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

REVISED STATE SURVEY REPORT

NAME OF FACILITY: Arden Courts

DATE SURVEY COMPLETED: September 8, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	REVISED STATE SURVEY REPORT An unannounced Annual and Complaint Survey was conducted at this facility from August 30, 2023, through September 8, 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 twenty-nine (29). The survey sample totaled eleven (11) residents. Abbreviations/definitions used in this state report are as follows: ASC -Administrative Services Coordinator; Cms (centimeters) - a metric unit of length, equal to one hundredth of a meter; Contract - a legally binding agreement made between parties involved in a transaction for the exchange of goods or services; Contusion - a region of injured tissue or skin in which blood capillaries have been ruptured; a bruise; DelVAX - Delaware's state immunization registry and serves as a database that contains the immunization records of Delaware residents; Distal - situated away from the point of attachment or origin or a central point; ED - Executive Director; EMR – Electronic medical record; FSC – Food Services Coordinator;		

Provider's Signature _____ Title Executive Director Date 11/17/23

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	Hematoma - a solid swelling of clotted blood within the tissues; HR – Human Resources; LPN – Licensed Practical Nurse; MC – Memory Care; Metacarpal - the long bones within the hand that are connected to the wrist bones and the finger bones; Metaphysis - the wide portions of long bones and the regions of the bone where growth occurs; NP – Nurse Practitioner; Paravertebral - adjacent to a vertebra or the vertebral column; Periorbital - refers to something related to or surrounding the orbit of the eye; POA – Power of Attorney; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; RC – Resident Caregiver; RSC – Resident Services Coordinator; 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 pro-		

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	vides. 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.		12/8/23
3225.0	**Assisted Living Facilities**	**Assisted Living Facilities**	
3225.7.0	**Specialized Care for Memory Impairment**	**3225.0/3225.7.0/3225.7.1/3225.7.2/3225.7.3/3225.7.3.5**	
3225.7.1	**Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations herein.**	A. No residents/individuals were impacted by this deficient practice pursuant to regulation 3225.7.0 providing specialized care for memory impairment.	
3225.7.2	**Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.**	B. The facility has taken corrective action to ensure each category outlined in the deficient practice is in substantial compliance with the state-required rules and regulations. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined in #c	
3225.7.3	**The information disclosed shall explain the additional care that is provided in each of the following areas:**		
3225.7.3.5	**Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care;** This requirement was not met as evidenced by:	C. The facility did not review the staffing plan, orientation, and regular in-service education for specialized care. The facility will implement this deficient practice in marketing materials with a signature page for the POA/Family to sign with signature page at the time of admission	

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	Based on policy review, interview, and review of other facility documentation, it was determined that the facility lacked some specific MC policy and procedures pursuant to the Memory Impaired resident. Findings include: 9/7/23 – Facility Policy and Procedure manuals, marketing materials and Resident Agreement packets were reviewed. There was evidence of some specific MC Information, however the above referenced regulation 7.3.5 staffing plan and training policies of the staff were not in evidence. 9/7/23 - Per interview with E1 (ED) at approximately 3:30 PM, E1 confirmed this element of memory care staffing and training were not included in the preadmission or admission packets. E1 stated she discusses this information when interviewing families prior to admission. 9/8/23 - Findings were reviewed with E1 and E2 (RSC) at the exit conference, beginning at approximately 10:30 AM.	specific to the operations and provision of care to the memory-impaired Resident. D. The MCA/Designee will monitor marketing materials with a signature page/acknowledgment of receipt. This will be reviewed for 4 weeks once every week monthly until 100% compliance and report any findings to the QAPI meeting	
3225.7.3.6	**Physical Environment: the physical environment and design features, including security systems, appropriate to support the functioning of adults with memory impairment;** This requirement was not met as evidenced by: Based on policy review, interview, tour of the facility and review of other facility documentation, it was determined that the facility lacked safety and security policy and procedures pursuant to the Memory Impaired resident. Findings include:	**Physical Environment** **3225.7.3.6** A. R1 alarm did not function properly door prompt was opened by staff – the lock was changed, and the door alarm was repaired – see attached – Exhibit A and B. This was fully investigated by the state with documentation on what was done. B. All residents could be potentially affected by this deficient C. System changed alarm on door repaired. Sign-on door is visible to staff. Staff education on exit door and door safety, the physical environment to support the	12/8/23

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	8/4/23 – R1 was reported being found by staff at the neighboring facility on the campus. The Arden Courts staff returned R1 to his room and R1 was found to have a skin tear to his left knee and thigh and some discoloration around his right eye. Reported camera footage revealed R1 exited the building at about 9:10 PM and was discovered by the other facility staff at about 9:30 PM. R1's EMR indicated he exhibited consistent exit seeking behaviors. His room was located near the door that was left propped open. 8/30/23 – Per review of the facility policy and procedures titled Safety and Security of Residents, page one, section 2 states: 2. **RESIDENT/MONITORING/SECURITY DEVICES** **A. Exit doors are secured and linked to the community's security system using electromagnetic door locked connected to coded keypads and alarm systems, delayed egress, and window securement devices. The security objectives of the system include:** *** Provides continuous (24 Hour/Day) monitoring of high-risk areas** *** Provides controlled access to exits and doors directly in the path between the community interior and exterior on other hazardous locations within the community.** *** Provides immediate audible and visual indication when the system has been activated and identified the specific point of activity.**	functioning of adults with memory impairment D. The BSC will document system tests by inspection and testing of the security system. This review should be completed weekly for the next month until 100% compliance and any findings reported to QAPI	

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	System activation indicators (i.e. alarms) must be distinguishable during peak period of community activity. **System activation (audible and/or visual) must be distinct from other community alarm system indicators, provide continuous activation until a formal reset process is performed.** **Incorporates a rest procedure that requires manual rest at the point of activation (employee must enter code to reset alarm at activated door).** **Deters unauthorized or fandom system releases/override.** **Where allowed by state or local code, incorporates a better backup system and emergency generator connection to ensure system operability during electrical power outages, at a minimum, incorporates a battery backup system to ensure system memory stays intact during power outages (i.e. system retains override code).** **8/30/23 – Per review of the facility policy and procedures titled Safety and Security of Residents, page five, section 7B states:** **B. Security Device Readiness** *** The Building Services Coordinator (BSC) is responsible for inspection and testing of security systems. A documeted system test should completed weekly.** The facility failed to provide evidence that inspection and testing of security systems and with documentation of such were done weekly prior to this incident.		

