

#### **STATE SURVEY REPORT**

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NAME OF FACILITY: Arden Courts of Wilmington

DATE SURVEY COMPLETED: January 30, 2025

STATEMENT OF DECICIONCIES ADMINISTRATORIS DI AN FOR COMPLETE				
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION	
	OI EON IO DEI IOIENOIES	CONNECTION OF DEFICIENCIES	DATE	
	The State Report incorporates by reference			
	and also cites the findings specified in the			
	Federal Report.			
	An unannounced Annual, Complaint and			
	Emergency Preparedness Survey was con-	= -		
	ducted at this facility from January 28, 2025,			
	through January 30, 2025. The deficiencies			
	contained in this report are based on inter-			
	view, record review and review of other facil-			
	ity documentation as indicated. The facility			
	census on the first day of the survey was			
)	twenty-two (22). The survey sample totaled			
	twelve (12) residents.			
	Abbreviations/definitions used in this state re-			
	port are as follows:			
	Department/DHCQ - Division of Healthcare			
	Quality;			
	ED - Executive Director;			
	LPN – Licensed Practical Nurse;			
	NSS (Normal Saline Solution) – sterile salt wa-			
	ter with similar concentration to body fluids;			
	Optifoam – An adhesive bandage made of			
	foam layers which provides cushioning to skin;			
	POA – Power of Attorney, a legal authorization			
	that gives the authority to act on behalf of an	-		
	individual;			
	Pressure Ulcers (PUs) - sore area of skin that			
	develops when blood supply to it is cut off due			
	to pressure;			
	Resident Assessment – evaluation of a resi-			
	dent's physical, medical, and psychosocial sta-			
	tus as documented in a Uniform Assessment			
	Instrument (UAI) by a Registered Nurse;			
	RSC/DON - Resident Services Coordinator/Di-			
	rector of Nursing;			
	-	1		
	RRHWS – Regional Residential Health and			
	Wellness Specialist;			
	RC - Resident Caregiver;			
	SA – Service Agreement – allows both parties			
	involved (the resident and the assisted living			

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# 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

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NAME OF FACILITY: Arden Courts of Wilmington

