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: State Street Assisted Living **DATE SURVEY COMPLETED: June 14, 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 June 12, 2023 through June 14, 2023. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was seventy-five (75). The survey sample totaled twelve (12) residents. Abbreviations/definitions used in this state report are as follows: AED - automated external defibrillator is a medical device designed to analyze the heart rhythm and deliver an electric shock to victims of ventricular fibrillation to restore the heart rhythm to normal; BOD - Business Office Director; Contract - a legally binding agreement made between parties involved in a transaction for the exchange of goods or services; CPR - Cardiopulmonary Resuscitation; DOM – Director of Maintenance; DOW - Director of Wellness; DSD – Dining Services Director; ED - Executive Director; EMR – Electronic medical record; LD – Lifestyles Director;		

Provider's Signature [signature], NHA Title Executive Director Date 7-8-2023

NAME OF FACILITY: State Street Assisted Living **DATE SURVEY COMPLETED: June 14, 2023**

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	LPN – Licensed Practical Nurse; Lividity – a reddish to bluish-purple discoloration of the skin due to the settling and pooling of blood following death; MCC – Memory Care Coordinator; MT – Med Tech; POA – Power of Attorney; Rigor- rigidity, as in rigor mortis, the rigidity of a body after death; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; 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; 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. **3225.0** **Assisted Living Facilities**		

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3225.5.0 **3225.5.2**	**General Requirements** **All records maintained by the assisted living facility shall at all times be open to inspection and copying by the authorized representatives of the Department, as well as other agencies as required by state and federal laws and regulations. Such records shall be made available in accordance with 16 Del.C. Ch. 11, Subchapter I., Licensing by the State.** This requirement was not met as evidenced by: Based on interview with E2 (DOW) on 6/14/23 at 1:00 PM, E2 stated some records are archived and not able to be retrieved at this time. E2 stated that she requested these records to be obtained. It was determined that for two (R2 and R12) out of the five active residents sampled, the facility failed to provide some of the resident records. Findings include: 1. 8/11/22 – R2 was admitted to the facility. The record failed to include the medical evaluation prior to admission and the initial service agreement. As of 6/19/23, E2 (DOW) communicated by email that the above information was not accessible, but E2 had requested them. 2. 6/15/21 – R12 was admitted to the facility. The record failed to include the initial service agreement. As of 6/19/23, E2 (DOW) communicated by email that the above information was not accessible, but E2 had requested them.	3225.5.2 A. R2 continues to reside in this community. Community is not able to locate the medical evaluation prior to admission and initial service agreement. R2 has an up-to-date medical evaluation and current service agreement in place as of 2/9/23. R12 continues to reside in this community. Community is not able to locate the medical evaluation prior to admission and initial service agreement. R12 has an up-to-date medical evaluation and current service agreement in place as of 2/9/23. B. Newly admitted residents have the potential to be affected by this practice. An audit of all current residents was conducted by DOW on 2/8/23 to ensure all required records are available. C. A root cause analysis revealed the need for re-education for licensed staff and administrative staff on State of Delaware	8/13/23

Provider's Signature [signature], NHA Title Executive Director Date 7-8-2023

NAME OF FACILITY: State Street Assisted Living

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.9.0 3225.9.7	6/14/23 - Findings were reviewed with E1 (ED), E2, E3 (DOM), E6 (DSD), E7 (LD), E8 (MCC) and E9 (BOD) at the exit conference, beginning at approximately 4:00 PM. **Infection Control** **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 Com-mittee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** 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 (R2) out of the five active residents sampled, the facility failed to provide evidence of the vaccination against pneumococcal pneumonia or a vaccination declination. Findings include: 8/11/22 – R2 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. As of 6/19/23, E2 (DOW)	regulations and facility procedures for record retention. This training was started on 7/5/23 by ED regarding the procedures for record retention regarding pre-admission and admission documentation, to be fully completed by 7/31/23. D. The DOW/designee will conduct a weekly audit, x4 weeks, until 100% compliance is verified, then, random audits will continue monthly x2 months until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation. 3225.9.7 A. R2 continues to reside in this community. Pneumonia record was obtained, resident is vaccinated. B. Newly admitted and current residents have the potential to be affected by this practice. An audit of current resident medical records was conducted by the DOW on 2/9/23 to ensure that vaccination or vaccination declination was documented for current residents. C. A root cause analysis revealed the need for administrative staff re-education on facility	8/13/23

