DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
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STATE SURVEY REPORT

NAME OF FACILITY: Sunrise Assisted Living

DATE SURVEY COMPLETED: June 14, 2013

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual and complaint survey was conducted at this facility beginning May 30, 2013 and ending June 14, 2013. The facility census on the entrance day of the survey was 73. The survey sample was composed of 15 residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures.	3225.9.1 • The Healthcare Coordinator (HCC) met with the resident and designated persons. It was decided that the community would apply for a waiver for the resident to remain being cared for at the community. • The HCC is obtaining a physician's evaluation of resident #14 to include with the with the waiver application. • Once a decision has been obtained from the Division of LTCRP a family meeting will be held to review the outcome and determine next action steps. • In the interim the resident will remain being cared for by the Care Managers who empty and change the bag and Nursing staff who monitor the process. • The HCC will conduct an audit of all residents to determine if there are any that require care by a nurse that is more than intermittent or for more than a limited period of time. If any residents are identified the HCC and Care team will meet with the resident and designated person to determine if to: (1) apply for a waiver in order for the resident to remain at the community or, (2) discharge the resident to an appropriate placement, is the most appropriate course of action. • During the initial assessment any resident moving in that is assessed by the HCC to need care by a nurse that is less than intermittent and only for a limited period of time, will be added to the agenda for "At Risk" meetings. During these monthly meetings the care team will discuss any changes in the residents' conditions, in order to monitor the level and
3225.0	**Assisted Living Facilities**	
3225.5.9	**An assisted living facility shall not admit, provide services to, or permit the provision of services to individuals who, as established by the resident assessment:**	
3225.5.9.1	**Require care by a nurse that is more than intermittent or for more than a limited period of time;** **This requirement is not met as evidenced by:** Based on clinical record review and staff interview it was determined that the facility failed to comply with Delaware state Assisted Living Regulations and provided services for one resident (Resident #14) out of 15 sampled who required monitoring of a colostomy by a nurse for more than an intermittent or a limited period of time. Findings include: Cross refer 3225.13.0, 3225.13.5, example 8.	

Joseph F. Kanuska, Executive Director 9-6-13

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	In an interview conducted between this surveyor and E1 (executive director), E3 (Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013 it was confirmed that the facility failed to comply with state regulations for assisted living facilities that prohibited the provision of services to a resident who required care by a nurse for more than an intermittent basis or for more than a limited period of time. This finding was reviewed with E1 (executive director), E2 (corporate director of Quality Assurance), E3 (Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	frequency of care needed. If any residents are identified to require care by a nurse that is more than intermittent or for more than the limited period of time previously identified the care team will meet with the resident and designated person to determine if to: (1) apply for a waiver in order for the resident to remain at the community or, (2) discharge the resident to an appropriate placement, is the most appropriate course of action. • During the monthly Quality Assurance (QA) meeting any resident that is being monitored through the monthly "At Risk" meetings will be reviewed with all Coordinators including the Executive Director (ED) to discuss the individual residents level of care and what action, if any, needs to be taken. **Date by when to be corrected: September 16, 2013 and ongoing**

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3225.6.0 **3225.6.1**	**Resident Waivers** **An assisted living facility may request a resident-specific waiver so that it may serve a current resident who temporarily requires care otherwise excluded in section 5.9. A waiver request shall contain documentation by a physician stating that the resident's condition is expected to improve within 90 days.** **This requirement is not met as evidenced by:** Cross refer 3225. 5, 3225.5.9, 3225.5.9.1. Based on clinical record review and staff interview it was determined that the facility failed to request a waiver from the state agency that was specific to one resident (Resident #14) out of 15 sampled with a colostomy. Findings include: In an interview conducted on 6/14/2013 with E1 (executive director) it was acknowledged that no waiver had been requested for Resident #14 who required monitoring and was dependent in the care of her colostomy. Review of the clinical record also revealed a written nursing assessment dated 10/29/2012 that described changes in the colostomy "over the last few months". This completed assessment was faxed to Resident #14's physician and included changes in the appearance and position of the colostomy. The colostomy was described as "more inverted", having a shift in the position of the colostomy site	**3225.6.0** • The HCC met with the resident and designated persons. It was decided that the community would apply for a waiver for the resident to remain being cared for at the community. • The HCC is obtaining a physician's evaluation of resident #14 to include with the with the waiver application. • Once a decision has been obtained from the Division of LTCRP a family meeting will be held to review the outcome and determine next action steps. • In the interim the resident will remain being cared for by the Care Managers who empty and change the bag and Nursing staff who monitor the process. • The HCC will conduct an audit of all residents to determine if there are any that require care by a nurse that is more than intermittent or for more than a limited period of time. If any residents are identified the HCC and Care team will meet with the resident and designated person to determine if to: (1) apply for a waiver in order for the resident to remain at the community or, (2) discharge the resident to an appropriate placement, is the most appropriate course of action. • During the initial assessment any resident moving in that is assessed by the HCC to need care by a nurse that is less than intermittent and only for a limited period of time, will be added to the agenda for "At Risk" meetings. During these monthly meetings the care team will discuss any changes in the residents' conditions, in order to monitor the level and frequency of care needed. If any residents are identified to require care by a nurse that is