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	C (11) )		
	facility) to understand the types of care and		
	services the assisted living provides. These in-		
	clude lodging, board, housekeeping, personal		
	care, and supervision services;		
	Stages (severity) of pressure ulcers (PUs):		
	-Stage I (1) - intact red skin often over a boney		
	area that does not turn white/light when		
	pressed;		
	-Stage II (2) - blister or shallow open sore with red/pink color;		
	-Stage III (3) - open sore that goes into the tis-		
	sue under below the skin. How deep it is de-		
	pends on the amount of tissue under the skin;		
	-Stage IV (4) - open sore so deep that muscle,		
	tendon or bone can be seen/felt;		
	-Unstageable - actual depth of the ulcer can-		
	not be determined due to the presence of		
	slough (yellow, tan, gray, green or brown soft		
	dead tissue) and/or eschar (hard dead tissue		
	that is tan, brown or black. Eschar is worse		
	than slough;		
	-Suspected Deep Tissue Injury (sDTI) - Purple		
	or maroon intact skin or blood-filled blister.		
	May start as tissue that is painful, mushy, firm,		
	boggy (wet, spongy feeling), warmer or cooler		
	than surrounding tissue.		
	Uniform Assessment Instrument" ("UAI") - A		
	document setting forth standardized criteria		
	developed by the Division to assess each resi-		
	dent's functional, cognitive, physical, medical,		
	and psychosocial needs and status. The as-		
	sisted living facility shall be required to use the		
	UAI to evaluate each resident on both an ini-		
	tial and ongoing basis in accordance with		
	these regulations.		
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			!
3225	Assisted Living Facilities	3225:	3/4/2025
3225.9.0	Infection Control	1. Resident R2's annual Flu vac-	
	The Assisted living facility shall have on file	cination has been entered into	
	evidence of annual vaccination against influ-	the Electronic Health Record	
3225.9.6	enza for all residents, as recommended by	(EHR) by the Resident Services	
	the immunization Practice Advisory Commit-	Coordinator (RSC).	
S/S – D	tee of the Centers for Disease Control, unless	2. A review of all current resi-	
	medically contraindicated. All residents who	dents Flu vaccination docu-	
	refuse to be vaccinated against influenza	mentation has been con-	
	must be fully informed by the facility of the	ducted to ensure all required	
	health risks involved. The reason for the re-	documentation is present in	
	fusal shall be documented in the resident's	the electronic health record.	
	medical record.	2 Unon fumbon investigation (	
	This requirement was not met as avidenced	3. Upon further investigation, it was determined that R2 did	
	This requirement was not met as evidenced by:	have her Flu and Pneumococ-	
	by.		
	Based on record review and interview, it was	cal vaccine prior to moving in.  However, the historical date	
	determined that for one (R2) out of seven res-	was not entered into the med-	
	idents reviewed for infection control, the facil-	ical record.	
	ity lacked evidence of an annual influenza vac-	icarrecord.	
	cination being administered or offered and	The RSC has re-educated all	
	declined. Findings include:	nurses regarding Flu vaccina-	
		tion documentation and the	
	12/19/24 – R2 was admitted to the facility. R2	importance of ensuring re-	
	had a medical evaluation completed the same	sults, including historical re-	
	day by E9 (Medical Director); the immuniza-	sults are documented in the	
	tion history on the medical evaluation docu-	EHR along with documented	
	ment in R2's chart was checked "unknown",	proof that it was offered and	
	and the influenza date section on the form	declined.	
	was blank.	4. Executive Director or Designee	
		will conduct weekly audits	
	1/29/25 1:45 PM – During an interview, (RSC)	times four weeks then	
	confirmed that R2's admission medical evalu-	monthly times three. Audits	
	ation did not have information regarding flu	will be conducted for all new	
	immunization status.	move ins and any new vac-	
		cines for current residents, to	1
		ensure the Flu vaccine histori-	
1		cal information is entered into	
		the electronic health record or	
1		offered if still in season as well	
		as required documentation	

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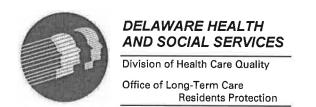
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		present for any declinations of the vaccine.  Audits results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.		
3225.9.7 S/S -D	The assisted living facility shall have on file evidence of vaccination 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 record review and interview, it was determined that for one (R2) out of seven res-	1. Resident R2's annual pneumococcal pneumonia vaccination has been entered into the Electronic Health Record (EHR) by the Resident Services Coordinator (RSC).  2. A review of all current residents Pneumonia vaccination documentation has been conducted to ensure all required documentation is present in the electronic health record.  3. Upon further investigation, it was determined that R2 did have her Flu and Pneumococcal vaccine prior to moving in. However, the historical data was not entered into the med-	3/4/2025	
	idents reviewed for infection control, the facility lacked evidence of R2's pneumococcal pneumonia vaccine status, or of R2 being administered or offered and declined. Findings include:  12/19/24 – R2 was admitted to the facility. R2 had a medical evaluation completed the same day by E9 (Medical Director); the immunization history on the medical evaluation document in R2's chart was checked "unknown" and there was no information regarding pneumonia vaccine status on the form.	ical record.  The RSC has re-educated all nurses regarding the Pneumococcal pneumonia vaccination documentation and the importance of ensuring results, including historical results are documented in the EHR along with documented proof that it was offered and declined.  4. Executive Director or Designee will conduct weekly audits		

