was not met as evidenced by:	<u>3225.10.10</u> A) Residents R3 and R7 were affected by this deficient practice and have already signed a contract and service agreement. No corrective action required. B) All residents have the potential to be affected by this deficient practice. ED will not do a contract signing prior	12/29/23

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	Based on record review, interview and review of other facility documentation, it was determined that for two (R3 and R7) out of nine sampled residents, the facility obtained a signed contract prior to the assessment or service agreements being executed. Findings include: 1. 9/28/18 – R3 was admitted to the facility. The contract was signed on 9/28/18 before the SA completion was done on 10/30/18. 2. 6/3/22 – R7 was admitted to the facility. The assessment, service agreement and the contract were all signed on 5/26/22. Surveyor found no times documented on the assessment, service agreement or contract and was unable to ascertain which were completed first. 11/2/23 Per interview with E2 (RWD) at approximately 4:00 PM, E2 confirmed the contracts were signed prior to or at the UAI and SA completions, some prior to her employment. E2 stated she performs the UAI and SA at the same time and the contracts are signed at the resident's admission. 11/2/23 - Findings were reviewed with E1 (ED), E2, E3 (RCD), E4 (Maintenance Director) and E5 (MCM) at the clinical exit conference, beginning at approximately 4:00 PM. The environmental exit conference was completed with E15 (DSM) on 11/7/23 at approximately 2:10 PM.	to the service agreement being executed/signed. C) Executive Director and RWD will ensure that the service agreement and UAI are completed prior to the contract signing. D) Business office manager will perform monthly audits weekly x4 and monthly x2 to ensure that the service agreement is signed prior to the contract until 100% compliance is obtained. Findings will be reviewed at quarterly QI to monitor compliance.	
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 admis-**	**3225.13.1** A) R3 was admitted over 5 years ago on 9/29/18. The service agreement is	12/29/23

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	sion. 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. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R3) out of nine sampled residents, the facility completed the service agreement after admission. Findings include: 9/29/18 – R3 was admitted to the facility. The SA was completed on 10/30/18, a month after admission. 11/2/23 Per interview with E2 (RWD) at approximately 4:00 PM, E2 confirmed this SA was completed after admission. This was prior to her employment. 11/2/23 - Findings were reviewed with E1 (ED), E2, E3 (RCD), E4 (Maintenance Director) and E5 (MCM) at the clinical exit conference, beginning at approximately 4:00 PM. The environmental exit conference was completed with E15 (DSM) on 11/7/23 at approximately 2:10 PM.	already signed and not able to be corrected. B) All residents have potential to be affected by this deficient practice. All residents currently have a signed service agreement on file. C) Unable to determine a RCA as this occurred 5 years ago. RWD will audit service agreement for signature prior to admission weekly x4 and monthly x 2 until 100% compliance is met. D) Audits to be monitored in QI for ongoing compliance.	
3225.19.0	**Records and Reports**		
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.**	3225.19.0 A) R1 no longer resides at the community. The facility is unable to correct this deficient finding.	12/29/23
3225.19.7	**Reportable incidents include:**		

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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: Based on record review, interview and review of other facility documentation, it was determined that for one (R1) out of nine sampled residents, the facility failed to report falls resulting in a resident's injury. Findings include: 3/22/11 – R1 was admitted to the facility with high blood pressure and depression. Per the medical record by E10 (LPN) on 4/14/23, R1 had an unwitnessed fall and was sent to the Emergency Room for evaluation. Per the ER record, R1 suffered a hematoma to her left eye and a nose abrasion. Per the Nurse Practitioner's follow up note on 4/18/23, the Nurse Practitioner's indicated R1 was seen post fall and sustained left face ecchymosis and hit her head. It was noted R1 had hit her head and there was soft tissue swelling, no fracture but significant ecchymosis to the left side of the face. The facility failed to report this fall with injury to the State. Per medical record entry by E11 (LPN) on 6/11/23, R1 had an unwitnessed fall and was sent to the Emergency Room for evaluation. Per the Hospital record, R1 suffered a fractured hip resulting in surgery on 6/13/23. The facility failed to report this fall with injury to the State.	B) All residents that have a fall with injury have the potential to be affected by this deficient practice. RWD completed an audit on incident report that occurred over the preceding 90 days to ensure that any reportable incidents were reported. None were noted on review. C) RCA determined that nurses were not adequately trained on reportable incidents. RWD will conduct an in-service education, consisting of refreshers on reportable incident requirements, timeframes to report, and the Portal ID for all state reporting requirements by 12/29/23. D) The RWD/designee will conduct a weekly audit of incident reports x 4 weeks and then monthly x2 months until 100% compliance is achieved. Results will be presented to QI for review and recommendations.	

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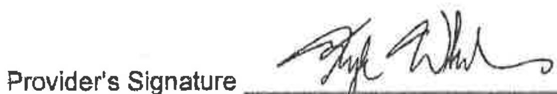
	11/2/23 - Per interview with E2 (RWD) at approximately 4:00 PM, E2 believed these were reported however the Surveyor was not able to verify that a State report from the facility was completed. 11/2/23 - Findings were reviewed with E1 (ED), E2, E3 (RCD), E4 (Maintenance Director) and E5 (MCM) at the clinical exit conference, beginning at approximately 4:00 PM. The environmental exit conference was completed with E15 (DSM) on 11/7/23 at approximately 2:10 PM.		

Provider's Signature  Title ED Date 12/4/23