**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

**STATE SURVEY REPORT**



**NAME OF FACILITY:** Arden Courts of Wilmington

**DATE SURVEY COMPLETED:** January 30, 2025

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| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from January 28, 2025, through January 30, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-two (22). The survey sample totaled twelve (12) residents.<br><br>Abbreviations/definitions used in this state report are as follows:<br><br>Department/DHCQ – Division of Healthcare Quality;<br>ED – Executive Director;<br>LPN – Licensed Practical Nurse;<br>NSS (Normal Saline Solution) – sterile salt water with similar concentration to body fluids;<br>Optifoam – An adhesive bandage made of foam layers which provides cushioning to skin;<br>POA – Power of Attorney, a legal authorization that gives the authority to act on behalf of an individual;<br>Pressure Ulcers (PUs) - sore area of skin that develops when blood supply to it is cut off due to pressure;<br>Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI) by a Registered Nurse;<br>RSC/DON - Resident Services Coordinator/Director of Nursing;<br>RRHWS – Regional Residential Health and Wellness Specialist;<br>RC - Resident Caregiver;<br>SA – Service Agreement – allows both parties involved (the resident and the assisted living | | |

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| | facility) to understand the types of care and services the assisted living provides. These include lodging, board, housekeeping, personal care, and supervision services;<br><br>Stages (severity) of pressure ulcers (PUs):<br>-Stage I (1) - intact red skin often over a boney area that does not turn white/light when pressed;<br>-Stage II (2) - blister or shallow open sore with red/pink color;<br>-Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin;<br>-Stage IV (4) - open sore so deep that muscle, tendon or bone can be seen/felt;<br>-Unstageable - actual depth of the ulcer cannot 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;<br>-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.<br><br>Uniform Assessment Instrument" ("UAI") - A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations. | | |

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| **3225**<br><br>**3225.9.0**<br><br>**3225.9.6**<br><br>**S/S – D** | **Assisted Living Facilities**<br><br>**Infection Control**<br>**The Assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review and interview, it was determined that for one (R2) out of seven residents reviewed for infection control, the facility lacked evidence of an annual influenza vaccination being administered or offered and declined. Findings include:<br><br>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 the influenza date section on the form was blank.<br><br>1/29/25 1:45 PM – During an interview, (RSC) confirmed that R2's admission medical evaluation did not have information regarding flu immunization status. | **3225:**<br><br>1. Resident R2's annual Flu vaccination has been entered into the Electronic Health Record (EHR) by the Resident Services Coordinator (RSC).<br>2. A review of all current residents Flu vaccination documentation has been conducted to ensure all required documentation is present in the electronic health record.<br><br>3. Upon further investigation, it was determined that R2 did have her Flu and Pneumococcal vaccine prior to moving in. However, the historical date was not entered into the medical record.<br><br>The RSC has re-educated all nurses regarding Flu 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.<br>4. Executive Director or Designee will conduct weekly audits times four weeks then monthly times three. Audits will be conducted for all new move ins and any new vaccines for current residents, to ensure the Flu vaccine historical information is entered into the electronic health record or offered if still in season as well as required documentation | **3/4/2025** |

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| | | present for any declinations of the vaccine.<br><br>Audits results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |
| **3225.9.7**<br><br>**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.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review and interview, it was determined that for one (R2) out of seven residents 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:<br><br>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. | **3225.97**<br><br>1. Resident R2's annual pneumococcal pneumonia vaccination has been entered into the Electronic Health Record (EHR) by the Resident Services Coordinator (RSC).<br>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.<br>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 medical record.<br><br>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.<br>4. Executive Director or Designee will conduct weekly audits | **3/4/2025** |

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| | 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. | times four weeks then 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.<br>Audits results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |
| **3225.10.0**<br><br>**3225.10.10**<br><br>**S/S - D** | **Contracts**<br><br>**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.**<br><br>This requirement was not met as evidenced by:<br><br>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:<br>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. | **3223.10.0**<br><br>1. Unable to correct the signed contract dated 4/10/2024.<br><br>2. 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.<br><br>3. 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 | **3/4/2025** |

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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.<br><br>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.<br><br>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.<br><br>Audits results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |
| **3225.11.0**<br><br>**3225.11.5**<br><br>**S/S – D** | **Resident Assessment**<br><br>**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.** | **3223.110**<br><br>1. Resident R7 had an assessment completed on 2/7/2025 by the Nurse Practitioner and the Uniform Assessment Instrument and Service Plan has been updated by the RSC. | **3/4/2025** |