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	and difficulty in placing the drainage bag over the colostomy site. Further review of the clinical record revealed a nurse's note dated 11/13/2012 and timed 3:09 PM that stated an assessment of Resident #14's colostomy by a specialist indicated the "development of a hernia in the area". According to the specialist "nothing will be done". However Resident #14 will require monitoring for output from the colostomy and pain. Although the facility was aware that Resident #14 required increased care by a nurse for more than an intermittent basis or for more than a limited period of time, it failed to submit a request for a waiver in order to provide services and to meet the needs of the resident who required care by a nurse for more than an intermittent basis or for more than a limited period of time. This finding was reviewed with E1 (executive director), E2 (corporate director of Quality Assurance), E3 (Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	more than intermittent or for more than the limited period of time previously identified the care team will meet with the resident and designated person to determine if to: (1) apply for a waiver in order for the resident to remain at the community or, (2) discharge the resident to an appropriate placement, is the most appropriate course of action. • During the monthly Quality Assurance meeting any resident that is being monitored through the monthly "At Risk" meetings will be reviewed with all Coordinators including the ED to discuss the individual residents level of care and what action, if any, needs to be taken. **Date by when to be corrected: September 16, 2013 and ongoing**

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3225.11.0 **3225.11.4**	**Resident Assessment** **The resident assessment shall be completed in conjunction with the resident.** **This requirement is not met as evidenced by:** Based on clinical record review it was determined that the facility failed to complete the UAI (Uniform Assessment Instrument) with dates and signatures in conjunction with six residents (Resident #1, #2, #3, #6, #7 and #11) out of 15 sampled. Findings include: 1. Review of the annual UAI dated 5/17/2012 revealed no evidence of completion of the date and signature of Resident #1 or her representative. These findings were reviewed with E1 (executive director), E2 (corporate director of Quality Assurance), E3 (Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 2. Review of the current UAI named for Resident #2 but absent classification also revealed no evidence of completion of the date and signature of the facility staff member and Resident #2 or her representative. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4	**3225.11.0** • Resident #1's UAI was updated on 5/17/13. With the most recent updated version, the HCC reviewed the UAI with the resident and the resident's representative. Signatures and dates were obtained when the UAI was reviewed. • Resident #2 has since passed. • Resident #3 no longer resides at the community. • Resident #6 has since passed. • Resident #7's UAI was updated on 6/26/13. With the most recent updated version, the HCC reviewed the UAI with the resident and the resident's representative. Signatures and dates were obtained when the UAI was reviewed. • Resident #11's UAI was updated on 8/12/13. With the most recent updated version, the HCC reviewed the UAI with the resident and the resident's representative. Signatures and dates were obtained when the UAI was reviewed. • The ED reviewed the UAI requirements with the Care Coordinators. • The HCC conducted an audit to determine if any other UAI's are missing full completion including dates and signatures. If any missing items were identified, a family meeting was held or has been scheduled to review and obtain signatures. • The HCC or designee (a Registered Nurse) completes the UAI in conjunction with the resident and/or designated persons upon

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	(facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 3. Cross refer 3225.13.0, 3225.13.5, example #3. Review of a UAI named for Resident #3 with missing pages and absent classification also revealed no evidence of completion of the date and signature of the facility staff member and Resident #3 or her representative. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 4. Review of the annual UAI dated 10/9/2012 revealed no evidence of the completion of the date and signature of the facility staff member and Resident #6 or her representative. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 5. Review of the UAI dated 1/4/2013 and completed for a significant change in condition revealed no evidence of completion of the date and signature of Resident #7 or his representative. These findings were reviewed E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility	move-in, including regular updates 30 days after admission, annually and when there is a significant change in the resident's condition. During the reviews the HCC or designee will obtain dates and signatures from all participants. • The ED will conduct random audits of UAI's to ensure full completion and that dates and signatures are being obtained. • During the monthly Quality Assurance meeting all UAI's completed for the month prior will be brought to the meeting to be reviewed for completeness, dates and signatures by the Coordinators, including the ED. **Date by when to be corrected: September 16, 2013 and ongoing**

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	care coordinator) on 6/14/2013. 6. Review of the annual UAI dated 8/4/2012 revealed no evidence of completion of the date and signature of the facility staff member and Resident #11 or her representative. These findings were reviewed E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	

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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 is not met as evidenced by:** Based on clinical record reviews and staff interviews it was determined that the facility failed to ensure that the Uniform Assessment Instrument-based resident assessments were updated annually or 30 days after admission for two residents (Resident #4 and Resident #7) out of 15 residents sampled. Findings include: 1. Review of the initial UAI assessment dated 8/9/2012 revealed the absence of an assessment completed within thirty days of the admission of Resident #4 to the assisted living facility on 8/31/2012. These findings were reviewed with E1 (executive director), E2 (corporate director of Quality Assurance), E3 (Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 2. Review of Resident #7's clinical record revealed the absence of an assessment completed within 30 days of admission to the assisted living facility on 5/9/2012. These findings were reviewed with E1	**3225.11.5** • Resident #4 has since passed. • Resident #7's UAI was updated on 6-26-13 by the HCC. • The Executive Director reviewed the UAI requirements with the Care Coordinators. • The HCC conducted an audit to determine if any other resident did not receive a 30 day UAI and annually UAI's. If any were identified, the HCC or designee (RN) completed a UAI to make it current and accurate to the resident's needs. A family meeting was held or has been scheduled to review and obtain signatures. • The HCC or designee (RN) completes the UAI in conjunction with the resident and/or designated persons upon move-in, including regular updates 30 days after admission, annually and when there is a significant change in the resident's condition. • The ED will conduct random audits of UAI's to ensure that the UAI's are being completed within the required time frames. • During the monthly Quality Assurance meeting all UAI's completed for the month prior will be brought to the meeting to be reviewed for timeliness and completeness by the Coordinators, including the ED. **Date by when to be corrected: September 16, 2013 and ongoing**

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	(executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/13.	

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3225.12.0 3225.12.1 3225.12.1.3 3-305.11	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **This requirement is not met as evidenced by:** Based on observations and interview during the tour of the kitchen on 5/30/2013 and 6/3/2013, it was determined that the facility failed to comply with the following sections: 3-305.11 (A) (2), 4-601.11 (C), 4-602.13, 4.903.11 (A) (2) and 7-201.11 (A) of the State of Delaware Food Code. **Food Storage** **(A) Except as specified in ¶¶ (B) and (C) of this section, food shall be protected from contamination by storing the food:** **(2) Where it is not exposed to splash, dust, or other contamination.** **This requirement is not met as evidenced by:** 1. Observations on 6/3/2013 at 7:40 AM of a kitchen refrigerator revealed that a package of hot dogs was stored uncovered. On 6/4/2013 at 9:36 AM, E50 (Dining Services Coordinator) stated that the hot dogs were thrown out.	**3.225.12.1.3** **3-305.11 Food Storage** • The Dining Services Coordinator (DSC) discarded the package of hot dogs on 6/4/13. • The DSC completed an audit of the kitchen refrigerator and freezer to ensure all items are properly covered, labeled and dated. • Each perishable food item will be properly labeled, dated and covered. If an item is found that it is not, it will be discarded and reported accordingly. Checks are conducted daily by the DSC and/or lead cook on duty and recorded for compliance. In addition, the DSC will conduct a random sanitation/compliance audit of the entire kitchen as well. • The DSC/Lead Cook will monitor the daily internal operations daily for proper storage compliance/monitoring through accurate completion of the daily Sunrise (SRZ) sanitation log. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen and report his findings at the monthly QA meeting. Compliance will be reviewed by the DSC for trends at the monthly QA meeting to determine if further corrective action is needed. **Date by when to be corrected: September 5, 2013 and ongoing** **4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.** • The convection oven was cleaned on 6/4/13 by the dishwasher on duty. • The DSC re-educated his team on proper sanitation procedures immediately upon exit

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4-601.11	**Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.** **(C) Non Food-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt Food residue, and other debris.** **This requirement is not met as evidenced by:** 1. Observations on 6/3/2013 at 7:37 AM of the convection oven revealed an accumulation of encrusted deposits. On 6/4/2013 at 9:34 AM, E50 stated that the convection oven needed cleaning.	conference on 6-14-13 and again on 8-14-13. • The DSC conducted an inspection of the kitchen and non-food-contact surfaces to ensure that they were free of accumulation of dust, dirt food residue and other debris. • Sanitation Checks are conducted daily by the DSC and/or Lead Cook on duty and recorded for compliance. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen as well. Any reoccurrence will be addressed by the DSC and corrected through re-education and/or corrective action. • The DSC/Lead Cook will monitor the daily internal operations daily for sanitation compliance/monitoring through accurate completion of the daily SRZ sanitation log. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen and report his findings at the monthly QA meeting. Compliance will be reviewed by the DSC for trends at the monthly QA meeting to determine if further corrective action is needed. This process will be monitored by the DSC and the ED. **Date by when to be corrected: September 5, 2013 and ongoing** **4-602.13 Nonfood –Contact Surfaces** • The DSC assigned the dishwasher to clean the identified single storage rack (for cans) on 6/4/13. • The DSC completed an inspection of the kitchen to ensure that all non-food contact surfaces are all clean to preclude accumulation of soil residue.
4-602.13	**Nonfood-Contact Surfaces** **NonFood-Contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.** **This requirement is not met as evidenced by:** 1. Observations on 5/30/2013 at 9:48 AM of the can storage rack revealed food spills. On 6/4/2013 at 9:32 AM, E50 stated that the food spills were due to splash from the mixer.	
4-903.11	**Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.** **(A) Except as specified in ¶ (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored:**	

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	(2) Where they are not exposed to splash, dust, or other contamination. **This requirement is not met as evidenced by:** 1. Observations on 5/30/2013 at 9:45 AM of the dry food storage room revealed that a bag of plastic forks was stored uncovered. On 6/4/2013 at 9:30 AM, E50 stated that the plastic forks should be covered.	• The DSC re-educated his team on proper sanitation procedures immediately upon exit conference on 6-14-13 and again on 8-14-13. • The can storage rack and other non food-contact surfaces shall be wiped down by the lead cook daily or more often if necessary • Sanitation Checks are conducted daily by the DSC and/or Lead Cook on duty and recorded for compliance. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen as well. Any instances of non-compliance will be addressed by the DSC and corrected through re-education and/or corrective action.
7-201.11	**Separation** **Poisonous or toxic materials shall be stored so they can not contaminate food, equipment, utensils, linens, and single-service and single-use articles by:** **(A) Separating the poisonous or toxic materials by spacing or partitioning.** **This requirement is not met as evidenced by:** 1. Observations on 5/30/2013 at 9:42 AM of the dry food storage room revealed that charcoal lighter fluid was stored next to a container of syrup and a box of coffee powder. On 6/4/2013 at 9:28 AM, E50 stated that charcoal lighter fluid should not be stored there.	• The DSC/Lead Cook will monitor the daily internal operations daily for sanitation compliance/monitoring through accurate completion of the SRZ sanitation log. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen and report his findings at the monthly QA meeting. Compliance will be reviewed by the DSC for trends at the monthly QA meeting to determine if further corrective action is needed. This process will be monitored by the DSC and the ED. **Date by when to be corrected: September 5, 2013 and ongoing** **4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.** • The DSC covered/sealed the bag of plastic forks on 6/4/13. • The DSC completed an inspection of all cleaned equipment and utensils, laundered linens, and single-service and single-use articles to ensure they are not exposed to