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	8/30/23 – During a tour of the facility with E1 (ED) at approximately 10:30 AM, the Surveyor was informed by E1 that the exterior utility door alarm was not in working order. R1 was able to exit the building without the door alarming. The inside door leading into the utility area needing a key to open, was left propped open by a staff member. R1 was able to enter the propped open door and exit the exterior door without a working alarm to leave the facility. E1 stated the alarm was repaired and the lock to the interior door was changed in which the key to open was no longer available for the staff to use. E1 stated she was not able to confirm which staff propped the interior door open and there was no camera surveillance in this area. 9/8/23 - Findings were reviewed with E1 and E2 (RSC) at the exit conference, beginning at approximately 10:30 AM.		
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 medical record review, interview, and review of other facility documentation, it was determined that for seven (R2, R5, R6, R7, R8, R10 and R11) out of eleven residents surveyed, the facility lacked evidence of a tuberculin test having been completed prior to admission. Findings include:	**Infection Control** **3225.9.0/ 3225.9.5/ 3225.9.5.1** A. Resident R5, R6, R8, R10, R11 is no longer a resident of this facility. R7 and R2 correction action taken to administered 2-step TB B. All residents on admission have the potential to not have a TB test done 30 days prior to admission. An audit will be conducted by the RSC/Designee to ensure all current resident TB tests prior to admission are completed. All residents could have the potential to be affected. C. ED/Designee will in-service MCA/RSC/License staff on the requirement for a resident to have received a TB test 30 days prior to admission and place it on their	12/8/23

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	1. 3/3/22 – R2 was admitted to the facility. The tuberculin test was administered on 3/3/22, once R2 was in the facility. 2. 5/17/21 - R5 was admitted to the facility. The facility lacked evidence that tuberculin testing was done prior to admission. 3. 9/23/21 - R6 was admitted to the facility. The facility lacked evidence that tuberculin testing was done prior to admission. 4. 8/8/19 - R7 was admitted to the facility. The tuberculin test was completed on 8/10/19, after R7's admission. 5. 9/3/20 – R8 was admitted to the facility. The tuberculin test was administered on 9/3/20, once R8 was in the facility. 6. 2/17/22 - R10 was admitted to the facility. The facility lacked evidence that tuberculin testing was done prior to admission. 7. 7/7/23 - R11 was admitted to the facility. The facility lacked evidence that tuberculin testing was done prior to admission. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the tuberculin testing prior to admission. 9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM.	record and document in PCC when admitted. Prior to admission the med. eval form to be reviewed by the MCA/RSC. The ED/designee will audit all new resident medical eval form weekly times four monthly 2 times to ensure TB information is present for all new admissions. D. The ED/Designee will audit all new resident files to ensure that the TB test has been completed per regulatory requirements weekly times three then monthly until 100% compliance is achieved. Findings will be reported monthly for 3 months to QAPI	
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 Quanti-FERON. Any required subsequent testing**	**Minimum requirement for pre-employment TB** **3225.9.5.2** A. The facility has a 2-step TB for all employees. Any required subsequent testing according to risk	12/8/23

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	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, interview, and review of other facility documentation, it was determined that for five (E2, E8, E9, E11 and E12) out of six employees surveyed, the facility lacked evidence of a two-step tuberculin test having been completed. Findings include: 1. 6/23/23 – E2 was hired. The first step Tuberculin test was done 6/9/23. The facility lacked evidence of a second step Tuberculin test being completed. 2. 7/19/23 – E8 was hired. The first step Tuberculin test was done 3/15/23. The facility lacked evidence of a second step Tuberculin test being completed. 3. 5/20/19 – E9 was hired. The first step Tuberculin test was done 4/30/19. The facility lacked evidence of a second step Tuberculin test being completed. 4. 3/23/00 – E11 was hired and then rehired on 9/12/22. There is no evidence of a two-step tuberculin testing being completed.	category shall be in accordance with the recommendation of regulatory requirements B. No resident was affected by this practice. All residents could be affected by this practice. All current staff reviewed for current TB results and being provided with TB if not documented. Employee health records will be documented C. ASC/Designee will present all new hires to the nursing department to begin the TB process. The ED will re-educate ASC/RSC/license staff on the TB process which includes a second step for all new hires for pre-employment requirements D. As new employees' complete orientation, the "Employee general orientation program checklist", will be reviewed and signed by the ED/designee indication check off TB results present in the employee file before orientation commences. The ED will report any findings to QAPI	

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	5. 6/15/21 – E12 was hired. There is no evidence of a two-step tuberculin testing being completed. 9/7/23 – Per interview with E3 (ASC) at approximately 3:00 PM, E3 stated she was new into the position was unable to locate some of the employees file information. 9/8/23 - Findings were reviewed with E1 (ED) and E2 (RSC) at the exit conference, beginning at approximately 10:30 AM.	**Annual Vaccination - Resident**	12/8/23
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 record review, interview, and review of other facility documentation, it was determined that for three (R3, R7 and R8) out of eleven residents sampled, the facility lacked evidence of an annual influenza vaccination being administered or offered and declined. 1. 5/24/21 – R3 was admitted to the facility. The facility lacked evidence of a 2021 annual influenza vaccination having been administered or offered and declined. 2. 8/8/19 - R7 was admitted to the facility. The facility lacked evidence of any annual	**3225.9.6** A. R3 and R8 are no longer at this facility. R7 review, influenza pneumonia consent declination to be reviewed, signed & and offered. If selected & the desired influenza order for pneumonia will be administered. B. All current resident's records are to be reviewed, as well as the Delvax database. Influenza/Pneumonia consent/declination is to be reviewed, signed & and offered if selected. C. Residents would be affected by a change in management and the transition from paper to electronic admin records. The vaccination consent/declination is to be placed in PCC on RSC/ License staff education to offer vaccination and documentation in PCC tab. All are to be reviewed by the nursing team. D. New admission & and immunization forms/PCC will be reviewed by the RSC/designee prior to admission & and during flu season. Report findings in QAPI, and check deficient practices to consistently meet 100% compliance	

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	influenza vaccination having been administered or offered and declined. 3. 9/3/20 – R8 was admitted to the facility. The facility lacked evidence of a 2020 or 2021 annual influenza vaccination having been administered or offered and declined. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the annual influenza vaccinations. 9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM.		
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 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, record review and review of other facility documentation, it was determined that for six (R3, R6, R7, R8, R10 and R11) out of eleven residents sampled, the facility failed to provide evidence of the	**Vaccination – Pneumococcal pneumonia -Residents** **3225.9.7** A. Resident R3, R6, R8, R10 & R11 are no longer a resident of the facility. Resident R7 reviewed by RSC no negative outcomes were identified. B. MCA/RSC to view the UAI assessment or other documentation for evidence of pneumococcal pneumonia vaccine upon admission for residents older than 65 years of age and 5years have elapsed. Residents who refuse and will be affected the documentation will be entered into PCC for review. C. MCA/RSC will review medical evaluation for pneumococcal pneumonia vaccine prior to admission, audit for compliance per state guidelines & CDC recommendations. As far as immunization is concerned education for the resident is eligible to.	12/8/23

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	vaccination against pneumococcal pneumonia or a vaccination declination. Findings include: 1. 5/24/21 – R3 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 2. 9/23/21 - R6 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 3. 8/8/19 - R7 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 4. 9/3/20 – R8 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 5. 2/17/22 - R10 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 6. 7/7/23 - R11 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the pneumococcal vaccination or a declination of such. R2 stated she does not have access to DelVAX but will request it.	D. The ED/Designee will audit resident admission files weekly x 4 weeks, then 2x per month x 2 months. The audit will be ongoing until 100% compliance of all residents is met. Then we will audit periodically at the facility's discretion.	