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| | This requirement was not met as evidenced by:<br><br>Based on record review and interview, it was determined that for one out of one resident reviewed for Uniform Assessment Instruments, the facility failed to revise the Uniform Assessment Instrument (UAI) within 30 days of admission and after a significant change requiring additional support.<br>4/24/24 - R7 was admitted to the facility with a diagnosis of dementia (a general term for a group of brain conditions that cause a decline in mental abilities), chronic kidney disease (stage 3) (a moderate level of kidney damage where the kidneys are not filtering waste effectively, resulting in mild to moderate loss of kidney function), osteoporosis (a disease that weakens bones, making them more likely to break), and major depressive disorder (a mental illness that causes a persistent low mood and loss of interest in activities). R7 has a past medical history of a fractures left hip and a fractured right shoulder prior to admission to the facility.<br><br>4/4/24 – a Uniform Assessment Instrument (an assessment tool that collects information regarding an assisted living applicant/resident's physical condition, mental status and psychosocial needs) was completed by an RN. A review of the UAI reveals that the resident required supervision, set up, cuing, coaching, reminders of meal times; is able to toilet themselves during the day, but requires assistance at night; is independent with mobility with a walker; needs supervision with bed mobility; needs standby assistance during transfers; needs supervision with grooming; and needs supervision with dressing.<br>There was no evidence that a 30-day follow up assessment was performed. | 2. A review of all current residents have been conducted to ensure all had current and updates assessments and service plans.<br>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 since.<br><br>The RSC / Designee provided Reeducation to the nursing team regarding the required schedule for initial and routine updates. The education also included updates to the assessment and service plans are required whenever there is a change in the residents condition.<br>4. A weekly audit times four weeks then monthly times three months will be conducted by RSC / Designee to ensure the timely completion of the UAI during routine schedules. Weekly reviews will include a clinical review of current residents for any changes in condition to ensure assessments and service plans are updated. | |

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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).<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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. | Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |

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| 3225.18.0<br><br>3225.18.6.2<br><br>S/S – E | **Emergency Preparedness.**<br><br>**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.**<br><br>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:<br><br>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.<br><br>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. | **3225.18.0**<br><br>1. A second full-time employee obtained the FEMA training for ICS-100 and NIMS-700b on 2/14/2025.<br>2. The community currently meets the Emergency Preparedness requirement with two full-time employees certified in FEMA training.<br>3. Upon further review and investigation, it was determined that the 2nd 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.<br>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.<br>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** |

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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.** | 1. Unable to correct R11's past late report from 7/21/2024.<br>2. A 30-day lookback review has been conducted on any residents who have passed away. All have been found to have been reported timely within 8-hours to the division. | |
| **3225.19.7** | **Reportable incidents include:** | | |
| **3225.19.7.6** | **Reportable incidents include: Death of a resident in a facility or within 5 days of transfer to an acute care facility.** | 3. Upon further review and investigation, It was determined that R11 was receiving Hospice (end of life services). 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. | |
| **S/S – D** | The requirement was not met as evidenced by:<br><br>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:<br><br>8/24/23 – R11 was admitted to the facility 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).<br><br>07/21/24 – R11was found non-responsive in his room by a facility caregiver at approximately 4:30 p.m. The caregiver notified the nurse, who contacted the RN. R11 was pronounced deceased by the RN at 5:25 p.m. R11's physician and POA were notified. | 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.<br>4. An audit of clinical records will be conducted by Executive Director / Designee to determine if any reportable incidents have occurred and if | |

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| | 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.<br><br>The facility reported the resident's death 4 days after it occurred, which is outside the time specified in the regulation. | they were reported within 8 hours. Audits will be conducted, weekly times four weeks then monthly times three months.<br><br>Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |
| **16 DE Code, Chapter 11 Subchapter I. Licensing By The State § 1108.**<br><br>**S/S-C** | **Posting of inspection summary and other information and public meetings.**<br><br>**(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:**<br><br>**(b) (3) The most recent state survey report prepared by the Department of the most recent inspection report for the facility.**<br><br>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:<br><br>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. | **E Code Chapter 11 Licensing**<br><br>1. Inspection results are posted and present in the community lobby.<br>2. A sign has been posted as to the location of the inspection reports.<br>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.<br>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.<br>4. A weekly audit times four weeks then monthly times three will be conducted to ensure the inspection reports remain available at all times. | **3/4/2025** |

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| | | Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |
| **16 DE Code, Chapter 11 Chapter 11. Long-Term Care Facilities and Services § 1131 Definitions.**<br><br>**S/S D** | **Subchapter 111 Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients**<br><br>**(9) Neglect**<br><br>**(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:**<br>**a. Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals, and safety.**<br><br>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.<br><br>Findings include:<br><br>4/24/24 – R7 was admitted to the facility.<br><br>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. Cover with Optifoam dressing every 3 days until healed. DX: Pressure Sore".<br><br>1/16/25 3:09 PM - A progress note was written by E2 documented "Was called to room to assess right heel. Dark area noted to right | **16 DE Code Chapter 11 Long Term Care Facility and Services.**<br><br>1. A clinical evaluation for R7 has been completed on 2/4/2025 by Nurse Practitioner. Description and staging of the wound was completed and MD orders obtained.<br>2. A full house audit on all current residents has been completed to ensure any areas found during skin assessments are documented, appropriate treatments are in place, and physician orders foreach treatment has been obtained.<br>3. After further investigation and review it was determined that upon discovery of the wound, The wound was evaluated by the nurse , identified, a verbal order was obtained, and treatment was put in place, the wound was documented by the nurse but a measurement of the wound was not obtained by the same nurse and she forgot to write the verbal order by the physician for the treatment that was put in place and implemented. It was determined that there was no delay in treatment but the nurse forgot to follow through regarding proper wound | **3/4/2025** |

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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".<br><br>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."<br><br>1/29/25 2:15 PM– A review of the documentation of R7's wound care status revealed the following:<br><br>-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.<br><br>The facility Physician's Order administration record and progress notes revealed the lack of a complete description of R7's wound including:<br><br>-No wound measurements;<br><br>-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.<br><br>-A Physician order for the wound care that R7 was receiving. | measurement and verbal order documentation.<br>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.<br>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.<br><br>Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |

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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.<br><br>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.<br><br>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.<br><br>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.<br><br>R7's 7/2024 service agreement was not updated to include her right heel pressure injury, making it unclear 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.<br><br>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 | | |

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| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|---|---|---|
| **16 DE Code, Chapter 11 Subchapter IX. Criminal Background Checks; Drug Testing — PPECC**<br>**§ 1146 Mandatory Drug Screening**<br><br>**S/S – E** | that would describe the increased pressure injury care that R7 now requires.<br><br>**(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening...**<br><br>**(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.**<br><br>**(c) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following illegal drugs:**<br><br>**(1) Marijuana/cannabis**<br><br>**(2) Cocaine**<br><br>**(3) Opiate**<br><br>**(4) Phencyclidines ("PCP")**<br><br>**(5) Amphetamines**<br><br>**(6) Any other illegal drug specified by the Department under regulations promulgated under this section...**<br><br>Based on record review and interview, it was determined that for seven (E5, E12, E13, E14, E15, E16 and E17) out of ten employees reviewed for mandatory drug screening, the facility failed to have evidence of screening results for marijuana and phencyclidine (PCP) on their pre-employment drug screen. Findings include:<br><br>9/29/23 2:31 PM – E13 (CNA) Initial Drug Screen Result form documented "negative" for amphetamine, cocaine, methamphetamine, opiates. | **E Mandatory Drug Screen**<br><br>1. E13, E5, E12, E13, E14, E15, E16 and E17 tested negative for marijuana and phencyclidine.<br>Drug testing form has been updated by Human Resource coordinator to include marijuana and phencyclidine.<br>2. A look back of all new hires for past 30 days have been reviewed and documented evidence of negative results have been added to the employee file.<br>3. Upon further investigation, it was discovered that although all applicants were being tested correctly with a 5 panel screen that included PCP and Marijuana, the form being utilized did not reflect the documented results.<br>The drug testing results form has since been revised to include PCP and marijuana.<br>Executive Director / Designee provided education on the revised form and proper documentation to the administrative team.<br>4. Audits of prehire drug test documentation will be conducted to ensure that all results from the drug test are clearly documented on the results form to include, Marijuana and PCP. Audits will be completed weekly on all new | **3/4/2025** |

Provider's Signature _____ Title __Executive Director_____ Date 2/28/2025

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| | There was no documentation regarding the testing for marijuana/cannabis and phencyclidines.<br><br>10/10/23 10:30 AM – E5 (FSM) Initial Drug Screen Result form documented "negative" for amphetamine, cocaine, methamphetamine, opiates.<br><br>There was no documentation regarding the testing for marijuana/cannabis and phencyclidines for E5.<br><br>11/7/23 1:58 PM – E14 (caregiver) Initial Drug Screen Result form documented "negative" for amphetamine, cocaine, methamphetamine, opiates.<br><br>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.<br><br>2/7/24 11:12 AM – E12 (caregiver) Initial Drug Screen Result form documented "negative" for amphetamine, cocaine, methamphetamine, opiates.<br><br>There was no documentation regarding the testing for marijuana/cannabis and phencyclidines for E12.<br><br>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.<br><br>Audit results will be forwarded to Quality Assurance for review and further recommendations for continued monitoring. | |

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