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		splash, dust, or other contamination. • All equipment and utensils, laundered linens, and single-service and single-use articles will be stored properly so there is no exposure to splash, dust, or other contamination. • Sanitation/Storage Checks are conducted daily by the DSC and/or Lead Cook on duty and recorded for compliance. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen as well. Any instances of non-compliance will be addressed by the DSC and corrected through re-education and/or corrective action. • The DSC/Lead Cook compliance/storage monitoring through accurate completion of the daily SRZ sanitation log. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen and report his findings at the monthly QA meeting. Compliance will be reviewed by the DSC for trends at the monthly QA meeting to determine if further corrective action is needed. This process will be monitored by the DSC and the ED. **Date by when to be corrected: September 5, 2013 and ongoing** **7-201.11 Separation** • The DSC immediately removed the lighter fluid from the dry food storage room on 5/30/13 and stored it in the proper cabinet for flammable materials. • The DSC completed a full inspection of the dry food storage room to ensure there were no other poisonous or toxic materials being stored with food, equipment, utensils, linens, and single-service and single-use articles.

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		• The DSC provided an in-service to his team proper food storage and separation of poisonous or toxic materials on 6/14/13 and again on 8/14/13. • Routine sanitation/storage checks are conducted daily by the DSC and/or Lead Cook on duty and recorded for compliance purposes. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen as well. Any instances of non-compliance for flammable/toxic materials will be addressed by the DSC and corrected through re-education and/or corrective action. • The DSC/Lead Cook will be the primary individuals to monitor internal operations for sanitation storage compliance through accurate completion of the daily SRZ sanitation log. In addition, the DSC will conduct a random monthly sanitation/storage compliance audit of the entire kitchen and report his findings at the monthly QA meeting. Compliance will be reviewed by the DSC for trends at the monthly QA meeting to determine if further corrective action is needed. This process will be monitored by the DSC and the ED. **Date by when to be corrected: September 5, 2013 and ongoing**

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3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by:** Based on clinical record review, review of facility documents and staff interview it was determined that the facility failed to ensure that service agreements were appropriately developed, reviewed, evaluated and revised to address fall risk, actual falls, and elopements exhibited by 9 residents (Residents #1, #2, #3, #4, #6, #7, #13, #14 and #15) out of fifteen residents sampled with measurable goals and specific interventions. Findings include: 1. Cross refer 16 Del., Chapter 11, Subchapter III, Section 1131, example 1. Review of the service agreement dated 10/12/2012 revealed that it failed to address elopement risk or an actual elopement with measurable goals and specific interventions. Additionally the facility failed to review and to revise the above referenced service agreement and to develop, implement and monitor the effectiveness of goals and interventions that addressed the risk of elopement and/or to address actual elopements committed by Resident #1. These findings were reviewed with E1 (executive director), E2 (corporate director of Quality Assurance), E3	**3225.13.5** • Prior to the elopement Resident #1 was not assessed to be an elopement risk. Immediately after the incident occurred, Resident # 1 received one to one supervision for safety. The resident was then reassessed and it was determined the resident was appropriate for the secured memory care unit and was moved there on 5/17/12. On 9/4/13 Resident #1's service agreement was updated by the Resident Care Coordinator to reflect that she was admitted to our secure unit as a result of her elopement in May of 2012 and (although no longer an elopement) remains there for safety purposes. The service agreement will be updated periodically by the Resident Services Coordinator to addresses effectiveness of goals and interventions. • Resident #2 has since passed. • Resident #3 no longer resides at the community; therefore we are unable to correct the service agreement for this particular resident. • Resident #4 has since passed. • Resident #6 has since passed. • The HCC and Resident Care Coordinator re-assessed Resident #7 and completed an updated service agreement. The updated service agreement addresses all of the resident's needs, including the fall history/risk and interventions put in place. • Prior to the elopement Resident #13 was not assessed to be an elopement risk. Immediately after the incident occurred, Resident # 13 was re-assessed and given a wander guard as an additional precaution. On 9/4/13, the HCC and

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	(Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 2. Cross refer 3225.11, 3225.11.4, example #2. Review of the closed clinical record revealed that Resident #2 had diagnoses that included dementia, hypertension, coronary artery disease, status post CVA (cardiovascular accident) and ambulatory dysfunction. Review of the annual UAI (Uniform Assessment Instrument) dated 10/22/2011 revealed that Resident #2 either ambulated or was wheeled with physical assistance and required two person physical assistance for bed mobility. The above referenced UAI dated 10/22/2011 also revealed that Resident #2 required complete assistance with transferring. Further review of the UAI dated 10/22/2011 revealed it was incomplete and absent section 3, "Fall Risk Assessment" and section 4, Psychological/Social/Cognitive Information". Review of the clinical record also revealed that Resident #2 was admitted to an acute care facility on 5/13/2013 following a fall and questionable syncope (fainting) with a nasal fracture, epistaxis (nosebleed) and facial ecchymosis (discoloration of the skin). Review of the facility incident report stated that Resident #2 "was found on the floor in her room" bleeding from the nose at 8:45 AM on 5/13/2013 and was transported to an acute care facility for an evaluation and	the Resident Care Coordinator updated the resident's service agreement. Resident #13's service agreement was revised to address the elopement that occurred, elopement risk, exit seeking behaviors and interventions. The service agreement will be updated periodically to addresses effectiveness of goals and interventions. • The HCC and the Resident Care Coordinator on 9/4/13 re-assessed Resident #14 and completed an updated service agreement. The updated service agreement addresses all of the resident's needs, including the fall history/risk and interventions put in place. • The HCC and the Resident Care Coordinator on 6/14/13 re-assessed Resident #15 and completed an updated service agreement. The updated service agreement addresses all of the resident's needs, including the fall history/risk and interventions put in place. • The HCC conducted an audit to determine if any other resident service agreements/care plans did not address falls, elopements and/or other needs and interventions. If any were identified, the HCC or designee (RN) completed the service agreements to ensure they were appropriately developed, reviewed, evaluated and revised. • The community has revised its process in development of the service agreement/care plan. The HCC with the Resident Care Coordinator will complete the service agreement/care plans detailing the services that will be provided to the resident. The service includes a Fall-Risk Assessment and addresses the Psychological/Social/Cognitive needs. The service agreement reflects the elopement that occurred, elopement risk, exit seeking behaviors, and interventions. The service agreement will be updated periodically

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	treatment at 9:05 AM on the same day. Review of the service agreement dated 11/13/2011 revealed that the facility failed to address the potential for falls with measurable goals and specific interventions for Resident #2 who had a diagnosis of ambulatory dysfunction. Additionally the facility failed to review the care plan and to develop measurable goals and specific interventions to address actual falls sustained by Resident #2. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 3. Clinical record review revealed an annual service agreement dated 1/23/2013 was developed without addressing six falls sustained by Resident #3 between 2/10/2013 and 4/8/2013. Additionally two of the six documented falls required the transport of Resident #3 to an acute care facility for surgical intervention. The facility failed to review and to revise the annual service agreement dated 1/23/2013 with measurable goals and interventions after actual falls sustained by Resident #3. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 4. Clinical record review revealed	to address effectiveness of goals and interventions. • The HCC will conduct a random audit monthly to review service agreements/care plans and ensure they properly reflect the resident's needs and services. These findings will be documented and reviewed with the Coordinator, including the ED during the monthly Quality Assurance meetings. **Date by when to be corrected: September 16, 2013 and on going**

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	Resident #4 had diagnoses that included dementia, seizure disorder and status post subdural hematoma. Review of the initial UAI dated 8/31/2012 revealed that Resident #4 required supervision, cueing and coaching for ambulation. The above referenced UAI dated 8/31/2012 also revealed that Resident #4 was alert and oriented to time, place, and person but experienced short-term memory and long-term memory problems. Additionally the above referenced UAI revealed that Resident #4 was at increased risk for falling as a result of "a gait problem, impaired balance and confusion". However review of the service agreement dated 8/31/2012 revealed that the facility failed to address Resident #4's assessed fall risk with measurable goals and specific interventions. Additionally the clinical record also revealed that two out of four falls sustained by Resident #4 between 4/4/2013 and 4/15/2013 required transport to an acute care facility for evaluation and treatment. The facility also failed to review and revise the above referenced service agreement and to develop, implement and monitor the effectiveness of goals and interventions that addressed actual falls sustained by Resident #4. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 5. Clinical record review revealed	

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	Resident #6 had diagnoses that included atrial fibrillation, hypertension, hypothyroidism and osteopenia. According to the annual UAI assessment dated 10/9/2012, Resident #6 was alert and oriented to time, place and person. Additionally the UAI dated 10/9/2012 revealed that Resident #6 was independently mobile and able to transfer herself without assistance. Review of the clinical record also revealed that Resident #6 sustained four falls between 4/11/2013 and 4/20/2013. One of the actual falls that occurred on 4/20/2013 required the transport of Resident #6 to an acute care facility for an evaluation that resulted in surgical intervention. However review of the annual service agreement dated 10/9/2012 revealed that the facility failed to address risk for falls or actual falls sustained by Resident #6 with measurable goals and specific interventions. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 6. Review of the clinical record revealed that Resident #7 had diagnoses that included Alzheimer's disease, atrial fibrillation, status post pacemaker insertion, hypertension and osteoarthritis. According to the UAI completed for a significant change in condition and dated 1/4/2013 Resident #7 was oriented to self only and exhibited short-term memory	

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	and long-term memory problems. The same UAI dated 1/4/2013 also revealed that Resident #7 was independent for ambulation with the assistance of a cane. Additionally the above referenced UAI revealed that Resident #7 was assessed at risk for falling due to a gait problem, confusion and balance problems when standing. Further review of the clinical record revealed that Resident #7 sustained approximately four falls between 1/15/2013 and 4/29/2013. However review of the service agreement dated 6/9/2012 and completed one month after Resident #7's admission to the assisted living facility revealed the facility failed to address fall risk and actual falls sustained by Resident #7 between 1/15/2013 and 4/29/2013. Resident #7 required transport to an acute care facility for an evaluation and treatment for one of the four falls. The facility failed to address Resident #7's risk for falls with measurable goals and specific interventions and to review and revise the service agreement and to develop measurable goals and specific interventions that addressed fall risk and/or actual falls sustained by Resident #7. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 7. Cross refer 16 Del., Chapter 11,	

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	Subchapter III, Section 1131, example 2. Review of the service agreement dated 1/31/2013 revealed that it was absent the risk for elopement and actual elopements exhibited by Resident #13. Additionally the facility failed to review and to revise the service agreement and to develop, implement and monitor the effectiveness of goals and interventions that addressed the risk of elopement and/or to address actual elopements committed by Resident #13. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 8. Clinical record review revealed that Resident #14 had diagnoses that included dementia, hypertension, CAD (coronary artery disease), history of DVT (deep vein thrombosis), COPD (chronic obstructive pulmonary disease), osteoporosis and status post colostomy. According to the annual UAI assessment dated 11/17/2012 Resident #14 was alert and oriented to time, place and person and had an intact short-term memory and long-term memory. Additionally the UAI dated 11/17/2012 also revealed that Resident #14 was at risk for increased falls due to a gait problem, confusion, osteoporosis and falling in the last 30 days. Further review of the clinical record revealed that Resident #14 sustained approximately ten falls between 3/4/2013 and 5/27/2013.	

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	Although review of the annual service agreement dated 11/15/2012 revealed that the facility identified Resident #14's fall risk, it failed to develop measurable goals and specific interventions to address the potential for falls. Additionally the facility also failed to review and to revise the annual service agreement dated 11/15/2012 and to develop, implement and evaluate measurable goals and specific interventions that addressed ten falls sustained by Resident #14. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 9. Review of the clinical record revealed that Resident #15 was admitted to the assisted living facility on 5/11/2013 with diagnoses that included dementia, Parkinson's disease, hypertension, atrial fibrillation, pacemaker and dizziness. According to the initial UAI (Uniform Assessment Instrument) dated 4/26/2013 Resident #15 was alert and oriented to time, place and person and exhibited no short-term and long-term memory problems. Review of the above referenced UAI also revealed that Resident #15 required supervision, cueing and coaching for mobility. Further review of the clinical record revealed that Resident #15 sustained a fall with injury on 5/30/2013 that resulted in transport to an acute care facility for	

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	evaluation. Review of the facility incident report dated 5/30/2013 stated that Resident #15 slipped while showering independently at 6:15 AM on 5/30/2013 and "hit his head on the shower wall". The incident report also revealed that Resident #15 sustained an open wound above his right eye that was repaired with sutures at the acute care facility before his return to the assisted living facility on 5/30/2013. Review of the initial service agreement dated 5/11/13 revealed the facility failed to address Resident #15's potential for falls as indicated by the UAI assessment of fall risk completed 4/26/2013 with measurable goals and specific interventions. Additionally the facility failed to review, evaluate and revise the service agreement with measurable goals and specific interventions for an actual fall with injury sustained by Resident #15. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	

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3225.13.6	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** **This requirement is not met as evidenced by:** Based on clinical record review, review of facility documents and staff interviews it was determined that the facility failed to ensure that service agreements were reviewed and revised in conjunction with UAI assessments for eight residents (Residents #2, #5, #7, #8, #9, #11, #13 and #14) out of 15 sampled. Findings include: 1. Review of the annual UAI completed for Resident #2 revealed it was dated 10/22/2011. However review of the annual service agreement dated 11/13/2011 revealed it was developed for Resident #2 approximately 21 days after completion of the above referenced annual UAI assessment. These findings were reviewed with E1 (executive director), E2 (corporate director of Quality Assurance), E3 (Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 2. Review of the annual UAI completed	3225.13.6 • Resident #2 has since passed. • Resident #5 no longer resides at the community; therefore we are unable to correct the service agreement for this particular resident. • The HCC and Resident Care Coordinator re-assessed Resident #7 and completed an updated service agreement in conjunction with the UAI. The updated service agreement addresses all of the resident's needs, including the fall history/risk and interventions put in place. • Resident #8 no longer resides at the community; therefore we are unable to correct the service agreement for this particular resident. • The HCC and Resident Care Coordinator re-assessed Resident #9 and completed an updated service agreement in conjunction with the UAI. The updated service agreement addresses all of the resident's needs, including the fall history/risk and interventions put in place. • The HCC and Resident Care Coordinator re-assessed Resident #11 and completed an updated service agreement in conjunction with the UAI. The updated service agreement addresses all of the resident's needs, including the fall history/risk and interventions put in place. • The HCC and Reminiscence Coordinator re-assessed Resident #13 and completed an updated service agreement in conjunction with the UAI. The updated service agreement addresses all of the resident's needs, including

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	for Resident #5 revealed it was dated 3/6/2013. However review of the annual service agreement dated 2/2/2013 revealed it was developed for Resident #5 approximately 32 days prior to completion of the above referenced annual UAI assessment. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 3. Review of the clinical record revealed that Resident #7 was absent a service agreement developed in conjunction with a UAI assessment dated 1/4/2013 for a significant change in condition. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 4. Review of the annual service agreement dated 10/1/2012 revealed it was developed for Resident #8 approximately seven days prior to the annual UAI dated and completed 10/8/2012. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 5. Review of the annual UAI completed for Resident #9 revealed it was dated 2/12/2013. However review of the annual	the fall history/risk and interventions put in place. • The HCC and the Resident Care Coordinator re-assessed Resident #14 and completed an updated service agreement in conjunction with the UAI. The updated service agreement addresses all of the resident's needs, including the fall history/risk and interventions put in place. • The HCC conducted an audit to determine if any other resident service agreements/care plans did not address falls, elopements and/or other needs and interventions. If any were identified, the HCC or designee (RN) completed the service agreements to ensure they were appropriately developed, reviewed, evaluated and revised. • The community has revised its process in development of the service agreement/care plan. The HCC with the Resident Care Coordinator will complete the service agreement/care plans detailing the services that will be provided to the resident. The service includes a Fall-Risk Assessment and addresses the Psychological/Social/Cognitive needs. The service agreement reflects the elopement that occurred, elopement risk, exit seeking behaviors, and interventions. The service agreement will be developed timely based on the UAI findings and will be updated periodically to address effectiveness of goals and interventions. • The HCC will conduct a random audit monthly to review service agreements/care plans and ensure they properly reflect the resident's needs and services and are completed timely. These findings will be documented and reviewed with the Coordinator, including the ED during the monthly Quality Assurance meetings.

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	service agreement revealed it was dated 1/8/2013 and developed for Resident #9 approximately one month prior to completion of the above referenced annual UAI assessment dated 2/12/2013. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 6. Review of the annual UAI completed for Resident #11 revealed it was dated 8/4/2012. However review of the annual service agreement revealed it was dated 7/30/2012 and developed for Resident #11 approximately 5 days prior to completion of the above referenced annual UAI assessment. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 7. Review of the annual UAI completed for Resident #13 revealed it was dated 3/15/2013. Further review of the clinical record revealed that an annual service agreement dated 1/31/2013 was developed for Resident #13 approximately six weeks prior to completion of the above referenced UAI assessment. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility	**Date by when to be corrected: September 16, 2013 and ongoing**

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	care coordinator) on 6/14/2013. 8. Review of the annual UAI completed for Resident #14 revealed it was dated 11/ 17/2013. Further review of the clinical record revealed that a service agreement dated 11/15/2013 was developed for Resident #14 approximately two days prior to completion of the above referenced UAI assessment. These findings were reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	

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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.** **This requirement is not met as evidenced by:** Based on clinical record review, review of facility documents and staff interview it was determined that the facility failed to immediately report two incidents of alleged abuse and one incident of substantiated abuse sustained by 3 residents (Resident #9, Resident #10 and Resident #11) out of 15 sampled. Findings include: 1. Review of a facility incident report submitted to the Division on 2/13/2013 at 4:37 PM revealed it was received approximately 31 days following an allegation of abuse that occurred on 1/14/2013 when Resident #9 became agitated after E7 (care manager) removed salt and pepper shakers from her dining table. The facility failed to immediately report an incident of alleged abuse within 8 hours to the Division. This finding was reviewed with E1 (executive director), E2 (corporate director of Quality Assurance), E3 (Registered Nurse/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	3225.19.6 • On 7/18/13 the ED completed a review of the reportable incidents process. The review covered, what is a reportable incident (by licensing standards) and the reporting procedure timeframes. This was reviewed with care staff and Coordinators. • On 7/18/13 the Wellness staff and Care Coordinators completed a review of other resident incidents to determine if any other were in need of reporting or not reported timely. • The community has added a section to back of the Resident/General Liability Report which provides everyone with the information needed to immediately report any types of reportable incidents to the Division of Long Term Care Residents Protection should a Nurse or Coordinator not be present. In order to meet the eight (8) hour window the main reporting tool now includes the contact telephone number to call until the HCC can provide the Division with a written follow-up. Staff has been instructed to call the HCC or appropriate coordinator at any time an incident occurs if there is question on whether something is reportable. • The HCC reviews all incident reports daily and tracks and trends incidents monthly. • All incidents are brought to the daily "Stand up" meeting with Coordinators and are reviewed with the ED for further action. • These findings are reviewed during the monthly quality assurance meeting to determine if the community is meeting the reporting requirements. **Date by when to be corrected: September 5,**

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	2. Review of a facility incident report submitted to the Division on 1/18/2013 at 1:16 PM revealed it was received approximately four days following substantiated abuse that occurred on 1/14/2013 at 9:45 AM and was directed toward Resident #10. According to the incident report E7 (care manager) was overheard by E8 (care manager) telling Resident #10, "No, you shut up." A five day follow up report dated 1/23/2013 of the above referenced incident revealed was E7 (care manager) "was taken off duty and subsequently terminated" at the conclusion of the incident investigation. The facility failed to immediately report an incident of substantiated abuse within 8 hours to the Division. This finding was reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 3. Review of a facility incident report submitted to the Division on 3/3/2013 at 4:16 PM revealed it was received approximately five weeks following alleged abuse that occurred on 1/14/2013 at 11:00 AM and was directed toward Resident #11. According to the incident report E7 (care manager) neglected to position Resident #11 properly in bed prior to the administration of care. The facility failed to immediately report an incident of alleged abuse within 8 hours to the Division. This finding was reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/HCC),	**2013 and ongoing**

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	E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	

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3225.19.7 3225.19.7.2	**Reportable incidents include:** **Neglect as defined in 16 Del.C 1131.** **16 Del., C., Chapter 11, Subchapter III Subchapter III. Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients** **Section 1131. Definitions.** **When used in this subchapter the following words shall have the meaning herein defined. To the extent the terms are not defined herein, the words are to have their commonly-accepted meaning.** **(9) "Neglect" shall mean:** **a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interviews it was determined that the facility failed to provide a safe environment for two residents (Resident #1 and Resident #13) out of 15 sampled who eloped from the facility without the knowledge of facility staff. Findings include: 1. Review of the clinical record revealed that Resident #1had diagnoses that included Alzheimer's disease, ambulatory	**3225.19.7.2** • Prior to the elopement Resident #1 was not assessed to be an elopement risk. Immediately after the incident occurred, Resident # 1 received one to one supervision for safety. The resident was then reassessed and it was determined the resident was appropriate for the secured memory care unit and was moved there on 5/17/12. On 9/4/13 the Resident Care Coordinator revised resident #1's service agreement to address the elopement that occurred, elopement risk, exit seeking behaviors and interventions. The service agreement will be updated periodically to addresses effectiveness of goals and interventions. • Prior to the elopement Resident #13 was not assessed to be an elopement risk. Immediately after the incident occurred, Resident # 13 was re-assessed and given a wander guard as an additional precaution. On 9/4/13 the HCC and the Resident Care Coordinator re-assessed the resident (UAI) and completed an updated the service agreement to address the elopement that occurred, elopement risk, exit seeking behaviors and interventions. The service agreement will be updated periodically to addresses effectiveness of goals and interventions. • The HCC and Care Coordinators reviewed all residents that have been identified to be exhibiting exit seeking behaviors to ensure their service agreements appropriately address elopement risk, exit seeking behaviors and interventions. They also reviewed any resident that leaves the premises independently to ensure that they have been appropriately assessed to do so and can continue to do so. All service agreements were updated accordingly.

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	dysfunction, osteoporosis and hypertension. According to the UAI (Uniform Assessment Instrument) dated 5/17/2013 Resident #1 was oriented to person only. Additionally Resident #1was assessed with short-term memory and long-term memory problems. Further review of the above referenced UAI indicated that Resident #1 required "supervision, set up, cueing and coaching" for mobility. The same UAI dated 5/17/2013 also revealed Resident #1 was absent a history of wandering. However, review of a facility incident report dated 5/8/2012 revealed that Resident #1 eloped from the facility without knowledge of staff. The facility was unaware of Resident #1's elopement until informed by a contracted employee who observed the resident walking up a busy road facing the facility. The facility failed to ensure a safe environment was provided for Resident #1. This finding was reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013. 2. Clinical record review revealed that Resident #13 had diagnoses that included Alzheimer's disease, TIA (transient ischemic attack), and history of urinary tract infections. According to the annual UAI dated 3/15/2013 Resident #13 was oriented to person only and experienced short-term memory and long-term	• The community reviews any unusual behaviors exhibited by its residents during its daily stand-up meeting. Information on any unusual behaviors comes directly from direct interaction from the care team. If a resident is displaying a change of condition they receive a visit from a wellness nurse to determine if a medical condition may exist that could be contributing to the behavior. If is determined that they are at risk for elopement, they may receive a wander-guard for safety or they may be transferred to our secure unit. The wander guard will be offered on a short term basis with the resident being reassessed in 30 days. If the community cannot guarantee resident safety (and the resident continues to pose a safety risk) the resident may be discharged. • A care manager has been assigned to monitor residents who like to sit outside after dinner. The community will place a wander-guard on any new residents who enter the community who have a prior documented history of wandering if not placed in our secure memory care unit. The community may also deny admission and if it cannot ensure proper safety of the resident. The concierge team has a roster of residents who have been issued a wander guard and are alerted to anyone who may be exhibiting unusual behaviors that may trigger the possibility of an elopement. • Residents (new or existing) with wander guards in place or are or maybe exit seeking are reviewed at the monthly Risk Management/QA meeting to determine level of safety risk and what interventions if any (including discharge) may be necessary to help ensure overall safety. The HCC will report on these individuals each month and will receive data from a number of sources including the care manager team and wellness. We will begin formal reporting at the August QA meeting scheduled for 9/18/13.

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	memory problems. Additionally the above referenced UAI assessment indicated that Resident #13 required physical assistance for ambulation and two person physical assistance for transferring. The UAI dated 3/15/2013 also revealed that Resident #13 was assessed as without a "history of wandering". However a physician telephone order dated 5/21/2013 stated "Wanderguard". Further review of the clinical record revealed a nurse's note documented 5/19/2013 and timed 3:52 PM that stated "(Resident #13) eloped…today. He was found on the premises outside the building…". Review of the facility incident report dated 5/19/2013 and timed 2:15 PM with attached statements revealed that Resident #13 had a past history of elopement from the facility. During this elopement on 5/19/2013 a visitor observed Resident #13 outside the facility and proximal to the back gate of the secured unit. Additionally the visitor stated that he observed Resident #13 seated in a wheelchair and without the presence of facility staff. After the visitor notified the facility of Resident #13's status he returned to aid Resident #13 by dislodging one of his chair wheels stuck in a storm drain and wheeled Resident #13 toward the facility as staff approached to return the resident to his room. During an interview conducted with E1 (executive director) on 6/14/2013 it was stated that Resident #13 was absent from the facility for approximately ten minutes. The facility failed to ensure a safe environment was provided for Resident	**Date by when to be corrected: September 18, 2013 and ongoing**

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	#13 who had a history of an actual elopement. This finding was reviewed with E1 (executive director), E2 (corporate director of QA), E3 (RN/Health Care Coordinator), E4 (facility care coordinator) and E5 (facility care coordinator) on 6/14/2013.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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(302) 577-6661

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