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		times four weeks then	
	1/29/25 1:45 PM — During an interview, E2 (RSC/DON) confirmed that R2's admission medical evaluation did not have information regarding flu pneumonia vaccine status.	monthly times three. Audits will be conducted for all new move ins and any new vaccines for current residents, to ensure the Pneumococcal vaccine historical information is entered into the electronic health record or offered if still in season as well as required documentation present for any declinations of the vaccine.  Audits results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.	₩
3225.10.0	Contracts	3223.10.0	3/4/2025
3225.10.10 S/S - D	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 it was determined that for one (R7) out of seven residents sampled for Contracts, the facility obtained a signed contract prior to the service agreement being executed. Findings include: 4/24/24 – R7 was admitted to the facility. The initial service agreement was dated 4/25/24. The contract was initiated and signed on 4/10/24, prior to the service agreement being completed and executed.	<ol> <li>Unable to correct the signed contract dated 4/10/2024.</li> <li>A review of all current resident contracts has been conducted. Three contracts were found to have been dated prior to assessments completed. Unable to correct as they are dated two years ago or greater. No other contracts found to have a signed date earlier than the service agreement.</li> <li>Upon further investigation and review, it was determined that R7 and three other residents had requested to reserve a room post tour and prior to the assessment being</li> </ol>	

Provider's Signature



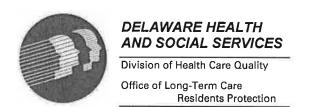
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		completed. In these situations, the organization has a room reserve form that should have been completed instead of a full resident contract. The Memory Care advisor now has the proper form and has been educated on the process.	
		Re-education was provided by the Executive Director to the Administrative team to include: proper documents to be used for a room reserve and no contract shall be signed before a full assessment shall be completed and service agreement executed.	
		4. A weekly audit times four weeks then monthly times three months will be conducted with all new move ins to ensure proper documentation is used when doing a room reserve and all contracts are signed after the completion of an assessment.	
		Audits results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.	
3225.11.0	Resident Assessment	3223.110	3/4/2025
3225.11.5 S/S – D	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	1. Resident R7 had an assessment completed on 2/7/2025 by the Nurse Practitioner and the Uniform Assessment Instrument and Service Plan has	
	condition.	been updated by the RSC.	

Provider's Signature	<u> </u>	Title _	_Executive Director	Date 2/28/2025



Provider's Signature

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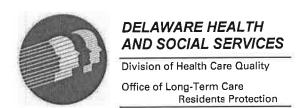
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Title \_\_Executive Director\_\_\_\_ Date 2/28/2025

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	2. A review of all current residents have been conducted to ensure all had current and updates assessments and service plans.  3. Upon futher review and investigation regarding R7's 30 day assessment and change in condition noted in July of 2024, it was determined that the RSC at the time did not follow through with updating the assessment and service plan.as required. The RSC during this time period is no longer employed. R7s UAI and Service plan has been updated	COMPLETION DATE



## STATE SURVEY REPORT

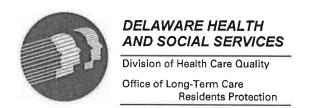
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	6/21/24 — R7 had an unwitnessed fall in the secure courtyard where she sustained a shoulder injury. She was sent to the ER for evaluation and returned to the facility on the same day with a fractured humeral neck (a bone in the shoulder).	Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.	
	6/27/24 – Record review reveals that the DON met with R7s POA to discuss care and documented in the progress note that the family agrees with interventions to prevent falls. These interventions were documented in the service plan.		
	7/13/24 — Review of the service plan reveals that R7 requires one person to assist with grooming and personal hygiene; requires one person to assist with dressing and undressing; requires one person to assist with night time care; requires one person to assist with ambulation and transfers; requires on person to assist with toileting.		
	7/16/24 – The homecare physical therapist documented in the progress note that they noted a decline secondary to the resident's fracture and that R7 is more dependent on staff.		
	1/30/25 11:30AM — an interview with E2 (DON, Divisional Mobile) revealed that neither a 30 day nor a significant change update was completed for E7's UAI.		
	The UAI was not revised after 30 days as required by regulation. R7 experienced a significant change due to a fall that required increased support which was documented in the service plan and by the physical therapist, but not captured in the UAI.		