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3225. 10.0 **3225. 10.10**	communicated by email that the above information was not accessible, but E2 had requested them. 6/14/23 - Findings were reviewed with E1 (ED), E2, E3 (DOM), E6 (DSD), E7 (LD), E8 (MCC) and E9 (BOD) at the exit conference, beginning at approximately 4:00 PM. **Contracts** **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: Based on record review, interview, and review of other facility documentation, it was determined that for four (R2, R10, R11 and R12) out of the five active residents sampled, the facility obtained a signed contract prior to the service agreement being executed. Findings include: 1. 8/11/22 – R2 was admitted to the facility. The record failed to include the initial service agreement. The contract was signed on 7/30/22. The facility lacked evidence that the initial Service Agreement was executed prior to the signed contact. As of 6/19/23, E2 (DOW) communicated by email that the above information was not accessible, but E2 had requested them.	processes for new admission paperwork and vaccination regulations for the State of Delaware. Training to be fully completed by 7/31/23. D. The DOW/designee will conduct a weekly audit for all new admissions for x4 weeks, until 100% compliance is verified, then, monthly x2 months until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation. 3225.10.10 A. R2 continues to reside in this community. Community is not able to locate the initial assessment. R2 had a full assessment and service agreement in place as of 2/9/23. R10 continues to reside in this community. Community was able to locate the initial assessment, it was signed and reviewed on 2/20/23 which was the same day as the contract signing. R11 no longer resides in this community; has since expired. Community is not able to locate the initial assessment. R11 had a full assessment and service agreement in place as of 2/20/23. R12 continues to reside in this community. Community is not	8/13/23

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	2. 5/17/23 - R10 was admitted to the facility. The contract was signed on 4/28/23 and the initial service agreement was signed on 5/17/23, after the contract was signed. 3. 2/20/23 - R11 was admitted to the facility. The contract was signed on 2/20/23 and the initial service agreement was signed on 2/21/23, after the contract was signed. 4. 6/15/21 – R12 was admitted to the facility. The record failed to include the initial service agreement. The contract was signed on 5/30/22. The facility lacked evidence that the initial Service Agreement was executed prior to the signed contact. As of 6/19/23, E2 (DOW) communicated by email that the above information was not accessible, but E2 had requested them. 6/14/23 – Per interview with E1 (ED) and E2 (DOW) at approximately 3:45 PM, E1 and E2 confirmed the contracts were signed by the resident/POA prior to the Service Agreement being completed or that the initial Service Agreement was not located. 6/14/23 - Findings were reviewed with E1, E2, E3 (DOM), E6 (DSD), E7 (LD), E8 (MCC) and E9 (BOD) at the exit conference, beginning at approximately 4:00 PM. **Resident Assessment**	able to locate the initial assessment. R11 had a full assessment and service agreement in place as of 2/20/23. B. Newly admitted residents have the potential to be affected by this practice. An audit of all current residents was conducted by DOW on 7/6/23 to ensure all assessments were completed. C. A root cause analysis revealed the need for administrative re-education on facility contract procedures and State of Delaware regulations. This training was started on 7/5/23 by ED, to be completed by 7/31/23. Additionally, the location of the signed resident assessment has been changed to ensure administrative staff are aware of when to proceed with executing the contract. Contract will not be executed without full assessment and service plan review prior to lease signing. D. The ED/designee will conduct a weekly audit, x4 weeks, until 100% compliance is verified, then, monthly x2 months until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	
3225. 11.0 **3225. 11.3**			

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3225.17.0 **3225.17.2** **3225.17.2.3**	**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 record review, interview, and review of other facility documentation, it was determined that for two (R2 and R3) out of the five active residents sampled, the facility failed to provide evidence of the medical evaluation being completed within 30 days prior to admission. Findings include: 1. 8/11/22 – R2 was admitted to the facility. The facility failed to provide evidence of the preadmission Physician's medical evaluation. Based on interview with E2 (DOW) on 6/14/23 at 1:00 PM, E2 stated some records are archived and not able to be retrieved at this time. E2 stated that she requested these records. As of 6/19/23, E2 communicated by email that the above information was not accessible, but E2 had requested them. 2. 5/8/19 – R3 was admitted to the facility. The preadmission Physician's medical evaluation was completed on 5/8/19, the day of admission. 6/14/23 - Findings were reviewed with E1 (ED), E2 (DOW), E3 (DOM), E6 (DSD), E7 (LD), E8 (MCC) and E9 (BOD) at the exit conference, beginning at approximately 4:00 PM. **Environment and Physical Plant**	3225.11.3 A. R2 continues to reside in this community. Community was not able to locate the prior medical evaluation; R2 has a current, appropriate medical evaluation completed by the physician in place as of 6/7/2023. R3 continues to reside in this community. Community was not able to locate the prior medical evaluation; R2 has a current, appropriate medical evaluation completed by the physician in place as of 6/23/2023. B. Newly admitted residents have the potential to be affected by this practice. C. A root cause analysis revealed the need for administration re-education on facility policy, "Admission Requirements". This training was started on 7/6/23 by DOW and is ongoing, to be completed by 7/31/23. D. The DOW/designee will conduct a weekly New Admission audit, x4 weeks, until 100% compliance is verified, then, monthly x2 months until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	8/13/23

Provider's Signature [signature], NHA Title Executive Director Date 7-6-2023

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Assisted living facilities shall: **Have a hazard-free environment.** This requirement was not met as evidenced by: Based on the observations and an interview on June 13, 2023, it was determined that the facility failed to meet this requirement. Findings include: During the survey of the facility, the Surveyor observed a water leak towards the porch entrance, near the snack area of the Memory Care Unit. The ceiling area had a constant drip of water coming from the ceiling and the ceiling had a medium sized hole, exposing the inner part of the drop ceiling with a brownish colored substance on the ceiling near the hole. Per interview with E3 (DOM) on 6/12/23 at approximately 11:30 AM, E3 confirmed a water leak was caused by a blocked air conditioning duct. E3 stated both the air conditioning company and a plumbing company were to address the issue.	3225.17.2.3 A. No residents were identified. B. Newly admitted and current residents have the potential to be affected by this practice. C. A root cause analysis revealed there was a leak from a main air conditioning line that resulted in property damage in the Memory Care neighborhood. The hazard was identified on 6/5/23 by the DOM. The hazard was fixed and corrected by an outside vendor on June 12, 2023. D. The ED/DOM/Designee will conduct a weekly memory care environmental audit, x4 weeks, until 100% compliance is verified, then, monthly x2 months until 100% verified. Results will be presented to the Quality Assurance Process Improvement team and the Safety Committee for review and recommendation.	8/13/23
3225. 19.0 **3225.19.6**	6/14/23 - Findings were reviewed with E1 (ED), E2 (DOW), E3, E6 (DSD), E7 (LD), E8 (MCC) and E9 (BOD) at the exit conference, beginning at approximately 4:00 PM. **Records and Reports**		
3225. 19.7 **3225.19.7.1**	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident,**		

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3225.19.7.1.1 **3225.19.7.1.1.1** **3225.19.7.4** **3225.19.7.6** **3225.19.7.7.1**	**to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Abuse as defined in 16 Del.C. §1131.** **Physical abuse.** **Staff to resident with or without injury.** **Financial exploitation as defined in 16 Del.C. §1131.** **Death of a resident in a facility or within 5 days of transfer to an acute care facility.** **Injury from an incident of unknown source in which the initial investigation concludes that there is reasonable basis to suspect that the injury is suspicious. An injury is suspicious based on; the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time or the incidence of injuries over time.** This requirement was not met as evidenced by: Based on record review, interview, and review of other facility and investigative documentation, it was determined that for six (R1, R2, R3, R4, R5, R6 and R7) out of twelve sampled residents, the facility failed to report seven incidents within the regulation timeline or the timely submission of the 5 day follow up. Findings include:		

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	1. 5/4/22 - R1 was admitted to the facility. On 4/10/23 at approximately 8:00 AM, R1 was found in his room unresponsive, face down on the floor in a fetal position, cold to touch and blue in color. The code status was unknown to E5 (LPN) on arrival to the room and had to be obtained from the nursing station. R1 was found to be a Full Code and E5 stated to E2 (DOW) per telephone on 4/10/23 that CPR was initiated. After conflicting information of the CPR being initiated surfaced, E5 clarified to E2 on 4/27/23, that initiating CPR meant applying the AED and getting R1 in position for chest compressions and checking for a pulse and respirations. On 6/14/23 at 1:45 PM - Per interview with E5 (LPN), E5 confirmed her statement clarification that she had to identify the code status and the initiating of CPR was to apply the AED and getting R1 in position for chest compressions. E5 confirmed that actual chest compressions were not begun and the Paramedics arrived a few minutes later. E5 stated that E4 (LPN) was applying the AED when the Paramedics arrived and told her that they would take over. E5 stated R1 was pronounced shortly after the Paramedics arrived. Per the Paramedics report, chest compressions were not initiated as R1 had lividity and rigor. The incident was reported on 4/17/23, seven days after the incident occurred. 2. 8/11/22 – R2 was admitted to the facility. It was reported by E14 (MT) to E1 (ED) by telephone on 2/3/23 around 7:05 PM, that E15 (Aide) reportedly hit R2 in the head. E1 called the facility and asked E15	3225.19.7 A. R1 no longer resides in the community, has since expired. The incident took place on 4/10/23, it was not reported by required time. R2 continues to reside in this community. Community was not able to locate the reported incident, it was not reported by required time. R3 continues to reside in this community. Community was not able to locate the reported incident, it was not reported by required time. R4 no longer resides in the community; has since expired. Community was not able to locate the reported incident, it was not reported by required time. R5 no longer resides in this community. The incident took place in June of 2022, the community filed report once DOW was made aware on 2/23/23. R6 no longer resides in this community. The incident took place on 2/9/23, was not reported by required time. B. Newly admitted and current residents have the potential to be affected by this practice. The DOW identified the need for improved internal processes for ensuring timely reporting.	8/13/23

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	to leave pending an investigation. E1 stated she then called the facility to confirm that E15 left the building. Per facility counseling documentation forms, E15 was suspended on 2/3/23 through 2/10/23 and E15's employment was terminated. 6/14/23 - Per interview with E1 (ED) and E2 (DOW) at approximately 3:50 PM, E2 confirmed that E15's (Aide) last full day of work was on January 28, 2023. E15's suspension took place on 2/3/23 pending investigation and E15's employment ended on 2/10/23. E1 and E2 confirmed that the facility failed to notify the State of the staff to resident abuse that occurred on 2/3/23, until 2/21/23, eighteen days after the incident was known to the facility. 3. 5/8/19 - R3 was admitted to the facility. R3 sustained a fall on 1/3/23 at 5:59 AM and was transferred to the hospital. The incident was reported to the State by the facility on 1/3/23 at 8:02 AM. The facility failed to submit the 5-day follow-up report until 2/7/23, over a month after the incident. 6/13/23 - Per interview with E2 (DOW) at approximately 11:00 AM, E2 stated she was new to the building earlier this year and found that some reports that were not completed. E2 confirmed she was in the process of "cleaning up the paperwork." 4. 6/25/22 – R4 was admitted to the facility. R3 sustained a fall on 1/3/23 at approximately 6:00 AM, her head against the bathroom door and bleeding from her head. The incident was reported by the facility on 1/3/23 at 7:53 AM. Per the	C. A root-cause analysis revealed the need for licensed staff to be re-educated on facility policies, "Abuse, Neglect, Exploitation" and "Reportable Events", as well as the reporting requirements for the State of Delaware. This training was started on 7/6/23 by DOW and is ongoing, to be completed by 7/31/23. All staff will receive in-service training on the community abuse and neglect policy and Delaware reporting requirements starting on 7/10/23, to be completed by 7/31/23. D. The DOW/ED/designee will conduct a weekly reporting audit, x4 weeks, until 100% compliance is verified, then, monthly x2 months until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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	hospital report, R4 expired on 1/5/23. The facility failed to submit the 5-day follow-up report reporting the death until 2/13/23, over a month after the fall. 6/13/23 - Per interview with E2 (DOW) at approximately 11:00 AM, E2 stated she was new to the building earlier this year and found that some reports that were not completed. E2 confirmed she was in the process of "cleaning up the paperwork." 5. 5/12/22 - R5 was admitted to the facility. The incident reporting person (F1) reported on 2/9/23 that on 2/3/23, she was notified by a staff member E14 (MT) that E15 (Aide) assaulted R5 and a neighboring roommate. F1 was informed that E15 was asked to leave the facility. F1 stated that E1 (ED) called F1 on 2/6/23 to advise that E15 would not be returning to the facility. Per facility counseling documentation forms, E15 was suspended on 2/3/23 and E15's employment was terminated on 2/22/23. 6/14/23 - Per interview with E1 (ED) and E2 (DOW) at approximately 3:50 PM, E2 confirmed that E15's (Aide) last full day of work was on January 28, 2023. E15's suspension took place on 2/3/23 pending investigation and E15's employment ended 2/22/23. E1 and E2 confirmed that the facility failed to notify the State of the staff to resident abuse that occurred on 2/3/23. 6. 5/12/22 – R5 was admitted to the facility. The incident reporting person (F1) reported on 2/9/23 that in June of 2022, R5 was abused by a different Aide than listed		

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	above in #5. E2 (DOW) reported this allegation to the State once F1 reported to E1 (ED) and E2 on 2/22/23. Per E2's investigation, the allegation was substantiated by E2 of E16 (Aide) yelling, screaming, and displaying severe aggression to R5. E2 stated that E16 was immediately suspended on 2/23/23. Per facility counseling documentation forms, E16 was suspended on 2/22/23 through 3/13/23 when E16's employment was terminated. The facility communications per an email, dated 6/7/22, with an outside caregiver company indicated this incident was brought to E17's (DOW2) attention. E2's (DOW) investigation statement from E17 indicated that E17 was verbally informed of the incident by R5's daughter and that E17 spoke to E1 (ED). E17's statement indicated that she and E1 jointly decided to remove E16 from R5's care. E17 stated an "investigation wasn't needed because nothing happened." The facility failed to report this abuse allegation to the State in June 2022. 6/13/23 - Per interview with E2 (DOW) at approximately 11:00 AM, E2 confirmed that the June 2022 allegation was not reported and confirmed it was brought to E2's attention on 2/22/23 when R6's daughter informed E2. E17 (Aide) was no longer employed at the facility. E2 reported this incident to the State on 2/23/23. 7. 11/3/22 – R6 was admitted to the facility. On 1/25/23, the incident reporting person (F2) reported to the State that an		

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	unknown Aide was demanding money from R6 and attempting to forcibly remove R6's money. F2 also reported a door was falling off the hinges in R6's room. Per the facility records, E19 (Aide) was the assigned caregiver. 6/1/23 at approximately 12:45 PM - F2 (R6's daughter) confirmed per telephone with the Surveyor, that the report submitted was correct and stated R6 was relocated to another facility. F2 stated the incident and some of the camera footage was shared with E1 (ED), the Ombudsman and that the Dover State Police were notified. F2 stated the State Police were pursuing a charge of attempted theft and crime against a vulnerable adult, but later stated there was not enough evidence to prosecute for criminal charges. Per facility counseling documentation forms, E1 (ED) noted a video was reviewed on 1/13/23 where E19 (Aide) and R6 were conversing about money. Per the counseling documentation, E1 immediately suspended E19 on 1/13/23. On 4/3/23, E1 (ED) terminated E19's employment when the State Police investigation substantiated their findings and informed E1 of this. 6/14/23 - Per interview with E2 (DOW) at approximately 11:00 AM and with the facility provided documentation, E2 confirmed that E19 was suspended pending investigation on 1/13/23 through 4/3/23 when E19's employment was terminated. E1 reported the incident of 1/13/23 on 1/30/23 to the State, two weeks after the allegation. The 5-day follow-up report was		

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	sent on 2/9/23, over five days later from the reporting date of 1/30/23. 6/14/23 - Findings were reviewed with E1 (ED), E2 (DOW), E3 (DOM), E6 (DSD), E7 (LD), E8 (MCC) and E9 (BOD) at the exit conference, beginning at approximately 4:00 PM.		

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