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3225.10.0 3225.10.10	9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM. **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 ten (R1, R2, R3, R4, R5, R6, R7, R8, R10 and R11) out of eleven residents sampled, the facility obtained a signed contract prior to the service agreement being executed. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The initial UAI was dated on 3/1/23 and the service agreement was dated on 3/14/23. The contract was initiated on 2/28/23 and signed on 3/1/23 prior to the assessment or service agreement being completed and executed. 2. 3/3/22 – R2 was admitted to the facility. The initial UAI was dated on 3/2/22 and the service agreement was not in evidence. The contract was signed on 2/28/23 prior to the assessments being completed and executed. 3. 5/24/21 – R3 was admitted to the facility. The initial UAI was dated on 5/17/21	**Contracts** **3225.10.10** A. R3, R4, R5, R6, R8, R10, and R11 are no longer residents of this facility. R1, R2, and R7, no corrective action can be taken on the service agreement being completed after the facility contract was signed. B. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined in #C C. ED/designee will provide education related to regulation 3225.10.10. The RSC/Designee will review all resident medical records to ensure that the UAI is completed in its entirety and the service agreement/plan executed prior to the MCA/Designee initiating a contract/resident agreement D. ED/Designee will audit all potential resident assessment and service agreements on a continuous basis to ensure 100% compliance regarding completion prior to contract initiation. Based on audit findings, the ED will be responsible for directing corrective actions which will include education and progressive discipline to ensure ongoing compliance	12/8/23

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	and the service agreement was completed on 5/22/21. The contract was signed on 5/18/21 prior to the service agreement being completed and executed. 4. 12/29/14 – R4 was admitted to the facility. The initial UAI was not in evidence and the service agreement was completed on 12/30/14. The contract was initiated on 12/19/14 and signed on 12/24/14 prior to the assessments being completed and executed. 5. 5/17/21 – R5 was admitted to the facility. The initial UAI and the service agreement were not in evidence. The contract was signed on 5/12/21 prior to the assessments being completed and executed. 6. 9/23/21 – R6 was admitted to the facility. The initial UAI was not in evidence and the service agreement was completed on 9/22/21. The contract was signed on 9/21/21 prior to the assessments being completed and executed. 7. 8/8/19 – R7 was admitted to the facility. The initial UAI and the service agreement were not in evidence. The contract was signed on 4/17/19 with the date of 8/7/19 written over the original date. Either date signed was prior to the assessments being completed and executed. 8. 9/3/20 – R8 was admitted to the facility. The initial UAI was dated 8/29/20 and the service agreement was completed on 9/2/20. The contract was signed on 7/20/17 with an effective date of 7/17/20 prior to the assessments being completed and executed.		

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	9. 2/17/22 - R10 was admitted to the facility. The initial UAI and the service agreement were not in evidence. The contract was signed on 2/12/22 prior to the assessments being completed and executed. 10. 7/7/23 – R11 was admitted to the facility. The initial UAI was dated on 7/7/23 and the service agreement was dated on 7/7/23. The contract was signed on 7/3/23 prior to the assessments being completed and executed. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the assessments being completed prior to the contract signing. 9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM.		
3225.11.0 3225.11.2	**Resident Assessment** **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 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:	**Resident Assessment** **3225.11.2** A. R4, R5, R6, R10, and R11 is no longer a resident at this facility. R9 is not listed on your resident roster 8/30/23 – 9/8/2023. See attached – Exhibit C. R7 UAI in evidence and signed prior to admission within 30 days – see attached -Exhibit D. R1 cannot be changed. The MCA/designee will confirm the initial UAI has been completed prior to admission and verified by the ED. B. The MCA/RSC will confirm the UAI has been completed prior to admission and verified with the admission checklist. No move-in affected by this practice	12/8/23

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	Based on record review, interview, and review of other facility documentation, it was determined that for eight (R1, R4, R5, R6, R7, R9, R10 and R11) out of eleven residents sampled, the facility lacked evidence that the pre-admission UAI was completed within 30 days prior to admission. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The initial UAI was dated on 3/1/23 after R1's admission. 2. 12/29/14 – R4 was admitted to the facility. The initial UAI was not in evidence. 3. 5/17/21 – R5 was admitted to the facility. The initial UAI was not in evidence. 4. 9/23/21 – R6 was admitted to the facility. The initial UAI was not in evidence. 5. 8/8/19 – R7 was admitted to the facility. The initial UAI was not in evidence. 6. 7/31/23 – R9 was admitted to the facility. The initial UAI was dated on 8/1/23 after R9's admission. 7. 2/17/22 - R10 was admitted to the facility. The initial UAI was not in evidence. 8. 7/7/23 – R11 was admitted to the facility. The initial UAI was dated on 7/7/23, the day of R11's admission. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the above initial UAIs being completed or done within 30 days prior to admission.	C. The RSC will perform the initial assessment within 30 days of admission, complete, and sign, the initial UAI, and the ED/Designee will be educated by the MCA/RSC on this process D. ED/Designee will conduct an audit of newly admitted resident UAI weekly times three or until 100% compliance. The findings of the audit will be reported to QAPI monthly for 3 months to ensure compliance is obtained and maintained.	

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.11.3	9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM. **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 eight (R1, R2, R4, R5, R6, R7, R8 and R10) out of eleven residents sampled, the facility lacked evidence that the pre-admission Physician's medical evaluation was completed within 30 days prior to admission. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The Physician's pre-admission medical evaluation was completed on 2/28/23, the day of admission. 2. 3/3/22 – R2 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 3. 12/29/14 – R4 was admitted to the facility. The Physician's pre-admission medical evaluation was completed on 11/18/14, over 30 days prior to admission. 4. 5/17/21 – R5 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 5. 9/23/21 – R6 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence.	**Medical Evaluation Completed by a physician** **3225.11.3** A. R2 was admitted on 3/3/22 and the physical pre-admission medical evaluation was completed on 2/23/22, Resident R7 completed on the date of admission cannot be changed – see attached, R5 physical's medical evaluation was completed on 5/13/23 according to regulatory requirements – see attached. Resident R1, no corrective action can be taken for the physician's evaluation was completed on the date of admission. Resident R4, R6, R8, and R10 no longer resides in the community B. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined in #C C. The RSC and MCA were provided an in-service related to regulation 3225.11.3 by the ED. The MCA and RSC will review all physician evaluations to ensure that any potential admission has a completed physician evaluation conducted within the 30-day timeframe, prior to admission and that the evaluation is signed and dated in its entirety. 4. The ED will audit all potential admission documentation to ensure that 100% of all physician evaluations are conducted within the appropriate time frame, within 30 days prior to admission, and are signed and dated in its entirety. Based on	12/8/23