Provider's Signature



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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES				
3225.18.0 3225.18.6.2 S/S – E	Emergency Preparedness.  Copies of the FEMA certificate of achievement which demonstrate that at least two active, full-time employees have completed FEMA training in ICS-100 and NIMS-700a in the past 24 months.  Based on interview and record review, it was determined that the facility failed to meet the requirement of having sufficient full time FEMA trained staff. Findings include:  1/29/25 – E1(ED) provided two FEMA certificates to the survey team, one for E7 (Facility Maintenance Manager), and one for E11 (former ED). E1 confirmed that E11 is a part time facility employee.  1/30/25 10:00 AM - E7 provided his ICS-100c and NIMS-700b certificates. E7 also provided an ICS-100c certificate for E11. E11 is a part time employee at the facility.	1. A second full-time employee obtained the FEMA training for ICS-100 and NIMS-700b on 2/14/2025. 2. The community currently meets the Emergency Preparedness requirement with two full-time employees certified in FEMA training. 3. Upon further review and investigation, it was determined that the 2 <sup>nd</sup> full time employee (E11) who was certified had changed her employee status to part time. There were no other FEMA certified employees at the time. As a result, the organization has chosen to have more than the required amount of full time employees FEMA certified.  Executive Director / Designee provided Education to the administrative team regarding the requirement for FEMA training and the importance of maintaining at least two full-time employees who are certified at all times. 4. A quarterly audit will be conducted by ED to ensure there are always two fulltime FEMA certified employees at all times.	3/4/2025		

Provider's Signature



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		Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.	
3225.19.0	Records and Reports	3225.19.0	3/4/2025
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.	<ol> <li>Unable to correct R11's past late report from 7/21/2024.</li> <li>A 30-day lookback review has been conducted on any residents who have passed away. All have been found to have</li> </ol>	
3225.19.7	Reportable incidents include:	been reported timely within 8-hours to the division.  3. Upon further review and in-	
3225.19.7.6	Reportable incidents include: Death of a resident in a facility or within 5 days of transfer	vestigation, It was determined	
S/S – D	to an acute care facility.	that R11 was receiving Hospice (end of life services).	
	The requirement was not met as evidenced by:  Based on record review, the facility failed to report the death of a resident within the required timeframe for one (R11) out of one resident sampled. Findings include:  8/24/23 – R11 was admitted to the facility	R11's passing was anticipated. Her death was reported to the responsible party, physician and hospice timely. Because of these facts, the nurse did not report to the agency thinking it was not a reportable death as it was anticipated.	
	with a diagnosis of dementia (a group of diseases that affect your thinking, memory, reasoning, personality, and behavior), chronic kidney disease stage 1 (an early stage of kidney failure that is marked by protein in the urine), and hypertension (high blood pressure).  07/21/24 – R11was found non-responsive in his room by a facility caregiver at approximately 4:30 p.m. The caregiver notified the	Re-education has been conducted by Regional RSC / Designee to all Nurses and the administrative team to review the requirement for reportable incidents including the passing of all residents within eight hours of the time of the incidents.  4. An audit of clinical records will be conducted by Executive Di-	
	nurse, who contacted the RN. R11 was pronounced deceased by the RN at 5:25 p.m. R11's physician and POA were notified.	rector / Designee to determine if any reportable incidents have occurred and if	



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CORRECTION OF DEFICIENCIES   DATE			ADMINISTRATORIO DI ANI EDE		
dent's death to DHCQ, which was four (4) days after the resident's death occurred and beyond the time specified in the regulation.  The facility reported the resident's death 4 days after it occurred, which is outside the time specified in the regulation.  The facility reported the resident's death 4 days after it occurred, which is outside the time specified in the regulation.  Posting of inspection summary and other in- formation and public meetings.  (a) Each facility shall prominently and con- spicuously post for display in a public area of the facility that is readily available to resi- dents, employees, and visitors the following:  (b) (3) The most recent state survey report prepared by the Department of the most re- cent inspection report for the facility.  Based on observation and interview, it was determined that the facility failed to have the most recent state survey report displayed in a public area. Findings include:  1/30/25 10:30 AM — A tour of the facility lobby and residential areas was conducted with E1. The tour revealed the lack of any state survey reports available for review. E1 confirmed that the survey results binder was not present in a public area of the facility.	SECTION			COMPLETION DATE	
tice must be present as to where it can be retrieved.  4. A weekly audit times four weeks then monthly times three will be conducted to ensure the inspection reports re-	16 DE Code, Chapter 11 Subchapter I. Licensing By The State § 1108.	07/25/24 – The facility reported the resident's death to DHCQ, which was four (4) days after the resident's death occurred and beyond the time specified in the regulation.  The facility reported the resident's death 4 days after it occurred, which is outside the time specified in the regulation.  Posting of inspection summary and other information and public meetings.  (a) Each facility shall prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors the following:  (b) (3) The most recent state survey report prepared by the Department of the most recent inspection report for the facility.  Based on observation and interview, it was determined that the facility failed to have the most recent state survey report displayed in a public area. Findings include:  1/30/25 10:30 AM – A tour of the facility lobby and residential areas was conducted with E1. The tour revealed the lack of any state survey reports available for review. E1 confirmed that the survey results binder was	they were reported within 8 hours. Audits will be conducted, weekly times four weeks then monthly times three months.  Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.  E Code Chapter 11 Licensing  1. Inspection results are posted and present in the community lobby. 2. A sign has been posted as to the location of the inspection reports. 3. Upon further investigation, it was determined that the housekeeper had put the survey inspection binder in the draw while she cleaned the furniture and neglected to place it back where it would be easily accessible.  Re-Education provided by the Executive Director / Designee to receptionist, housekeeping and administrative staff on the requirement to have the most recent inspection reports displayed at all times. If removed for temporary reasons, a notice must be present as to where it can be retrieved.  4. A weekly audit times four weeks then monthly times three will be conducted to en-	DATE	

Provider's Signature \_



Provider's Signature \_

# DELAWARE HEALTH AND SOCIAL SERVICES

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

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Title \_\_Executive Director\_\_\_\_ Date 2/28/2025

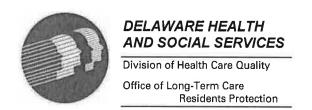
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ADMINISTRATOR'S PLAN FOR COMPLETION

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
SECTION  16 DE Code, Chapter 11 Chapter 11. Long-Term Care Facilities and Services § 1131 Definitions.  S/S D	Subchapter 111 Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients  (9) Neglect  (12) "Neglect" means the failure to provide goods 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, but not limited to toileting, bathing, meals, and safety.  Based on record review and interview, it was determined that for one (R7) out of five residents reviewed for wound care, the facility failed to provide wound care according to professional standard of care.  Findings include:  4/24/24 – R7 was admitted to the facility.  1/16/25 – The facility's Treatment Binder revealed a Physician's Order Administration Record document for R7. The Administration Record documented "Clean R heel of foot with NSS. Pat dry. Monitor for infection.		3/4/2025
	Record documented "Clean R heel of foot	tained by the same nurse and	