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	6. 8/8/19 – R7 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 7. 9/3/20 – R8 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 8. 2/17/22 - R10 was admitted to the facility. The Physician's pre-admission medical evaluation was completed on 2/17/22, the day of admission. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the above listed Physician's medical evaluations or that the evaluations were completed within 30 days prior to admission. 9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM.	audit findings, the ED will be responsible for directing corrective actions which will include re-training and progressive discipline to ensure ongoing compliance.	
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 record review, interview, and review of other facility documentation, it was determined that for eight (R1, R2, R4, R5, R6, R7, R8 and R10) out of eleven residents sampled, the facility lacked evidence that the pre-admission Physician's medical evaluation was completed within 30 days prior to admission. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The Physician's pre-admission medical	**Medical Evaluation Completed by a physician** **Duplicate** **3225.11.3** A. R2 was admitted on 3/3/22 and the physical pre-admission medical evaluation was completed on 2/23/22, Resident R7 completed on the date of admission cannot be changed – see attached, R5 physical's medical evaluation was completed on 5/13/23 according to regulatory requirements – see attached. Resident R1, no corrective action can be taken for the physician's evaluation was completed on the date of admission. Resident R4, R6, R8, and R10 no longer resides in the community	12/8/23

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	evaluation was completed on 2/28/23, the day of admission. 2. 3/3/22 – R2 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 3. 12/29/14 – R4 was admitted to the facility. The Physician's pre-admission medical evaluation was completed on 11/18/14, over 30 days prior to admission. 4. 5/17/21 – R5 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 5. 9/23/21 – R6 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 6. 8/8/19 – R7 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 7. 9/3/20 – R8 was admitted to the facility. The Physician's pre-admission medical evaluation was not in evidence. 8. 2/17/22 - R10 was admitted to the facility. The Physician's pre-admission medical evaluation was completed on 2/17/22, the day of admission. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the above listed Physician's medical evaluations or that the evaluations were completed within 30 days prior to admission. 9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM.	B. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined in #C C. The RSC and MCA were provided an in-service related to regulation 3225.11.3 by the ED. The MCA and RSC will review all physician evaluations to ensure that any potential admission has a completed physician evaluation conducted within the 30-day timeframe, prior to admission and that the evaluation is signed and dated in its entirety. 4. The ED will audit all potential admission documentation to ensure that 100% of all physician evaluations are conducted within the appropriate time frame, within 30 days prior to admission, and are signed and dated in its entirety. Based on audit findings, the ED will be responsible for directing corrective actions which will include re-training and progressive discipline to ensure ongoing compliance.	

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3225.11.4	**The resident assessment shall be completed in conjunction with the resident.** This requirement was not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that for nine (R1, R3, R4, R5, R6, R7, R9, R10 and R11) out of eleven residents sampled, the facility lacked evidence that the resident assessments were completed in conjunction with the resident or the resident's family/POA. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The initial UAI was completed on 3/1/23 and did not contain R1's family or POA's signature. 2. 5/24/21 – R3 was admitted to the facility. The initial UAI was completed on 5/17/21 and did not contain R1's family or POA's signature. The annual UAI's for 2022 and 2023 were not in evidence and the surveyor was unable to ascertain if these were completed or done in conjunction with the family/POA. 3. 12/29/14 – R4 was admitted to the facility. The initial UAI was not in evidence and the surveyor was unable to ascertain if this was completed or done in conjunction with the family/POA. 4. 5/17/21 – R5 was admitted to the facility. The initial UAI, the 2022 and 2023 annual UAIs were not in evidence and the surveyor was unable to ascertain if these were completed or done in conjunction with the family/POA.	**Resident Assessment** **3225.11.4** A. Resident R1, no corrective action can be taken for the UAI completed on 3/1/23 review and POA signed on 10/19/23. Residents R3, R4, R6, R9, R10, and R11 are no longer residents in our community. Resident R5 completed with POA signature for 2022 – see exhibit E and 2023 is not due until 11/22/23(see attached). The ED with the RSC told the survey that all 2022 is located on the misc. tab in PCC and all 2022 original is in the resident's file. B. All residents have the potential to be affected by this deficient practice. All residents will be protected by taking corrective action(s) outlined in #c C. The ED and RSC conducted an in-service to review regulation 3224.11.4 (see attached). The RSC will review all resident medical records to ensure that all UAIs have been signed and dated by either the resident or resident representative as well as the registered nurse who administered the UAI. D. The RSC/Designee will be responsible for completing audits of all new admissions as well as conducting quarterly audits to verify 100% ongoing compliance. The results of these audits will be provided to the ED for review. Based on audit findings, the ED will be responsible for directing additional corrective actions which will include re-education and progressive discipline of staff that did not properly administer and complete the UAI to ensure ongoing compliance	12/8/23

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	5. 9/23/21 – R6 was admitted to the facility. The initial UAI was not in evidence and the surveyor was unable to ascertain if this was completed or done in conjunction with the family/POA. 6. 8/8/19 – R7 was admitted to the facility. The initial UAI was not in evidence and the surveyor was unable to ascertain if this was completed or done in conjunction with the family/POA. 7. 7/31/23 – R9 was admitted to the facility. The initial UAI was completed on 8/1/23 and did not contain R1's family or POA's signature. 8. 2/17/22 - R10 was admitted to the facility. The initial UAI was not in evidence and the surveyor was unable to ascertain if this was completed or done in conjunction with the family/POA. 9. 7/7/23 – R11 was admitted to the facility. The initial UAI was completed on 7/7/23 and did not contain R1's family or POA's signature. 8/31/23 – Per interview with E1 (ED), E1 stated the family signs both the UAI and SA and receives a copy of both. E1 was unable to provide signed and dated documents to the Surveyor. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the above UAIs being completed or done in conjunction with the resident's family/POA. E2 stated the resident's families receive a copy of the UAI and service agreement if they request it.		

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	9/8/23 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 10:30 AM.		
3225.11.5	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates 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 record review, interview, and review of other facility documentation, it was determined that for nine (R1, R2, R3, R4, R5, R6, R7, R10 and R11) out of eleven residents sampled, the facility lacked evidence that the 30-day post admission or annual UAIs were completed. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The 30-day post admission UAI was not in evidence. 2. 3/3/22 – R2 was admitted to the facility. The 30-day post admission UAI was not in evidence. 3. 5/24/21 – R3 was admitted to the facility. The 30-day post admission UAI was not in evidence. The annual UAIs due in June 2022 and 2023 were not in evidence. 4. 12/29/14 – R4 was admitted to the facility. The 30-day post admission UAI was not in evidence. 5. 5/17/21 – R5 was admitted to the facility. The 30-day post admission UAI was not in evidence. The annual UAIs due in June 2022 and 2023 were not in evidence.	The UAI 3225.11.5 A. Resident R3, R4, R6, R10, and R11 have no correction action as the resident no longer resides in the facility. Residents R1, R2, R5, and R7 cannot be changed. B. Nothing can be done to change passed assessment dates for residents. All residents have the potential to be affected by this practice. C. It was determined that the completion of UAIs in the 30-day requirement was missed. The RSC was educated by the regional nurse and then the RSC in service by the ED on regulation 3225.11.5. Resident in accordance with regulation 3225.11.5 will be discussed at clinical meetings weekly if a new assessment is needed. Ed or the designee will monitor the discussion to ensure the review is completed prompted. This audit will occur weekly times four and twice per month to achieve regulatory compliance. D. The ED/Designee will audit 15% of UAI assessments to ensure compliance with state regulations. This will be reviewed weekly times 4 weeks and then monthly until 100% compliance is achieved. The frequency of the audits adjusted according to outcomes	12/8/23

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	6. 9/23/21 – R6 was admitted to the facility. The 30-day post admission UAI was not in evidence. 7. 8/8/19 – R7 was admitted to the facility. The 30-day post admission UAI was not in evidence. 8. 2/17/22 - R10 was admitted to the facility. The 30-day post admission UAI was not in evidence. 9. 7/7/23 – R11 was admitted to the facility. The 30-day post admission UAI was not in evidence. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the above 30-day or annual UAIs being completed. 9/8/23 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 10:30 AM.		
3225.13.0 **3225.13.1**	**Service Agreements** **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.** This requirement was not met as evidenced by:	**Service Agreement** **3225.13.0 and 3225.13.1** A. Residents R3, R4, R6, R8, R10, and R11 no longer reside in the community and are unable to correct. Resident R9 is not on the resident roster 8/30 – 9/8/23 – see Exhibit C. Resident R1, R2, R5, and R7 service agreements will be completed and brought to the current with POA/signature. B. The RSC will be conducting an audit of current resident medical records to identify the need for a signed service agreement. The RSC will incorporate the process of initiating a signed agreement with	12/8/23

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	Based on record review, interview, and review of other facility documentation, it was determined that for eleven (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10 and R11) out of eleven sampled residents, the facility failed to provide evidence that the service agreement was completed in conjunction with the resident/POA. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The initial service agreement was completed on 3/14/23, approximately two weeks after admission and did not contain R1's family or POA's signature. 2. 3/3/22 – R2 was admitted to the facility. The facility lacked evidence that an initial service agreement was completed prior to or on admission and the Surveyor was unable to ascertain if it was completed or done in conjunction with the family/POA. Subsequent service agreements completed on 5/1/23, 11/3/22 and 10/30/22 did not contain the signature of the family/POA. 3. 5/24/21 – R3 was admitted to the facility. The initial service agreement dated 5/22/21 did not contain the family/POA signature. Subsequent service agreements completed on 5/4/23, 11/3/22 and 8/30/21 did not contain the signature of the family/POA. 4. 12/29/14 – R4 was admitted to the facility. The initial service agreement was completed on 12/30/14, one day after admission and did not contain the family/POA signature. Subsequent service agreements completed on 1/27/21, 3/28/20 and 1/7/20 did not contain the signature of the family/POA.	each new admission in conjunction with the family/POA signature. C. The findings of 3225.13.1 will be reviewed with the RSC. The RSC will review all resident medical records to ensure that all service agreements have been reviewed, signed, and dated by the POA/family. The ED will provide the RSC education on the needs identified in the service agreement D. The RSC/Designee will be responsible for completing audits of all new admissions as well as conducting quarterly audits to verify 100% ongoing compliance. The results of these audits will be provided to the ED for review. Based on the review the ED will be responsible for directing additional corrective actions to ensure ongoing compliance.	

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	5. 5/17/21 – R5 was admitted to the facility. The facility lacked evidence that an initial service agreement was completed prior to or on admission and the Surveyor was unable to ascertain if it was completed or done in conjunction with the family/POA. Subsequent service agreements completed on 11/2/22 and 8/5/21 did not contain the signature of the family/POA. 6. 9/23/21 – R6 was admitted to the facility. The initial service agreement was completed on 9/22/21 and did not contain the signature of the family/POA. A subsequent service agreement completed on 11/3/22 did not contain the signature of the family/POA. 7. 8/8/19 – R7 was admitted to the facility. The facility lacked evidence that an initial service agreement was completed prior to or on admission and the Surveyor was unable to ascertain if it was completed or done in conjunction with the family/POA. Subsequent service agreements completed on 5/4/23, 8/5/21 and 8/10/20 did not contain the signature of the family/POA. 8. 9/3/20 - R8 was admitted to the facility. The initial service agreement was completed on 9/2/20 and did not contain the signature of the family/POA. Subsequent service agreements completed on 5/4/23 and 1/26/21 did not contain the signature of the family/POA.		
	9. 7/31/23 – R9 was admitted to the facility. The initial service agreement was completed on 8/1/23, one day after admission and did not contain R1's family or POA's signature.		

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	10. 2/17/22 - R10 was admitted to the facility. The initial service agreement was not in evidence and the surveyor was unable to ascertain if this was completed or done in conjunction with the family/POA. Subsequent service agreements completed on 5/4/23, 11/2/22 and 10/29/22 did not contain R1's family or POA's signature. 11. 7/7/23 – R11 was admitted to the facility. The initial service agreement was completed on 7/7/23 and did not contain R1's family or POA's signature. 8/31/23 – Per interview with E1 (ED), E1 stated the family signs both the UAI and SA and receives a copy of both. E1 was unable to provide signed and dated documents to the Surveyor. 9/8/23 – Per interview with E2 (RSC) at approximately 10:05 AM, E2 confirmed these residents' records lacked evidence of the above service agreements being completed or done in conjunction with the resident's family/POA. E2 stated the resident's families receive a copy of the UAI and service agreement if they request it. 9/8/23 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 10:30 AM.	**Physician's Information/Service Agreement**	12/8/23
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, interview, and review of other facility documentation, it was determined that for eleven (R1, R2, R3, R4,	**3225.13.3** A. The RSC/Designee indicated the physician's name address and phone number will added on R1. R2, R5, and R7 to the service plan. Residents R3, R4, R5, R6, R8, R10, and R11 are no longer residents of this community. Resident R9 is not on the roster for 8/30/23 – 9/8/23.	

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	R5, R6, R7, R8, R9, R10 and R11) out of eleven sampled residents, the facility failed to provide evidence that the service agreement contained the resident's personal Physician's name, address, and phone number. Findings include: 1. 2/28/23 - R1 was admitted to the facility. The facility lacked evidence that the service agreement completed on 3/14/23 contained the personal Physician's address and phone number. 2. 3/3/22 – R2 was admitted to the facility. The facility lacked evidence that the service agreements completed on 10/30/22, 11/3/22 and 5/1/23 contained the personal Physician's address and phone number. 3. 5/24/21 – R3 was admitted to the facility. The facility lacked evidence that the service agreements completed on 5/22/21, 8/30/21, 11/3/22 and 5/4/23 contained the personal Physician's address and phone number. 4. 12/29/14 – R4 was admitted to the facility. The facility lacked evidence that the service agreements completed on 12/30/14, 1/7/20, 3/28/20 and 1/27/21 contained the personal Physician's address and phone number. 5. 5/17/21 – R5 was admitted to the facility. The facility lacked evidence that the service agreements completed on 8/5/21 and 11/2/22 contained the personal Physician's address and phone number. 6. 9/23/21 – R6 was admitted to the facility. The facility lacked evidence that the service agreements completed on 9/22/21	B. All residents have the potential to be affected by this practice. A notation has been made on the current service plan of all residents' attending physician's names, addresses, and phone numbers by RSC/Designee. C. It was determined that the RSC/Designee was not following the regulation related to listing the physician's contact information. The RSC will be serviced by the ED on regulation 3224.13.3 on the policy to include the physician's name, address, and phone number on the resident service plan. D. The ED/Designee will audit all resident medical records to ensure the attending physician's contact information is accurate weekly times 4 weeks and then monthly until 100% compliance. Based on findings will be reported during the monthly QAPI and reviewed for compliance.	

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	and 11/3/22 contained the personal Physician's address and phone number. 7. 8/8/19 – R7 was admitted to the facility. The facility lacked evidence the service agreements completed on 8/10/20, 8/5/21 and 5/4/23 contained the personal Physician's address and phone number. 8. 9/3/20 - R8 was admitted to the facility. The facility lacked evidence that the service agreements completed on 9/2/20, 1/26/21 and 5/4/23 contained the personal Physician's address and phone number. 9. 7/31/23 – R9 was admitted to the facility. The facility lacked evidence that the service agreement completed on 8/1/23 contained the personal Physician's address and phone number. 10. 2/17/22 - R10 was admitted to the facility. The facility lacked evidence that the service agreements completed on 10/29/22, 11/2/22 and 5/4/23 contained the personal Physician's address and phone number. 11. 7/7/23 – R11 was admitted to the facility. The facility lacked evidence that the service agreement completed on 7/7/23 contained the personal Physician's address and phone number. 9/8/23 – Per interview with E1 (ED) and E2 (RSC) at approximately 10:25 AM, E2 confirmed the service agreements do not contain the personal Physician's address and phone number. E1 stated she will look into the EMR system to get the fields added to the electronic version of the service agreements.		

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	9/8/23 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 10:30 AM.	**Fire and Safety Missing Resident Drills**	12/8/23
3225.16.6	**The Director/Nursing Home Administrator shall have overall responsibility for managing the assisted living facility such that all requirements of state law and regulations are met.**	**3225.16.6/ 3225.16.14/ 3225.16.14.2/ 3223.16.14.2.1** A. The community was unable to find missing resident drill documentation due to the recent management turnoff of RSC and RSS	
3225.16.14	**Assisted living facility resident assistants shall, at a minimum:**		
3225.16.14.2	**Participate in a facility-specific orientation program that covers the following topics:**	B. All residents have the potential to be Affected by this deficient practice.	
3225.16.14.2.1	**Fire and life safety, and emergency disaster plans;**	C. The RSC/RSS will be educated on missing resident drills and the safety of all residents. All new hires will be educated and in-service on missing resident drills. Missing resident drills will be completed with alternating shifts.	
	This requirement was not met as evidenced by:		
	Based on interview and review of other facility documentation, it was determined that the facility lacked sufficient staff training for life safety of residents. Findings include:	D. The RSC/RSS will perform monthly missing resident drills on all shifts biweekly for the next two months. The ED/Designee will ensure that missing resident drills are completed on all shifts. All findings will be reported monthly to QAPI until 100% compliance	
	9/7/23 – Per review of the facility policy and procedure on page 5, section 7A of the Safety and Security of Residents states:		
	Missing Resident Drills – completed with alternating shifts. Documentation Drills will be completed by RSC or RSS.		
	The facility lacked evidence these drills were completed.		
	9/8/23 – Per interview with E1 (ED) at approximately 10:25 AM, E1 confirmed elopement drills should be done monthly, however E1 confirmed that none were in		

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	evidence other than the one drill that was conducted after the August 4, 2023, elopement of a resident. 9/8/23 - Findings were reviewed with E1 and E2 (RSC) at the exit conference, beginning at approximately 10:30 AM.	**Records and Report** **3225.19.0/ 3225.19.6/ 3225.19.7/ 3225.19.7.1/** **3225.19.7.1.1/ 3225.19.7.1.1.2**	12/8/23
3225.19.0	**Records and Reports**	A. R1 incident on 5/20/23 was reported Web Take **#81176** – see exhibit H. R1 incident on 5/27/23 was reported Web take **#81273 – see exhibit I**. R2 per surveyor notes of Resident to resident altercation on this 2567 no EMR notes on 12/22/22. R2 incident on 6/21/23 Notes on 2567 has incorrect date. R2 incident Occur on 6/25/23 and reported with Web take **#81554 – see exhibit .** R4 and R6 no longer residents in the Facility. R6 incident on 4/17/23 was reported Web take **#69080**	
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.**		
3225.19.7	**Reportable incidents include:**		
3225.19.7.1	**Abuse as defined in 16 Del.C. §1131.**		
3225.19.7.1.1	**Physical abuse.**		
3225.19.7.1.1.2	**Resident to resident with or without injury.** This requirement was not met as evidenced by: Based on interview and review of other facility documentation, it was determined that for four (R1, R2, R4 and R6) out of eleven sampled residents, the facility failed to report a resident-to-resident incident. Findings include: 1. 3/3/22 – R2 was admitted to the facility. On review of the EMR, an entry on 8/21/22 at 6:00 PM, indicated R2 was yelling/screaming and hitting other residents. This resident-to-resident altercation was not reported to the State by the facility.	B. All residents have the potential to be affected by this practice. Reportable incidents need to be reported within 8 hours of the occurrence to the Division. Incidents that require reported will be confirmed timely reporting; instances when reportable notification within 8 hours of the occurrence were delinquent will be reported immediately. C. ED/Designee will provide education to all licensed nurses/Agency nurses regarding timely notification of reportable incidents and identification of reportable incident reports that require timely notification to the Division and report within 8 hours of the occurrence to the Division.	

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	On 12/22/22 at 9:00 PM, the EMR entry indicated R2 had an altercation with another resident. 12/23/22 at 1:27 PM, the EMR entry indicated R2 was doing better and indicated no injuries from being hit. Per the NP entry on 12/29/22 at 1:47 PM, the NP noted late entry that R2 was hit by another peer. This resident-to-resident altercation was not reported to the State by the facility. On 6/21/23 at approximately 11:00 PM, R2 was in her room. At approximately midnight R2 was presumably hit in the face by R12 who was seen leaving R2's room. R2 was found sitting on the floor and stated that a male resident hit her in the face, and she fell off of her chair. This incident was not witnessed. On 6/19/23 at 11:51 AM, the EMR entry indicated R2 has discoloration around the right eye. The resident-to-resident altercation was reported to the State by the facility on 6/26/23, five days after the incident. 3. 12/29/14 – R4 was admitted to the facility. Per the EMR entry on 9/19/22 at 8:19 PM, the record indicated that an aide reported to E2 (RSC) that a male resident slapped R4 in the face resulting in bruising. R4 was sent to the hospital for evaluation and seen per the trauma team. Examination revealed periorbital area/eye bruising and swelling. This resident-to-resident altercation was not reported to the State by the facility.	D. The ED/Designee will audit 100% of incident reports to ensure the community is reporting according to regulatory compliance for reportable incident reporting, state reportable incidents of unknown origin. The time frame for documentation will be weekly times three then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendation	
3225.19.7.7 3225.19.7.7.1	**Significant injuries.** **Injury from an incident of unknown source in which the initial investigation concludes that there is reasonable basis to suspect**	**3225.19.7.7/ 3225.19.7.7.1** A. R3 and R4 are no longer a resident in our community. R1, R2, and R7 agency and	12/8/23

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	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 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 documentation, it was determined that for five (R1, R2, R3, R4 and R7) out of eleven sampled residents, the facility failed to report or report timely the resident injuries of unknown cause. Findings include: 1. 2/28/23 - R1 was admitted to the facility. Per a facility incident report, R1 was found on 7/30/23 at 4:15 PM in the dining room bleeding from his eyebrow and inner left arm. It was unknown how this injury occurred. The facility failed to report this incident to the State. On 8/10/23 at approximately 11:50 AM, R1 was found in his bed bleeding from his head from the upper area of R1's right eyelid. It was unknown how the injury occurred but there was blood noted on the floor next to R1's bed. R1 had no history of falls over the previous six months but was noted to be combative at times. R1 was also lethargic, unable to form sentences and unable to stand. 911 was called and R1 was transported to the hospital at 11:55 AM. Per the hospital record on 8/11/23 at approximately 11:55 AM, R1 had fallen in the hospital. R1 was returned to the facility and was noted to have five stitches to his head, multiple upper extremity bruising,	community RSS did not report incidents of unknown origin to the state. B. All residents have the potential to be affected by this practice. Incident report of unknown origin needs to be reported within 8 hours of the occurrence to the Division. Incidents that require reported will be confirmed timely reporting; instances when reportable notification within 8 hours of the occurrence were delinquent will be reported immediately. C. ED/Designee will provide education to all licensed nurses/Agency nurses regarding timely notification of incidents and identification of incident reports that require timely notification to the Division and report within 8 hours of the occurrence to the Division. D. The ED/Designee will audit 100% of incident reports to ensure the community is reporting according to regulatory compliance for incident reporting, state reportable incidents of unknown origin. The time frame for documentation will be weekly times three then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendation	

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	combative behaviors and was COVID positive. The facility reported this incident on 8/14/23, four days after the event. 2. 3/3/22 – R2 was admitted to the facility. On 3/24/23 at 6:20 PM, the EMR entry noted that R2's family reported bruising on R2's left hand. Per the EMR entry on 3/21/23 at 6:46 AM, R2's left wrist and fingers were swollen with black and blue discoloration. R2 was given Ibuprofen for the pain and swelling. On 3/25/23 at 10:52 AM, the EMR entry indicated a fluid filled like swelling was noted on her left wrist. The Physician and POA were notified, x-rays were obtained which revealed a fracture of the distal metaphysis of the fifth metacarpal. R2 was sent to the hospital on 4/1/23 for complaints of dizziness and pain to the left hand. The facility failed to report this injury of unknown origin to the State. On 8/27/23 it was noted in R2's EMR entry of having a bruise under the right eye measuring 1.8 x 2 cms. On 8/28/23 the NP noted R2 had right side face swelling and ordered a facial x-ray. Results were pending. The facility failed to report this injury of unknown origin to the State. 3. 5/24/21 – R3 was admitted to the facility. On 8/6/23 at approximately 1:59 PM, the EMR entry noted R3 with discoloration and signs of pain on R3's right foot. On 8/7/23 at 8:31 AM, x-rays of R3's right ankle and foot were ordered. Results were pending. The facility failed to report this injury of unknown origin to the State. On 8/7/23 at 3:52 PM, R3's EMR entry noted R3 was missing during hourly checks and was found in the public restroom. During R3's assessment, it was noted R3 had a		

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	small mark on her forehead, discoloration on right shoulder and both hands, and a bruise on her left buttock and right shin. The facility failed to report this injury of unknown origin to the State. 4. 12/29/14 – R4 was admitted to the facility. On 7/12/23 per review of an emergency room record, R4 was evaluated for a closed head injury after hitting her head. R4 sustained a hematoma to the left side of her head. The facility failed to report this injury of unknown origin to the State. 5. 8/8/19 – R7 was admitted to the facility. Per R7's EMR entry on 5/5/23 at 3:40 PM, the nurse found R7 with a hematoma on her forehead of unknown origin. The facility failed to report this injury of unknown origin to the State. 9/8/23 – Per interview with E1 (ED) at approximately 10:25 AM, E1 was unable to provide evidence of the above incidents being reported to the State. 9/8/23 - Findings were reviewed with E1 and E2 (RSC) at the exit conference, beginning at approximately 10:30 AM.		
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 interview and review of other facility documentation, it was determined that for two (R5, and R11) out of eleven	A. R11 incident was reported web intake #81830 – see attached – exhibit L – R11 no No longer reside at our community B. All residents have the potential to be affected by this practice. Reportable incidents need to be reported within 8 hours of the occurrence to the Division. Inci-	12/8/23

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	sampled residents, the facility failed to report or report timely resident falls resulting in an injury. Findings include: 1. 5/17/21 - R5 was admitted to the facility. On 8/5/23 at 5:45 PM it was reported that staff in the kitchen heard yell for help from the lounge. Staff found R5 sitting on the floor in front of the couch. When staff assisted R5 off the floor, R5 complained of back pain. The NP was notified and ordered R5 to be sent to the hospital. Per R5's history, she had sustained one fall within the last six months which was without injury. The residents in the lounge were unattended at the time of the incident and the event was unwitnessed. ER evaluation revealed R5's lumbar spine was with mild tenderness to the lumbar-sacral area in the paravertebral spine muscles. X-rays were not remarkable for acute injury. Discharge diagnosis for R5 was listed as a back contusion. The facility reported this incident on 8/14/23 at 1:42 PM, nine days after the occurrence. 2. 7/7/23 - R11 was admitted to the facility. Per R11's EMR entry on 7/21/23 at approximately 12:30 AM, the staff was attending R11 after a fall to the floor by the nightstand. On assessment, R11 was noted to have sustained a hematoma on the right side of her forehead. R11 was sent to the emergency room at 11:48 PM and returned to the facility later that morning with a noted bruise over her right eye. The facility failed to report this incident to the State. On 8/12/23 at 10:25 AM, it was reported that R11 was screaming for help after being assisted to bed. The RC found R11 on the floor next to the bed lying in a pool of blood. On assessment it was noted R11 was	dents that require reported will be confirmed timely reporting; instances when reportable notification within 8 hours of the occurrence were delinquent will be reported immediately. C. ED/Designee will provide education to all licensed nurses/Agency nurses regarding timely notification of reportable incidents and identification of reportable incident reports that require timely notification to the Division and report within 8 hours of the occurrence to the Division. D. The ED/Designee will audit 100% of incident reports to ensure the community is reporting according to regulatory compliance for reportable incident reporting, state reportable incidents of unknown origin. The time frame for documentation will be weekly times three then monthly till 100% compliance is achieved. Findings will be reported during the monthly QAPI meeting for review and recommendation	

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	bleeding from the right side of her forehead. 911 was called and R11 was transported to the hospital. R11 was returned to the facility under Hospice care on 8/15/23 via stretcher at 1:50 PM. The hospital discharge record revealed R11 received two stitches to her right eyebrow. The facility reported this injury to the State on 8/14/23 at 11:49 AM, two days after incident. 9/8/23 – Per interview with E1 (ED) at approximately 10:25 AM, E1 confirmed the above incidents were not reported or reported timely to the State. 9/8/23 - Findings were reviewed with E1 and E2 (RSC) at the exit conference, beginning at approximately 10:30 AM.		
16 Delaware Code, Chapter 11, Subchapter 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.)** **(1) "Abuse" means the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and includes all of the following:** **a. Physical abuse. —** **"Physical abuse" means the unnecessary infliction of pain or injury to a patient or resident. "Physical abuse" includes hitting, kicking, punching, slapping, or pulling hair. If any act constituting physical abuse has been proven, the infliction of pain is presumed.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was	**16 Delaware Code, Chapter 11, Subchapter III** A. R3 incident was investigated and employee was terminated, and this was shown to the surveyor. The state investigated this incident and all request information sent o QA/State. B. All residents have the potential to be affected C. All staff educated and in service on 4/7/23, 4/8/23, 4/10/23, and 4/11/23 on Abuse, Neglect, Mistreatment, Financial exploitation, or Medication Diversion of patients or residents. For all current residents who reside in our community will be conducted in order to identify potential physical abuse behaviors and associated behavior management intervention in order to minimize risk of such potential behaviors D. The RSC/designee will conduct weekly audits until compliance 100%	12/8/23

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	determined that for four (R1, R2, R4 and R6) out of eleven sampled residents, the facility failed to prevent abuse to residents. Findings include: 1. 2/28/23 - R1 was admitted to the facility. On 5/27/23 an entry into the EMR at 9:22 PM indicated that at approximately 2:30 PM staff responded to shouts for help due to R1 punching another male resident (R12). R1 was noted to have sustained a bump to his right cheek and scratch on the right side of his forehead. 2. 3/3/22 – R2 was admitted to the facility. On review of the EMR, an entry on 8/21/22 at 6:00 PM, indicated R2 was yelling/screaming and hitting other residents. On 12/22/22 at 9:00 PM, the EMR entry indicated R2 had an altercation with another resident. 12/23/22 at 1:27 PM, the EMR entry indicated R2 was doing better and indicated no injuries from being hit. Per the NP entry on 12/29/22 at 1:47 PM, the NP noted late entry that R2 was hit by another peer. On 6/21/23 at approximately 11:00 PM, R2 was in her room. At approximately midnight R2 was presumably hit in the face by R12 who was seen leaving R2's room. R2 was found sitting on the floor and stated that a male resident hit her in the face and she fell off of her chair. This incident was not witnessed. On 6/19/23 at 11:51 AM, the EMR entry indicated R2 has discoloration around the right eye. 3. 12/29/14 – R4 was admitted to the facility. Per the EMR entry on 9/19/22 at 8:19 PM, the record indicated that an aide reported to E2 (RSC) that a male resident slapped R4 in the face resulting in bruising.	is achieved and audit will be completed monthly and report quarterly as part of the QA monitor plan	

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	R4 was sent to the hospital for evaluation and seen per the trauma team. Examination revealed periorbital area/eye bruising and swelling. 4. 9/23/21 – R6 was admitted to the facility. Per the EMR entry on 4/17/22 at 4:45 PM, the EMR entry indicated that R6 was aggressively approaching another male resident (R12) who retaliated and started throwing punches toward R6. On 9/19/22 at 8:06 PM, the record indicated that an aide reported to E2 (RSC) that R6 slapped a female resident across the face. On 2/4/23 at 3:47 PM the record indicated R6 was observed slapping another resident. Residents were separated and removed from the environment. 9/8/23 – Per interview with E1 (ED) at approximately 10:25 AM, E1 stated some of these incidents occurred prior to her hire and E1 was unsure of incident details and was unable to provide facility documentation of such. 9/8/23 - Findings were reviewed with E1 and E2 (RSC) at the exit conference, beginning at approximately 10:30 AM. **(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.**	A. R1 incident was investigated. The state investigated this incident as well and all request information sent to QA team at the state. See attached Exhibit A and B B. All residents have the potential to be affected C. All staff will be educated and in service being present in the day room when residents are in the day room. For all current residents who resides in our community	12/8/23

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	This requirement was not met as evidenced by: Based on interview, facility tour, medical records review and review of other facility documentation, it was determined that for one (R1) out of eleven sampled residents, the facility failed to provide good and services necessary to avoid physical, harm, mental anguish, or mental illness. Findings include: 1. 8/4/23 – R1 was reported being found by staff at the neighboring facility on the campus. The Arden Courts staff returned R1 to his room and R1 was found to have a skin tear to his left knee and thigh and some discoloration around his right eye. Reported camera footage revealed R1 exited the building at about 9:10 PM and was discovered by the other facility staff at about 9:30 PM. R1's EMR indicated he exhibited consistent exit seeking behaviors. 8/30/23 – During a tour of the facility with E1 (ED) at approximately 10:30 AM, the Surveyor was informed by E1 that the exterior utility door alarm was not in working order. The facility failed to properly monitor the working order of door alarms and R1 was able to exit the building without the door alarming. The inside door leading into the utility area needing a key to open, was left propped open by a staff member. R1 was able to enter the propped open door and exit the exterior door without a working alarm to leave the facility. E1 stated she was not able to confirm which staff propped the interior door open and there was no camera surveillance in this area.	will be conducted in order to identify potential lack of attention behaviors and associated with providing management intervention in order to minimize risk of to avoid physical, harm, mental anguish or mental illness. D. The RSC/designee will conduct weekly audits until compliance 100% is achieved and audit will be completed monthly and report quarterly as part of the QA monitor plan.	

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	9/8/23 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 10:30 AM.		

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