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	heel. Nurse cleaned, skin prep applied and ordered off-loading boots. Will educate staff to float heels while in chair/bed".  1/16/25 6:43 PM - A progress note by E20 (LPN) documented "Pressure ulcer to R heel of foot. Applied skin prep and foam pressure padding. Tx (treatment) to change every three days until healed. Ordered heel protectors to wear in and out of bed."  1/29/25 2:15 PM— A review of the documentation of R7's wound care status revealed the following:  -The facility Treatment Binder revealed an updated Physician's Order Administration Record document for R7: "Clean R heel of foot with NSS. Pat dry. Monitor for any change in discolored area, signs and symptoms of infection and/or softness of heel. Document in PCC. Cover with Optifoam dressing every 3 days until healed. DX: Pressure Ulcer". The space for a physician signature on the document was blank.  The facility Physician's Order administration record and progress notes revealed the lack of a complete description of R7's wound including:  -No wound measurements;  -No current wound description (color or the wound or skin condition) to indicate the response to the wound care that had been performed for thirteen days, 1/16/25 through 1/29/25.  -A Physician order for the wound care that R7 was receiving.	measurement and verbal order documentation.  Re-Education was provided by RSC / designee to the nursing team regarding skin assessment process, MD notification of any findings, ensuring physician orders are present, and documentation of wound description and measurements.  4. A review of skin assessments, documentation, interventions and corresponding physicians' orders will be conducted weekly times four weeks then monthly times three months to ensure continued compliance.  Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.	

Provider's Signature \_\_\_\_\_

\_\_\_\_\_Title \_\_Executive Director\_\_\_\_

Date 2/28/2025



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	1/29/25 1:15 PM — During an interview, E2 confirmed that R7's current wound care documentation did not include wound measurements or wound color for R7's right heel pressure ulcer.			
	According to the National Library of Medicine Pressure Injury 2/28/24, a clinical evaluation of the pressure injury should include the staging of the pressure injury, as the stage of a pressure injury can guide options for treatment.			
	R7 experienced neglect because the facility did not provide R7 the services that she needed for the professional evaluation of her right foot heel the pressure injury.			
8	On 1/16/25 R7's right foot heel pressure injury was first observed; however, the pressure injury documentation lacked a complete clinical assessment, including the staging of the pressure injury to guide the options for treatment. Additionally, R7's wound care documentation lacked a physician order for the pressure injury care, including the heel protectors that were referenced in the 1/16/25 6:43 PM progress note.			
	R7's 7/2024 service agreement was not updated to include her right heel pressure injury, making it undear if R7's family and the facility staff were aware of R7's right heel pressure injury and the care that R7 needed for the pressure injury to heal.			
	R7 was placed at risk for harm from the lack of a complete clinical assessment of her right foot pressure injury, the lack of physician oversight of her right foot pressure injury care and the lack of an updated service agreement			

Provider's Signature



## **STATE SURVEY REPORT**

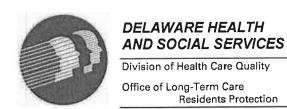
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NAME OF FACILITY: Arden Courts of Wilmington

DATE SURVEY COMPLETED: January 30, 2025

SECTION	STATEMENT OF DEFICIENCIES  SPECIFIC DEFICIENCIES  ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES			
	<del>\</del>			
	that would describe the increased pressure			
	injury care that R7 now requires.			
	(a) An employer may not employ an appli-	E Mandatani Duig Saraan	2/4/2025	
16 DE Code,	cant without first obtaining the results	E Mandatory Drug Screen	3/4/2025	
Chapter 11	of that applicant's mandatory drug	1. E13, E5, E12, E13, E14, E15,		
Subchapter	screening	E16 and E17 tested negative		
IX. Criminal		for marijuana and phencycli-		
Background	(b) All applicants must submit to manda-	dine.		
Checks; Drug	tory drug screening, as specified by reg-	Drug testing form has been		
Testing —	ulations promulgated by the Depart-	updated by Human Resource		
PPECC	ment.	coordinator to include mariju-		
§ 1146 Man-	(c) The Department shall promulgate regu-	ana and phencyclidine.		
datory Drug Screening	lations, regarding the pre-employment	2. A look back of all new hires for		
Screening	testing of all applicants, for use of all of	past 30 days have been re- viewed and documented evi-		
S/S – E	the following illegal drugs:	dence of negative results have		
	(4) 11	been added to the employee		
	(1) Marijuana/cannabis	file.		
	(2) Cocaine	3. Upon further investigation, it		
		was discovered that although		
	(3) Opiate	all applicants were being		
	(4) Phencyclidines ("PCP")	tested correctly with a 5 panel		
		screen that included PCP and		
	(5) Amphetamines	Marijuana, the form being utilized did not reflect the docu-		
	(6) Any other illegal drug specified by	mented results.		
	the Department under regulations	The drug testing results form		
	promulgated under this section	has since been revised to in-		
		clude PCP and marijuana.		
	Based on record review and interview, it was	Executive Director / Designee		
	determined that for seven (E5, E12, E13, E14,	provided education on the re-		
	E15, E16 and E17) out of ten employees re-	vised form and proper docu-		
	viewed for mandatory drug screening, the fa-	mentation to the administra-		
	cility failed to have evidence of screening re-	tive team.		
	sults for marijuana and phencyclidine (PCP)	4. Audits of prehire drug test		
	on their pre-employment drug screen. Find-	documentation will be con- ducted to ensure that all re-		
	ings include:	sults from the drug test are		
	9/29/23 2:31 PM – E13 (CNA) Initial Drug	clearly documented on the re-		
	Screen Result form documented "negative"	sults form to include, Mariju-		
	for amphetamine, cocaine, methampheta-	ana and PCP. Audits will be		
	mine, opiates.	completed weekly on all new		
I				

Provider's Signature



Provider's Signature \_

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

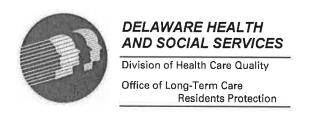
### STATE SURVEY REPORT

\_\_ Title \_\_Executive Director\_\_\_\_\_ Date 2/28/2025

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NAME OF FACILITY: Arden Courts of Wilmington

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE	
	There was no documentation regarding the testing for marijuana/cannabis and phencyclidines.  10/10/23 10:30 AM — E5 (FSM) Initial Drug Screen Result form documented "negative" for amphetamine, cocaine, methamphetamine, opiates.  There was no documentation regarding the testing for marijuana/cannabis and phencyclidines for E5.  11/7/23 1:58 PM — E14 (caregiver) Initial Drug Screen Result form documented "negative" for amphetamine, cocaine, methamphetamine, opiates.  There was no documentation regarding the testing for marijuana/cannabis and phencyclidines for E14. E14's Drug Screen form did not have the urine specimen temperature documented.  2/7/24 11:12 AM — E12 (caregiver) Initial Drug Screen Result form documented "negative" for amphetamine, cocaine, methamphetamine, opiates.  There was no documentation regarding the testing for marijuana/cannabis and phencyclidines for E12.  1/30/25 — Findings were reviewed with E1(ED) and E10 (RRHWS) at the exit conference, beginning at 11:50 AM.	hire- times four weeks, then monthly times three months.  Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring.		



## STATE SURVEY REPORT

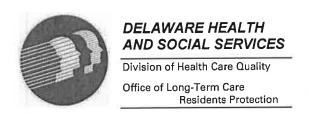
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NAME OF FACILITY: Arden Courts of Wilmington

DATE SURVEY COMPLETED: January 30, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		-	

Provider's Signature \_\_\_\_\_ Title \_Executive Director\_\_\_\_ Date 2/28/2025



## STATE SURVEY REPORT

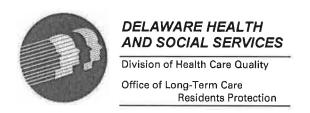
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NAME OF FACILITY: Arden Courts of Wilmington

DATE SURVEY COMPLETED: January 30, 2025

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Provider's Signature \_\_\_\_\_ Title \_Executive Director\_\_\_\_ Date 2/28/2025



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NAME OF FACILITY: Arden Courts of Wilmington

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE