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

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

REVISED STATE SURVEY REPORT

NAME OF FACILITY: AL-Arden Courts (Wilmington) **DATE SURVEY COMPLETED:** June 14, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Complaint Survey was conducted at this facility from June 3, 2024, through June 14, 2024. 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-five (25). The survey sample totaled eighteen (18) residents. Abbreviations/definitions used in this State Report are as follows: CG – Caregiver; DON – Director of Nursing; ED – Executive Director; Hospice - an agency licensed by the State of Delaware that provides palliative and supportive medical and other health services to terminally ill residents and their families; LPN – Licensed Practical Nurse; MAR – Medication Administration Record; RDO – Regional Director of Operations; RHWS – Regional Health and Wellness Specialist RN – Registered Nurse; RSC – Resident Services Director; SA (Service Agreement) – allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include lodging, board, housekeeping, personal care, and supervision services; TAR – Treatment Administration Record; UAI (Uniform Assessment Instrument) – a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be re-		

Provider's Signature Joanne Hoff Title Interim ED Date 8/19/24

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	quired to use the UAI to evaluate each resident on both initial and ongoing basis in accordance with these regulations; VPHW – Vice President of Health and Wellness; VPO - Vice President of Operations.	Facility staff will be educated on the new processes resulting from this plan of correction upon hire, annually, and as needed.	
3225.0	**Assisted Living Facilities**		
3225.5.0	**General Requirements**	General Requirements. It is the practice of this community that residents receiving hospice will have written assurance that residents' needs are being met	8/14/24
3225.5.10	**The provisions of section 5.9 above do not apply to residents under the care of a Hospice program licensed by the Department as long as the Hospice program provides written assurance that, in conjunction, with care provided by the assisted living facility, all of the resident's needs will be met without placing other residents at risk.**	1) Resident 1 is unable to be corrected as they no longer reside in the community. Resident 16 is unable to be corrected as they no longer reside in the community. 2) Residents receiving hospice care have the potential to be affected. The Community will conduct an audit of current residents receiving hospice to include wound care, pain management, hospice notes presence, and RN assessment. 3) A Root Cause Analysis (RCA) indicated a system breakdown due to poor communication & lack of follow-up with hospice services. Executive Director or designee will in-service licensed professionals the following topics: Planning and Monitoring Services, Scope of Practice, and Pain Management. Resident Services Coordinator (Registered Nurse) met with hospice on July 11, 2024 regarding needs, including an exit meeting with each visit, and written assurance of resident needs being met with notes within 7 days of a visit, after Hospice services have been established. The process of exit meetings after each visit and ensuring receipt and review by facility staff of visit notes within 7 days of hospice visits will be ongoing as long as the resident(s) continues to receive Hospice services. 4) Resident Services Coordinator (RN) or licensed nurse designee will audit current	
S/S - D	**This requirement was not met as evidenced by:** Based on interview and review of facility and hospice documentation, it was determined that for two (R1 and R16) out of two residents reviewed for hospice, the facility failed to ensure that each residents' needs were met by hospice and the facility. Findings include: 1. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 3 R16's facility records and hospice record (requested from hospice by the Surveyor) revealed: 4/15/24 – R16 was admitted to hospice services during a hospitalization.		

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	4/19/24 – R16 was readmitted to the facility under hospice services with needs that included wound care and pain management. Per the hospice plan of care, the following hospice visits requiring nursing assessments did not take place: - 4/23/24: no RN (Registered Nurse); - 4/30/24: no RN. 5/4/24 – R16 was sent to the hospice inpatient unit at the hospital for uncontrolled pain as R16 was not being administered pain medications as ordered and her wound infection continued. In addition, it should be noted that hospice notes were not accessible in R16's facility clinical record to ensure the collaboration of care. Review of R16's available records, there was no written assurance by the hospice that, in conjunction with the care provided by the assisted living facility, that all of R16's needs were met. 2. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 6 R1's facility records and hospice record (requested from hospice by the Surveyor) revealed: 4/3/24 – R1 was admitted to hospice services during his hospitalization. 4/4/24 – R1 was readmitted to the facility. From 4/21/24 through 5/20/24, R1 had 23 falls, with two falls where R1 sustained a wrist fracture and multiple rib fractures.	residents receiving hospice for pain management (goal: pain identified and responded to by nursing) and hospice coordination of care (goal: notes present by hospice RN) by licensed nurses weekly x 4 weeks then monthly x 2 months to ensure pain is identified and followed up. Findings will be reviewed by the QAPI committee. 5) Date of Compliance: 08.14.2024	

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	Review of R1's available records, there was no written assurance by the hospice that, in conjunction with the care provided by the assisted living facility, that all of R1's needs were met. 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office.		
3225.8.0	**Medication Management**		
3225.8.1.5	**Provision for a quarterly pharmacy review conducted by a pharmacist which shall include:**		
3225.8.1.5.1	**Assisting the facility with the development and implementation of medication-related policies and procedures;**		
3225.8.1.5.2	**Physical inspection of the medication storage areas;**	3225.8.1.5.3 Medication Management. It is the practice of this community that residents will have their medications managed including a review of medication regimen by pharmacy that reports on irregularities. 1) Residents 2,3,5,6,7,8,9,10,11,12,13 and 14 were reviewed by a Registered Nurse who reported to the physician to obtain orders for diagnoses/indication for use. 2) Residents residing in the community have the potential to be affected. The community will conduct an audit of current residents' medication orders. Those that do not have diagnoses or indications for use will be corrected. 3) A Root Cause Analysis (RCA) indicated a system breakdown where the medication order review process was not being monitored by the RN or the consultant pharmacist for diagnoses/indications of use. RN will review move-in orders for diagnosis	8/14/24
3225.8.1.5.3	**Review of each resident's medication regimen with written reports noting any identified irregularities or areas of concern.**		
S/S - E	**This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for 12 (R2, R3, R5, R6, R7, R8, R9, R10, R11, R12, R13 and R14) out of 12 residents reviewed for Medications, the facility failed to ensure the pharmacist identified irregularities, specifically the failure to include a reason for use, diagnosis or clinical indication for prescribed medication. Findings include:		

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	Facility policy for Medication and Treatment Guidelines (6/2021) "General: - Medications are administered in accordance with standards of practice and state specific and federal guidelines... Medication and Treatment Orders: - A complete medication order includes... - directions for use including the reason for use, diagnosis, or clinical indication...". 1. Review of R2's clinical record revealed: 6/13/24 - R2 had eight active medication orders, with only six of the medication orders including a clinical indication or diagnosis. 2. Review of R3's clinical record revealed: 6/13/24 - R3 had nine active medication orders, with only five of the medication orders including a clinical indication or diagnosis. 3. Review of R5's clinical record revealed: 6/13/24 - R5 had eleven active medication orders, with only two of the medication orders including a clinical indication or diagnosis. 4. Review of R6's clinical record revealed: 6/13/24 - R6 had two active medications orders, with only one of the medication orders including a clinical indication or diagnosis. 5. Review of R7's clinical records revealed:	and indications upon move in and with new orders. Executive Director or designee will in-service licensed professionals on the following topics: Medication/Treatment Guidelines (which includes a complete order and diagnoses/indication for use), Medication Pass. The Executive Director or designee will conduct a meeting with the pharmacy team to clarify needs of the community for written medication review. New admissions orders will be reviewed after admission for diagnosis or indication for use. 4) Resident Services Coordinator (RN) or licensed nurse designee will audit 5 random residents for complete medication orders (goal: 100% orders include diagnosis or indication for use) weekly x 4 weeks, then monthly x 2 months. Findings will be reviewed by the QAPI Committee. 5) Date of Compliance: 08.14.24	

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	6/13/24 - R7 had nine active medication orders, with only five of the medication orders including a clinical indication or diagnosis. 6. Review of R8's clinical record revealed: 6/13/24 – R8 had seven active medication orders, with only three of the medication orders including a clinical indication or diagnosis. 7. Review of R9's clinical record revealed: 6/13/24 – R9 had eleven active medication orders, with only seven of the medication orders including a clinical indication or diagnosis. 8. Review of R10's clinical record revealed: 6/13/24 – R10 had fifteen active medication orders, with only nine of the medication orders including a clinical indication or diagnosis. 9. Review of R11's clinical record revealed: 6/13/24 – R11 had eleven active medication orders, with only eight of the medication orders including a clinical indication or diagnosis. 10. Review of R12's clinical record revealed: 6/13/24 – R12 had twenty-two active medication orders, with only ten of the medication orders including a clinical indication or diagnosis. 11. Review of R13's clinical record revealed:		

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	6/13/24 – R13 had thirteen active medication orders, with only six of the medication orders including a clinical indication or diagnosis. 12. Review of R14's clinical record revealed: 6/13/24 – R13 had sixteen active medication orders, with only four of the medication orders including a clinical indication or diagnosis. 6/14/24 11:35 AM – During an interview, E1 (ED) stated that upon their review of the residents' orders only two residents' medication orders were complete with reasons for usage or diagnosis. "E3 (Mobile DON) spent yesterday evening fixing all the orders. For some of the orders, the doctor had written the diagnosis within the written order, but when the pharmacy transcribed it to the EMR (electronic medical record), the diagnosis was not included." 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's office.		
3225.8.3 **3225.8.3.5** **S/S - A**	**Medication stored by the assisted living facility shall be stored and controlled as follows:** **All expired or discontinued medication, including those of deceased residents, shall be disposed of according to the assisted living facility's medication policies and procedures.** **This requirement was not met as evidenced by:**	**3225.8.3.5** Medication Management. It is the practice of this community that residents' medications will be disposed of per policy, including discontinued or discharged medications and controlled substances. 1) Resident 16 is unable to be corrected as they no longer reside in the community. 2) Residents residing in the community have the potential to be affected. The community will conduct an audit of current residents' medications that are expired or discontinued and properly dispose of those	8/14/24

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	Based on interview and review of clinical record and facility documentation as indicated, it was determined that for one (R16) out of one resident reviewed for controlled medication, the facility failed to ensure that nursing staff disposed of the resident's Morphine (for pain) and Ativan (for anxiety) medication properly. Findings include: The facility's policy and procedure, entitled Medication Disposal/Destruction, dated 8/2018, stated, "... 8. The Nursing Center destroys Controlled Substances... - Nursing Center destroys controlled substances in the presence of a registered nurse (RN) and a licensed nurse or pharmacist witness in accordance with Nursing Center policy or applicable law. - Nursing center records controlled substance destruction on: Controlled Substance Proof-of-Use Form; Medication Destruction Log Book... - Destruction of controlled medications is documented with the signatures of DON or designee and witnessing licensed nurse. Record quantity destroyed. Record date of destruction...". R16's clinical record revealed: 5/9/24 – R16 was readmitted to the facility after an inpatient hospice stay. R16's Morphine and Ativan medication was sent to the facility with the resident without a controlled medication utilization record. 5/16/24 – R16 was pronounced in the facility. 5/23/24 – R16's clinical record included a blank piece of paper with the following information handwritten on it: "[R16's name] (Wasted)	medications. The community will conduct an audit of current resident's who have controlled substances for appropriate control sheets. 3) A Root Cause Analysis (RCA) indicated a system breakdown where the Registered Nurse was not overseeing controlled substances in the community per policy or law. Executive Director or designee will in-service licensed professionals on the following topics: Medication Pass, Medication/Treatment Guidelines, and controlled substance accounting sheets. 4) Resident Services Coordinator (RN) or licensed nurse designee will audit 5 random residents' medications to identify any expired or discontinued medications (goal: 5 of 5 no expired meds) and presence of controlled substance accounting sheets (goal: 100% sheets are present/accurate) weekly x 4 weeks then monthly x 2 months. Findings will be reviewed by the QAPI Committee. 5) Date of Compliance: 08.14.24	

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	Ativan Count: 123 tabs Morphine Count: 12 ml 5/23/24 [Signed by E7 (LPN) and E8 (LPN)]" The facility failed to ensure controlled substances were disposed of and documented properly by an RN and a licensed nurse or pharmacist. 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's office.		
3225.8.8.2 S/S - D	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered.** **This requirement was not met as evidenced by:** Based on interview and review of clinical records and other documentation as indicated, it was determined that for one (R16) out of six sampled residents, the facility failed to administer the Physician ordered medications. Findings include: 1. R16's clinical record revealed: Review of the March 2024 MAR revealed that two (2) scheduled doses of Lasix medication were not administered on 3/29/24. Review of the April 2024 MAR revealed: - that four (4) scheduled doses (4/3/24 and 4/4/24) of Lasix medication were not administered to R16 as they were pending pharmacy delivery; and - the resident was not administered any pain medications despite having orders for	**3225.8.8.2** Medication Management. It is the practice of this community that residents receive their medications in the manner they are prescribed by the prescriber. 1) Resident 16 is unable to be corrected as they no longer reside in the community. 2) Residents residing in the community have the potential to be affected by this practice. The community will audit the MAR for missed medication administration and notify the physician for orders if appropriate. 3) A Root Cause Analysis (RCA) indicated a knowledge deficit regarding education on pharmacy processes for follow-up when medications do not arrive as ordered. Executive Director or designee will in-service licensed professionals and medication technicians on the following topics: Medication/Treatment Guidelines, Process when a medication is unavailable. 4) Resident Services Coordinator (RN) or licensed nurse designee will audit 5 random residents MARs to identify any missed medications or treatments (goal: 0 missed medications or 100% followed up if missing) weekly x 4 weeks then monthly x 2 months. Findings will be reviewed by the QAPI Committee	8/14/24

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	both Morphine and Tylenol from 4/19/24 through 4/30/24. Review of the May 2024 MAR revealed that the resident was not administered any pain medications despite having orders for both Morphine and Tylenol from 5/1/24 through 5/4/24. 6/14/24 at 10:30 AM – During a combined interview, finding was reviewed with E2 (RSC) and E3 (Mobile DON). 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office.	5) Date of Compliance: 08.14.24	
3225.11.0 3225.11.5 S/S - D	**Resident Assessment** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement was not met as evidenced by:** Based on interview and review of the clinical records, it was determined that for three (R1, R16 and R18) out of six sampled residents, the facility lacked evidence that the UAI assessment was updated when there was a significant change in each residents' condition. Findings include: 1. R1's clinical record revealed:	**3225.11.5** Resident Assessment. It is the practice of this community that a UAI's are completed at minimum 30 days after admission, annually, and with significant change of condition. 1) Resident 1 and Resident 16 are unable to be corrected as they no longer reside in the community. Registered Nurse completed the UAI for Resident 18. 2) Residents residing in the community have the potential to be affected by this practice. The community will audit current residents for an updated UAI annually or if significant change. Identified concerns will be updated and completed. 3) A Root Cause Analysis (RCA) indicated a system breakdown/failure to execute the process for UAI's to be updated as changes occurred to resident care needs. An update to the community's morning meeting process will prompt staff if a change in condition may require a UAI.	8/14/24

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	a) 4/5/24 – The UAI assessment was updated to reflect that R1 signed onto hospice services as it had a handwritten note of the name of the hospice. However, the UAI was incomplete (missing R1's date of birth, date of admission, assessment type, source of information, mobility assessment, hospice services were checked "No", vision and hearing not assessed, nutrition/hydration/diet missing information, sleep patterns were not completed, fall risk assessment was not completed, pain management was "Not Applicable", medications were not listed nor attached as it was written "See MAR". b) 5/8/24 - The facility failed to revise R1's UAI assessment in conjunction with updating R1's Service Plan. 6/14/24 at 10:30 AM – During a combined interview, findings were reviewed with E2 (RSC), E3 (Mobile DON) and E12 (RHWS). No further information was provided to the Surveyor. 2. R16's clinical record revealed: 12/6/23 – R16's annual UAI was signed by E2 (RSC). However, it was documented that the UAI was reviewed by phone with R16's family member but was not signed. 3/17/24 – R16 was readmitted to the facility with a necrotic wound on the back of her left leg that required daily and PRN dressing changes and monitoring. The facility lacked evidence of an updated UAI to reflect R16's change of condition. 4/19/24 – R16 was readmitted to the facility after a second hospitalization and returned with hospice services. The facility	Executive Director or designee will in-service registered nurses on the following topics: UAI's (from the state website) 4) Executive Director or designee will audit 5 random resident records for a completed UAI (goal: 100% up to date) weekly x 4 weeks then monthly x 2 months. Findings will be reviewed by the QAPI Committee 5) Date of Compliance: 08.14.24	

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	lacked evidence that R16's UAI was updated to reflect hospice services. 6/14/24 at 10:30 AM – During a combined interview, findings were reviewed with E2 (RSC) and E3 (Mobile DON). 3. R18's clinical record revealed: 9/14/23 – The signed admission UAI assessment documented that R18 required: - occasional physical assistance for mobility; - one-person physical assistance for bed mobility and transferring; - used a walker for mobility; - fall risk assessment "N/A" (Not applicable); and - pain management (checked) Not applicable. The facility failed to update R18's UAI assessment after the 2/14/24 fall with hip fracture and pain; rehabilitation stay from 3/3/24 to 4/25/24 and a fall on 4/26/24. 6/7/24 at 11:12 AM – Finding was confirmed with E3 (Mobile DON). 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office.		
3225.13.0	**Service Agreements**		
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**	**3225.13.6** Service Agreements. It is the practice of this community that services agreements (ISP) are reviewed when needs change and in conjunction with UAI and executed within 10 days.	

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S/S - D	**living facility shall execute a revised service agreement, if indicated.** **This requirement was not met as evidenced by:** Based on interview and review of clinical records, it was determined that for one (R16) out of six sampled residents, the facility lacked evidence that the Service Plan was reviewed when the needs of the resident changed. Findings include: R16's clinical record revealed: 12/6/23 – R16's service plan was signed by E2 (RSC). However, it was reviewed with R16's family member but was not signed. 3/17/24 – R16 was readmitted to the facility with a necrotic (black, dead tissue) wound on the back of her left leg that required daily and PRN (as needed) dressing changes and monitoring. The facility lacked evidence of an update service agreement to reflect R16's change of condition. 4/19/24 – R16 was readmitted to the facility after a second hospitalization and returned with hospice services. The facility lacked evidence that R16's service agreement was updated to reflect hospice services. 6/14/24 at 10:30 AM – During a combined interview, findings were reviewed with E2 (RSC) and E3 (Mobile DON). 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office.	1) Resident 16 is unable to be corrected as they no longer reside in the community. 2) Residents residing in the community have the potential to be affected. The community will audit current service plans and update and execute if changes are needed. 3) A Root Cause Analysis (RCA) indicated a system breakdown related to updating service agreements as care needs change along with the UAI. An update to the community's morning meeting process will prompt staff if a change in condition may require a UAI. Executive Director or designee will in-service licensed professionals on the following topics: Planning and monitoring services and change in condition. 4) Executive Director or designee will audit 5 random resident records for up-to-date service plan done in conjunction with UAI's (goal: audited service plans will be up-to-date and consistent with the current UAI) weekly x 4 weeks then monthly x 2 months. Findings will be reviewed by the QAPI Committee. 5) Date of Compliance: 08.14.24	8/14/24

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3225.15.0 S/S - E	**Quality Assurance** **The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction.** **This requirement was not met as evidenced by:** Based on interview and record review of the facility's Quality Assurance Program, the facility failed to implement an internal monitoring process which identified, tracked, and trended falls for 4 (four) residents (R1, R2, R8 and R11) with multiple falls to identify the root cause analysis (of the falls), implement fall reduction interventions, and track the effectiveness of the interventions. Findings include: 1. Review of R2's clinical records revealed: 4/25/24 – R2 was admitted to the facility with diagnoses including dementia. 6/14/24 9:15 AM – A review of R2's clinical records revealed a total of 6 (six) falls from 5/23/24 to 6/10/24. The facility lacked evidence that R2's falls were reviewed to determine the root cause analysis and implement fall interventions. 2. Review of R1's clinical records revealed: 2/25/24 – R1 was admitted to the facility with diagnoses including dementia and Parkinson's Disease.	3225.15.0 Quality Assurance. It is the practice of this community to conduct an ongoing QA Program including internal monitoring process of tracking performance and measuring resident satisfaction. 1) Resident 1 is unable to be corrected as they no longer reside in the community. Residents 2, 8, and 11 were reviewed by a Registered Nurse and trended for falls and root cause analysis. 2) Residents reside in the community have the potential to be affected. The community will audit residents that have 3 or more falls in 30-day time frame and conduct root cause analysis. Findings will be followed up. 3) A Root Cause Analysis (RCA) indicated a failure to execute and need for updated QAPI program processes. An updated QAPI program has been created and implemented to include tracking and trending of issues, such as falls. Executive Director or designee will in-service on the following topics: Falls, QAPI Program, Investigations. QAPI program implemented. 4) Executive Director or designee will conduct internal monitoring of fall performance and trending of falls monthly x 3 months to include analysis of intervention success for those with 3 or more falls in a 30-day period. Goal: No injuries to residents with 3 or more falls in a 30-day period. Findings will be reviewed by the QAPI Committee. 5) Date of Compliance: 08.14.24	8/14/24

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	6/14/24 9:30 AM – A review of R1's clinical records revealed a total of 34 (thirty-four) falls from 3/3/24 to 6/13/24. The facility lacked evidence that R1's falls were reviewed to determine the root cause analysis and implement fall interventions. 3. Review of R8's clinical records revealed: 2/23/24 – R8 was admitted to the facility with diagnoses including dementia, seizure disorder and left femur fracture. 6/14/24 9:45 AM – A review of R8's clinical records revealed a total of 9 (nine) falls from 3/6/24 to 6/14/24. The facility lacked evidence that R8's falls were reviewed to determine the root cause analysis and implement fall interventions. 4. Review of R11's clinical records revealed: 5/9/22 – R11 was admitted to the facility with diagnoses including dementia and difficulty walking. 6/14/24 10:00 AM – A review of R11's clinical records revealed a total of 4 (four) falls from 5/9/24 to 6/13/24. The facility lacked evidence that R11's falls were reviewed to determine the root cause analysis and implement fall interventions. The facility failed to implement an internal monitoring process which identified, tracked, and trended the residents with multiple falls to determine the root cause analysis of the falls, implement interventions for fall reduction, and evaluate the outcome of the interventions.		

Provider's Signature [signature] Title Interim ED Date 8/19/24

NAME OF FACILITY: AL-Arden Courts (Wilmington)

DATE SURVEY COMPLETED: June 14, 2024

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	6/14/24 at 2:24 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office.		
3225.16.0	Staffing		
3225.16.2	**A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** **Per the State of Delaware Board of Nursing's Scope of Practice document entitled "RN, LPN and NA/UAP Duties 2024", last revised 4/10/24, only a Registered Nurse (RN) can perform post fall assessment and documentation.**	3225.16.2 Staffing. It is the practice of this community to have sufficient staffing adequately trained, certified, or licensed to meet the needs of the resident. 1) Resident 17 is unable to be corrected as they no longer reside in the community. A Registered Nurse completed a clinical evaluation (assessment) for Residents 3 and 18 with no new findings. 2) Residents residing in the community who have incurred a fall since survey exit have the potential to be affected. The community will audit current residents with falls since 6.14.24 to ensure post-fall monitoring of residents not transferred from the facility, and activation of EMS for evaluating residents who sustain an unwitnessed fall or fall with suspected head injury or other obvious injury. 3) A Root Cause Analysis (RCA) indicated a knowledge deficit of the Post Fall Protocol – DE specific guidance related to post-fall monitoring of residents not transferred from the facility and lack of execution of post-fall process when sending a resident to the hospital after an unwitnessed fall or fall with suspected head injury or other obvious injury. Executive Director or designee will inservice staff on what to do when a fall occurs by 8/14/2024. 4) Resident Services Coordinator (RN) or licensed designee will conduct an audit of falls to identify post-fall monitoring of residents not transferred from the facility, activation of EMS for evaluating residents who sustain an unwitnessed fall or fall	8/14/24
S/S - D	**This requirement was not met as evidenced by:** Based on interview and review of clinical records and other documentation as indicated, it was determined that for three (R3, R17 and R18) out of seven residents reviewed for falls, the facility failed to ensure that a RN performed the post fall assessment and documentation after each resident's fall. Findings include: 1. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 2 R3's clinical record revealed: 5/29/24 at 7:00 PM – A nurse's note by E7 (LPN) documented, "...resident had an unwitnessed... laying on the floor... Upon assessment... Has a bruise to the left eye with		

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	some swelling... hematoma by the temple with bruising...". 6/5/24 at 3:14 PM – During an interview, E7 (LPN) confirmed that she assessed R3 after her fall and completed post fall documentation. 2. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 5 R18's clinical record revealed: a) 2/14/24 at 3:27 PM – A facility incident report by E7 (LPN) documented, "This nurse was notified by caregiver that resident was on the floor. Upon repositioning resident to the bed patient was assessed by the nurse (sic) no sign of injury noted... Patient's vitals were obtained, and patient was repositioned back in bed...". 2/18/24 at 1:42 PM – The facility's incident report by E2 (RSC) documented, "Care aide called this nurse via phone and stated that the resident was found on the floor in another resident's room on 2/14/24 at around 9pm (sic). Resident was transferred back to his room via wheelchair, because he wouldn't stand. The aide stated that she then notified the nurse that the resident had fell (sic) on the shift." 2/21/24 at 2:56 PM – A nurse's note by E10 (LPN) documented that R18 remained hospitalized for left hip fracture. 6/5/24 at 3:14 PM - During an interview, E7 (LPN) acknowledged that she assessed R18 after the 2/14/24 fall and completed post fall documentation. b) 4/26/24 at 4:00 AM – A facility incident report by E8 (LPN) documented, "This	with suspected head injury or other obvious injury (goals: 100% of residents with falls not requiring transfer from the facility will have post-fall monitoring completed per protocol. 100% of residents with a suspected head injury OR unwitnessed fall will be sent to ER appropriately) weekly x 4 weeks then monthly x 2 months. Findings will be reviewed by the QAPI Committee. 5) Date of Compliance: 08.14.24	

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	nurse found resident (sic) floor besides bed lying on his right side. Upon assessment BP elevated, no noted injuries. Assisted resident back in bed with caregiver. Neurochecks started." 6/4/24 at 5:38 AM – During interview, E8 (LPN) acknowledged that she assessed R18 after the 4/26/24 fall and completed post fall documentation. The facility failed to ensure that all nursing staff worked within the Delaware Board of Nursing Scope of Practice with respect to RN's performing post fall assessment and documentation. 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office.		
3225.19.0	**Records and Reports**		
3225.19.5 **S/S - E**	**Incident reports, with adequate documentation, shall be completed for each incident.** **This requirement was not met as evidenced by:** Based on interview and review of clinical records and other documentation as indicated, it was determined that for three (R1, R2 and R8) out of seven residents sampled for falls, the facility failed to have adequate documentation and completed the post fall assessments. Findings include: 1. Review of R2's clinical records revealed:	**3225.19.5** Records & Reporting. It is the practice of this community to complete incident reports with adequate documentation for each incident. 1) Resident 1 is unable to be corrected as they no longer reside in the community. Residents 2 and 8 falls, the community is unable to complete incident reports for these events in the past but were reviewed. 2) Residents residing in the community have the potential to be affected. The community will audit current residents in the past 30 days of fall incidents to determine the Resident Protection protocol was followed by facility staff.	8/14/24

Provider's Signature Joshua Hoop Title Interim ED Date 8/19/24

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	4/25/24 – R2 was admitted to the facility with diagnoses including dementia. 5/23/24 7:00 PM – R2's clinical records documented that she had an unwitnessed fall and sustained a head injury. 6/2/24 3:30 PM – R2's clinical records documented that she had an unwitnessed fall, complained of right hip pain, and a possible head injury. R2 was sent to the ER for evaluation. 6/14/24 12:00 PM – A review of R2's clinical records lacked evidence of that post fall assessments were completed at the time of the falls, and the incident reports lacked witness statements from the staff members who were present. Additionally, the facility lacked evidence that the falls were reviewed by the interdisciplinary team and fall prevention interventions were implemented. 2. Review of R8's clinical records revealed: 2/23/24 – R8 was admitted to the facility with diagnoses including dementia and difficulty walking. 6/14/24 1:30 PM – A review of R8's clinical records revealed that she fell a total of 9 (nine) times from 3/6/24 to 6/11/24. The facility lacked evidence that post fall assessments were completed for 7 (seven) out 9 (nine) falls. Additionally, the facility lacked evidence that the falls were reviewed by the interdisciplinary team and fall prevention interventions were implemented. 3. R1's clinical record revealed:	3) A Root Cause Analysis (RCA) indicated a knowledge deficit of facility Post Fall Protocol – DE Specific. Executive Director or designee will in-service licensed professionals on the Post Fall Protocol – DE specific. 4) Executive Director or designee will conduct an audit of 100% of fall occurrences to ensure post-fall protocols have been followed. (goal: 100% of fall occurrences follow post-fall protocols) weekly x 4 weeks, then monthly x 2 months. Findings will be reviewed by the QAPI Committee. 5) Date of Compliance: 08.14.24	

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	The facility lacked evidence of the following seven (7) fall incident reports: - 3/3/24 - 3/5/24 - 3/20/24 - 3/21/24 - 3/23/24 - 3/28/24 - 4/25/24. 6/14/24 at 10:30 AM – During a combined interview with E2 (RSC), E3 (Mobile DON) and E12 (RHWS), finding was confirmed after several requests by the Surveyor during the survey. 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office.		
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division.**		
3225.19.7	**Reportable incidents include:**		
3225.19.7.7	**Significant injuries.**		
3225.19.7.7.2	**Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.**	**3225.19.7.7.2** Records & Reports > Reportable Events Includes > Significant Injuries. It is the practice of this community to report to the state agency any injury from fall that results in transfer to acute care for treatment or evaluation which requires periodic reassessment of clinical status by facility professional staff for up to 48 hours.	8/14/24
S/S - B	**This requirement was not met as evidenced by:**	1) Residents 1, 16, and 17 are unable to be corrected as they no longer reside in the community. Residents 2,5,6, and 18 were	

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	Based on interview and review of clinical records and other documentation as indicated, it was determined that for seven (R1, R2, R5, R6, R16, R17 and R18) out of eleven residents reviewed for incidents, the facility failed to report the fall with significant injury to the Division within the 8-hour requirement. Findings include: 1. Review of R2's clinical records revealed: 4/25/24 – R2 was admitted to the facility with diagnoses including dementia. 5/23/24 7:00 PM - R2's clinical records documented, "...This nurse was notified...at 7 PM that the patient had an unwitnessed fall...patient did have a small laceration to the back of her head. Pressure was applied to the laceration to stop the bleeding. Patient's family was notified, MD notified." 5/24/24 7:45 AM – R2's EMR documented, "Resident sent to the ER for evaluation for the laceration to the back of her head status post fall on 5/23/24." 6/7/24 12:30 PM – A review of the facility's submission of the incident report revealed that R2 fell on 5/23/24 at 7:00 PM and the incident report to the Division incorrectly documented the date and time of the fall as 5/24/24 at 7:00 PM. The report was submitted to the Division on 5/24/24 at 10:53 AM, more than 8 (eight) hours later than the required time of 8 (eight) hours. 2. Review of R5's clinical records revealed: 10/4/23 – R5 was admitted to the facility with diagnoses including dementia.	not reported timely and are unable to be corrected. 2) Residents that meet the definition of Significant injuries in 3225.19.7.7.2 who incurred a fall since survey exit have the potential to be affected. The community will audit current residents with falls in the last 30 days to determine significant injuries and conduct an investigation and report if not already completed. 3) A Root Cause Analysis (RCA) indicated a system breakdown and knowledge deficit where there was no system in place to assure nurses were reporting timely. Executive Director or designee will in-service licensed professionals on the following topics: Resident Protection and Regulation 3225.19.6 and 3225.19.7 (includes reporting time requirements). 4) Executive Director or designee will conduct an audit of falls with significant injuries to ensure reporting to the state agency (goal: reportable falls will be reported timely) weekly x 4 weeks then monthly x 2 months. 5) Date of Compliance: 08.14.24	

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	4/13/24 11:45 – A facility incident report documented, "R5 kissed another resident (R4) on the mouth...". 6/7/24 11:30 AM – A review of the facility's submission of the incident report revealed that it submitted to the Division on 5/15/24 at 10:42 AM, more than 16 (sixteen) hours later than the required time of 8 (eight) hours. 3. Review of R6's clinical records revealed: 10/14/23 – R6 was admitted to the facility with diagnoses including dementia. 5/17/24 7:57 PM – A facility incident report documented, "Building service coordinator manager stated that he saw an aide punched a resident (R6) on the right shoulder." 6/7/24 12:30 PM – A review of the facility's submission of the incident report revealed that the incident occurred on 5/17/24 at 7:57 PM. The incident reported was submitted to the Division on 5/18/24 at 9:40 AM, 5 (five) and one ½ (half) hours later than the required time of 8 (eight) hours. The facility failed to meet the required timeline of 8 (eight) hours for submission of incident reports to the Division. 4. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 3 R16's clinical record revealed: 5/16/24 at 1:15 PM – A nurse's note documented that R16 passed away in the facility.		

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	The facility reported R16's death to the State Agency on 5/21/24 at 10:07 AM, which exceeded the 8-hour reporting requirement. 5. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 4 R17's clinical record revealed: 5/7/24 – A facility incident report, with attached statements, documented that R17 was sent to the hospital emergently on 5/3/24 after a fall and x-ray revealing a left hip fracture. R17's family member was notified of the Xray results on 5/3/24 at 10:49 PM. 5/4/24 at 10:59 AM – The facility reported the 4/27/24 fall to the Division. The facility failed to report within the 8-hour time requirement. It should be also noted that when the facility reported R17's fall, the facility failed to disclose at the time of 5/4/24 reporting date that R17's x-ray results on 5/3/24 revealed a left hip fracture. 6/14/24 at 10:09 AM – Finding was reviewed and confirmed with E2 (RSC), E3 (Divisional Mobile ADNS) and E12 (RHWS). 6. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 5 R18's clinical record revealed: 2/18/24 at 1:42 PM – The facility's incident report by E2 (RSC) documented, "Care aide called this nurse via phone and stated that the resident was found on the floor in another resident's room on 2/14/24 at		

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	around 9pm (sic). Resident was transferred back to his room via wheelchair, because he wouldn't stand. The aide stated that she then notified the nurse that the resident had fell on the shift." 2/19/24 at 1:36 AM – A nurse's note by E24 (LPN) documented, "... NP issued order for patient to go to the ER for further evaluation. [R18's family member] in agreement with POC (plan of care). Upon shift change he was observed to vomit green bile looking liquid with a foul smell. Moaning and flinching upon being repositioned. X-ray results back; there is osteoarthritis to right knee...". 2/19/24 at 4:22 PM – E2 (RSC) reported to the State Agency that R18 was transferred to the ER where the resident was diagnosed with a fractured hip. It should be noted that the facility failed to report accurate information to the State Agency, including the correct incident date/time and incident description (R18 had been exhibiting pain upon repositioning and suddenly would not stand). 7. Cross refer to 16 Del. C., Chapter 11, Subchapter III, (12) Neglect, example 6 R1's clinical record revealed: 7a) 4/28/24 at 2:18 AM – An incident report documented that R1 fell and was sent to the ER. 4/28/24 at 2:21 PM – A nurse's note documented that R1 was readmitted to the facility with a left arm (sic wrist) fracture.		

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	4/28/24 at 6:04 PM – Per facility's documentation, the State Agency was notified of R1's fall and transfer to the ER after the 8-hour requirement. 7b) 5/20/24 at 1:57 AM – R1 had an unwitnessed fall and was transferred to the hospital. R1 was diagnosed with multiple rib fractures. 5/20/24 at 11:25 AM – The facility reported R1's fall to the State Agency, which exceeded the 8-hour reporting requirement. 6/14/24 at 10:30 AM – During a combined interview, findings were reviewed with E2 (RSC), E3 (Mobile DON) and E12 (RHWS). No further information was provided to the Surveyor. 6/14/24 at 2:45 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RSC), E12 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office. **16 Delaware Code, Chapter 11, Subchapter II** **Rights of Residents** **§ 1121 Resident's Rights** **(a) It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the residents in long-term care facilities.** **(b) It is declared to be the public policy of this State that the interests of the resident shall be protected by a declaration of a resident's rights, and by requiring that all**	**16 Delaware Chapter 11, Subchapter II** Resident Rights. It is the practice of this community that each resident shall receive care that meets professional standards of care. 1) Resident 16 is unable to be corrected as they no longer reside in the community. Residents 2 and 3 were evaluated by an licensed nurse for pain on July 11, 2024 and vital signs were obtained on July 21, 2024. 2) Residents residing in the community have the potential to be affected by this practice who are experiencing pain or have a medication with a blood pressure parameter.	8/14/24

Provider's Signature Jaclyn Hall Title Interim ED Date 8/19/24

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S/S- E	**facilities treat their residents in accordance with such rights, which shall include the following:** **(13) Each resident shall receive care that meets professional standards of care.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined for three (R2, R3 and R16) residents out of seven residents sampled, the facility failed to ensure each resident received care per professional standards of care with respect to pain management and monitoring vital signs per physician orders. Findings include: A facility policy titled, "Pain Management," and dated 6/21, documented, "Pain should be evaluated...following a change in condition, or fall." 1. 4/25/24 – R2 was admitted to the facility with diagnosis including dementia. 5/23/24 7:00 PM - R2's clinical records documented, "... This nurse was notified... at 7 PM that the patient had an unwitnessed fall... patient did have a small laceration to the back of her head. Pressure was applied to the laceration to stop the bleeding. Patient's family was notified, MD notified." 5/24/24 7:45 AM – R2's clinical records documented that she was sent to the hospital for evaluation because her head wound continued to bleed. R2's clinical records lacked evidence of pain assessment for 12 (twelve) hours and 45	The community will conduct a onetime audit of current residents to determine if pain is present. The community will conduct an audit for medications with parameters. 3) A Root Cause Analysis (RCA) indicated a knowledge deficit related to pain assessments/evaluations and following physician orders. Executive Director or designee will in-service licensed professionals and medication technicians on the following topics: Pain Management, Medication Administration and Treatment guidelines, and Med Pass (includes parameters), change of condition, and PAIN-AD. The community implemented a new process of daily pain evaluations that is in place. 4) Executive Director or designee will audit 5 random residents for pain management and parameters (goal: pain will be identified and followed up on where present and parameters will be followed with MD notification) weekly x 4 weeks then monthly x 2 months. Findings will be reviewed by the QAPI committee. 5) Date of Compliance: 08.14.24	

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	(forty-five) minutes despite having an obvious head injury and complaints of pain. 5/24/24 4:245 PM – R2's clinical records documented, "...Returned from the ER...stated, "Body hurts, no visible causes..." R2's clinical records lacked evidence that the doctor was informed of her complaint of pain, or whether any type of pain interventions was implemented. 6/10/24 2:30 PM – During a telephone interview E9 (Medical Doctor) stated, "My service was called on 5/23/24 at 7:48 PM about R2's unwitnessed fall and head wound. The report documented that R2 was crying and appeared to be in pain... My service received another call at 9:49 PM with a request for Tylenol for (R2). 6/10/24 3:00 PM – A review of R2's clinical records lacked evidence of an order for Tylenol on 5/23/24. The facility failed to assess and treat R2 for complaint of pain after a fall with an obvious and documented head injury. 2. R3's clinical record revealed: 5/29/24 at 7:00 PM – A nurse's note documented that R3 had an unwitnessed fall where she sustained visible head injuries and stated that "she didn't feel so good." Review of R3's clinical record lacked evidence that R3's pain was evaluated, treated and documented after the 5/29/24 fall.		

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	The facility failed to ensure each residents' pain was evaluated, treated and documented using the appropriate pain scale after a change of condition or a fall per the standards of care. 3. R16's clinical record revealed: 10/20/23 – R16's had an active physician's order to check R16's blood pressure and pulse before administering Metoprolol. Review of the following MARs lacked evidence that R16's blood pressure and pulse were checked and documented per the physician's order prior to the administration of her blood pressure medication, Metoprolol: - March 2024 MAR: 27 out of 31 days; and - April 2024 MAR: 7 out of 7 days. 6/14/24 at 2:24 PM – Findings were reviewed during the exit conference with E1 (ED), E2 (RHWS), E15 (RDO), E16 (VPHW), E17 (VPO) and representatives from the Ombudsman's Office. **16 Delaware Code, Chapter 11, Subchapter III** **Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)** **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:**	**16 Delaware Chapter 11, Subchapter III Immediate Jeopardy POC** Abuse, Neglect, Mistreatment, Exploitation, or Medication Diversion of Patients or residents. It is the practice of this community for residents to be free of abuse, neglect, mistreatment, exploitation, or medication diversion. 1) R2 & R3 were evaluated for head injury with no further findings noted. 2) Residents residing in the community have the potential to be affected by this practice. The community did conduct a review of current residents to identify any potential head injuries and complete a single	6/11/24

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S/S - J	**a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.** **c. Failure to carry out a prescribed treatment plan for a patient or resident.** **This requirement was not met as evidenced by:** Based on interview and review of facility records and other documentation as indicated, it was determined that for six (R1, R2, R3, R16, R17 and R18) out of six residents sampled for neglect, the facility neglected each dependent resident with dementia by failing to provide the goods and services as follows: For R2 and R3, the facility failed to ensure that emergent care and services were provided after each resident had a fall and sustained visible head injuries. The facility failed to ensure residents with suspected head, neck or spinal injury were not moved until emergency personnel arrive and further injury has been ruled out. The facility's failure placed R2 and R3 at potential risk for a serious adverse outcome or death. Due to this failure, an Immediate Jeopardy (IJ) was called at 2:13 PM on 6/11/24. The IJ was abated at 3:30 PM on 6/11/24. For R16, the facility failed to ensure that she was provided wound care and pain management, and failed to coordinate with hospice services to ensure all her needs were met in the facility. As a result of these multiple failures, R16 was harmed.	neurocheck on each resident in the community. 3) Executive Director or designee has in-serviced the following topics: post-fall evaluation, fall prevention, identification of head injuries, notifying executive director or resident services coordinator, change of condition, and skin/Wound. This was completed Monday, June 10, 2024. New hires are educated during orientation. 4) Executive Director or designee will audit incident reports to validate that if a head injury is suspected, EMS was activated and residents were not moved as possible until EMS arrives. This will be conducted daily x 5 days, weekly x 3 weeks, then monthly x 2 months. Findings will be reviewed by the QAPI committee. 5) Date of Compliance: 06.11.24 **16 Delaware Chapter 11, Subchapter III Ongoing POC for Jeopardy after immediacy removal** Abuse, Neglect, Mistreatment, Exploitation, or Medication Diversion of Patients or residents. It is the practice of this community for residents to be free of abuse, neglect, mistreatment, exploitation, or medication diversion. 1) R2 & R3 were evaluated for head injury with no further findings noted. 2) Residents residing in the community have the potential to be affected by this practice. The community did conduct a review of current residents to identify any potential head injuries and complete a single neurocheck on each resident in the community. 3) Executive Director or designee has in-serviced the following topics: post-fall evaluation, fall prevention, identification of head	

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	For R17, who fell on 4/27/24 at 8:35 PM, the facility failed to have her evaluated until 5/3/24 (6 days later) when an x-ray revealed a left hip fracture. R17 sustained harm due to this delay in care. For R18, the facility failed to recognize that the resident required emergent care after a fall and provide pain management. As a result of these failures, R18 was harmed. For R1, the facility failed to investigate the resident's 34 falls, two with significant injuries (fractures), and re-evaluate interventions to determine the effectiveness. In addition, the facility failed to collaborate with hospice on these falls. As a result of these failures, R1 was harmed. Findings include: Cross refer to 16.2 A facility document titled, "Falls Prevention", dated 6/20/21 documented, "...In the event of a fall with suspected head, neck or spinal injury....do not move the patient until emergency personnel arrive, or head/neck or spinal injury has been ruled out." 1. Review of R2's clinical records revealed: 4/25/24 – R2 was admitted to the facility with diagnoses including dementia. R2's medications included aspirin eighty-one milligrams by mouth daily. 4/25/24 - R2's fall care plan documented, "Will receive prompt medical care in the event of a fall". 5/23/24 7:00 PM – R2's EMR documented, "...This nurse was notified...at 7 PM that the patient had an unwitnessed fall...patient did have a small laceration to the back of	injuries, notifying executive director or resident services coordinator, change of condition, and skin/Wound. This was completed Monday, June 10, 2024. New hires are educated during orientation. 4) Executive Director or designee will audit incident reports to validate that if a head injury is suspected, EMS was activated and residents were not moved as possible until EMS arrives. This will be conducted daily x 5 days, weekly x 3 weeks, then monthly x 2 months. Findings will be reviewed by the QAPI committee. 5) Date of Compliance: 08.14.24 **16 Delaware Chapter 11, Subchapter III Related Violations** 1) Identified Residents a. R16 no longer resides in the community and is unable to be corrected b. R17 no longer resides in the community and is unable to be corrected c. R18 continues to reside in the community. A pain evaluation was completed and resident continues to reside in the community. d. R1 no longer resides in the community and is unable to be corrected. 2) Like Residents a. Residents residing in the community have the potential to be affected in the following ways: i. Potential for missed pain management (medication and evaluation) ii. Potential for residents on hospice to have missed	

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	her head. Pressure was applied to the laceration to stop the bleeding. Patient's family was notified, MD notified. No further concerns at this time." 5/23/23 10:27 PM – R2's EMR documented, "...This nurse applied gauze pads to patient's laceration on the back of the head and wrapped with gauze to keep (dressing) in place." 5/24/24 6:58 AM – R2's EMR documented, "...Status post fall on 5/23/24...resident has a small laceration on the back of her head. Wound was cleaned and wrapped with bandage." 5/24/24 7:45 AM – R2's EMR documented, "Resident sent to the ER for evaluation for the laceration to the back of her head status post fall on 5/23/24." 5/24/24 3:32 PM - R2's ER hospital records documented a diagnosis of a closed head injury. 6/7/24 11:20 AM – During a telephone interview E7 (LPN) stated, "I was told by the caretaker that the resident had fallen in her room. I saw some blood on the back of her head, but I did not know how large the laceration was because I did not measure it. I put a dressing on it and called the doctor (E13). The doctor told me to monitor the resident." The surveyor asked E7 if E13 was informed of R2's head injury and bleeding, E7 stated, "I don't remember exactly what I told her (E13)". E7 stated that R2 was then transferred to her bed and a wound dress with a bandage was applied to the wound. The surveyor asked E7 how many times the dressing on R2's head was changed. E7 stated, "I am not sure, but I changed the	medications and assessments iii. Potential for missed wound management/ treatments, consultation with wound care specialist, and RN Assessment of wounds iv. Potential for failed reporting after fall v. Potential for injury if patient moved after potential injury vi. Potential to miss monitoring needs due to shift to shift communication vii. Potential for missing a change in condition and need for emergent care viii. Potential for missed incident report and thorough investigation ix. Potential for missed collaborative services (PT) x. Potential for missed Hospice notification/lack of facility/hospice care collaboration xi. Missed UAI assessments xii. Not using standard pain scale for pain assessment xiii. Lack of post fall monitoring 3) a. A Root Cause Analysis (RCA) indicated a the following root cause(s) : i. Potential for missed pain management (medication and evaluation). RCA: System breakdown due to poor communication, lack of standard pain evaluation process, and lack of follow-up with hospice services). System Change: Executive Director or designee Educated	8/14/24

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	dressing more than once on my shift which ended at 11:30 PM". 6/7/24 11:45 AM – During a telephone interview E8 (LPN) stated, "When I came in to work on the 11-7 shift, I was told that the resident (E2) had fallen on the 3-11 shift and had a laceration on the back of her head. I changed the dressing approximately three (3) times on my shift because the wound won't stop bleeding. I eventually decided to send her to the ER because I thought she might need stitches." 6/10/24 2:30 PM – During a telephone interview E9 (Medical Doctor) stated, "My service was called at 7:48 PM about R2's unwitnessed fall and head wound. The report documented that R2 was crying and appeared to be in pain. An order was given to send her to the urgent care for evaluation. My service received another call at 9:49 PM with a request for Tylenol for R2. 6/10/24 3:00 PM – A review of R2's clinical records lacked evidence of an order for Tylenol on 5/23/24. 6/11/24 4:28 PM – R2's clinical records documented, "Resident has approximately a 2.5 cm scabbed area to the top of the back of her head. Area is well approximated and is in the healing stage (no bleeding with scab firmly intact). No redness/odor/or drainage noted to scabbed area." This is the first documentation of measurements and description in R2's clinical records of the head injury. The facility failed to provide emergent care after R2 fell and sustained an obvious head injury.	staff on pain management. Met with hospice to discuss needs; implemented weekly meetings with hospice to obtain needed visit notes and RN assessments. ii. Potential for residents on hospice to have missed medications and assessments. RCA: Knowledge deficit on pharmacy processes and medication ordering. System Correction: Resident Services Coordinator or licensed nurse designee educated licensed nurses on Medication/Treatment Guidelines iii. Potential for missed wound management/ treatments, consultation with wound care specialist, and RN Assessment of wounds. RCA: System breakdown/ failed to execute physician orders for skin care. System Correction: Resident Services Coordinator or licensed nurse designee educated licensed staff on skin/wound process. iv. Potential for failed reporting after fall. RCA: System breakdown and knowledge deficit where there was no system in place to assure nurses were reporting timely. System Correction: Executive director or designee educated staff on Resident Protection	

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	2. R3's clinical record revealed: 2/22/21 – R3 was admitted with diagnoses that included, but not limited to, dementia and seizure disorder. 11/22/23 – The annual UAI assessment documented that R3 needed: - toileting assistance with hygiene after use, toilets self during the day and assisted at night. - supervision, cueing and coaching for mobility and dressing. The following sections in the UAI lacked evidence of a completion: fall risk assessment, pain management, and list of medications. 3/28/24 – The Service Plan documented that: - R3 was able to transfer and ambulate without assistance and perform toileting tasks independently; and - to observe body language, facial and verbal expressions, for indications of pain; and administer prescribed medication as indicated for pain. The facility lacked evidence of an updated March 2024 UAI at the time R3's 3/28/24 service plan was updated and signed. 5/29/24 at 7:00 PM – A nurse's note by E7 (LPN) documented, "This nurse was notified by caregiver @ (at) 1830 (6:30 PM) that the resident had an unwitnessed S/P (status post) (sic). Patient was laying on the floor by (name) bathroom in hallway. Caregiver stated she heard a noise as if someone fell and that when she saw patient laying on the floor. Upon assessment patient said, 'she didn't feel so good.' Has a bruise	(abuse/neglect that includes incidents & Investigations and reporting). v. Potential for injury if patient moved after potential injury. RCA: knowledge deficit related to post-fall evaluation and suspected head injuries. System Correction: Executive Director or designee educated staff on post-fall evaluation process and head trauma for nurses. vi. Potential to miss monitoring needs due to shift to shift communication. RCA: System breakdown due to poor communication. System Correction: Executive Director designee will in-service licensed staff on documentation, alert charting, and planning and monitoring vii. Potential for missing a change in condition and need for emergent care. RCA: Knowledge deficit related to change in condition process and post-fall evaluation. System Correction: Executive Director or Designee will educate licensed professionals on change in condition process. viii. Potential for missed incident report and thorough investigation. RCA: system breakdown and knowledge deficit where there was no system in place to assure nurses were reporting timely; and knowledge deficit on how to document and follow	

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	to the left eye with some swelling. Also, patient has a hematoma by the temple with bruising. Tylenol given for pain. Vitals stable neuro checks started. MD notified (left message) POA notified (left message)." Review of R3's MAR lacked evidence that Tylenol was administered after R3's fall. 5/29/24 at 7:01 PM – The facility's incident report by E7 (LPN) documented: - "... Describe care and medications, if any, provided to patient following incident and by whom provided: Tylenol given for pain. - Was patient taken to a hospital? No... - Was physician notified? Yes... Date: 5/29/24... Physician Name: [name of E9] ... - Name of Person Notified: [name of R3's family member] ... Date: 5/29/24... Notification Method: Left Message, Requested Call Back... - Person Preparing Report Name and Title (blank), Signature (blank), Date (blank)... - [E1 (ED)] signed and dated 6/1/24. - [E2 (RSC)] signed and dated 6/3/24. - Medical Director Signature and date was blank." Attached Investigative Statements included: - E7's (LPN) statement on 5/30/24: "At approximately 6:15 PM – The caregiver called to tell me [R3] had a fall. When I got to [name of area] resident was on the floor face down (sic). I did my initial assessment while resident on the floor. I moved her extremities to see if anything was broken. I did her vitals, she just said she didn't feel good. The caregiver and I got her up and took her to her room. Resident stated, "I don't feel good, I want to lay down." We laid resident down, no sign of blood, R (right) eye was swollen. Vitals were taken	up on events. System Correction: Executive Director or designee will educate staff on resident protection (abuse/neglect that includes incidents & investigations and reporting). ix. Potential for missed collaborative services (PT). RCA: Failure to execute physician ordered consult. System Correction: Review of consult orders added to the Daily Kickoff Meeting. x. Potential for missed Hospice notification/lack of facility/hospice care collaboration. RCA: System breakdown due to poor communication and lack of follow up with hospice services. System Correction: Executive Director or designee educated staff on documentation, alert charting, and planning and monitoring services. Resident Services coordinator met with hospice team to discuss needs and meeting weekly with hospice and facility nursing. xi. Missed UAI assessments. RCA: System breakdown due to knowledge deficit related to UAI process and failure to execute the UAI process per state guidance. System Correction: Resident Services Coordinator or licensed designee educated RNs on the UAI process	

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	again when we put resident in bed. Vitals were the same. I called the doctor and left a message. The doctor called back approximately an hour later. I informed her the resident had fallen, had a hematoma, discoloration and that I had started neuro checks. At that time the resident was complaining of nausea but no pain. Resident was only saying "she didn't feel good." At last neuro check I thought she may vomit because when I gave her the "crushed" Tylenol she didn't want it and tried to spit it out. For my neuro checks pupillary response was present. I used a flashlight when I checked, her limbs moved freely during range of motion. I should've called the RSC or ED it wasn't on my mind. However, I did the incident report, neuro(checks), notified MD and left message for family. Regarding my statement of "not on my mind" the practice of calling the RSC or ED with all falls just started last week and it slipped my mind to call. I also had a med tech who was not familiar w (with) the residents on [name of another resident area] that was calling me numerous times to ask questions." - E14's (Caregiver) statement on 5/30/24 at 10:45 AM and 2:30 PM: "... At 6PM- [R3] was exiting the dining room and I was cleaning up from dinner. At approximately 615-630 PM I heard a loud noise and a [name of another resident] said 'she fell, she went blank and fell forward'. When I saw her, she was lying face down with her belly to the ground. Her head was outside the bathroom pointing towards the living room and her feet were still in the bathroom. Most of her body was out of the bathroom. I called the nurse [E7] and she came over and assessed [R3], we got her up and put her in bed after the fall. [E7] took	xii. Not using standard pain scale for pain assessment. RCA: knowledge deficit related to pain assessments/evaluation and following physician's orders. System Correction: Executive Director or designee educated staff on pain management, which includes the PAIN-AD and pain monitoring processes. Pain evaluations added to MAR with physician order for daily monitoring. xiii. Lack of post fall monitoring. RCA: A Root Cause Analysis (RCA) indicated a knowledge deficit related to Post Fall Protocol – DE Specific. 4) Monitoring i. Potential for missed pain management (medication and evaluation). Monitoring: Executive Director or designee will audit 5 random residents for pain management and parameters (goal: residents' pain will be identified and followed up on where present and parameters will be followed with MD notification where necessary) weekly x 4 weeks then monthly x 2 months. ii. Potential for residents on hospice to have missed medications and assessments. 1. Monitoring: Resident Services Coordinator (RN) or licensed nurse	

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	her vital signs. [R3] had a lump over her right eye and the discoloration had already started. She told us she was in pain that her head hurt. [R3] kept saying she didn't feel good. [E7] and I both talked about her 'not being herself'. [R3] is usually really talkative and she wasn't. I was checking on her every 30 minutes and she stopped talking a lot and was groaning. The nurse was coming over approximately every 45 minutes to an hour to check on [R3]. [R3] never conveyed anything hurt other than her face right after she initially fell. At around 9PM I saw the nurse go into her room with a med (medication) cup. I did my final checks around 10:45PM, I changed her pull up and was wet. I never saw any vomiting or blood. I informed my relief that [R3] had a fall that evening." The facility's fall investigation lacked written statements from the 11PM to 7AM shift, including E8 (LPN) and the Caregiver. Review of R3's MAR lacked evidence that E7 (LPN) documented the Tylenol that was administered and spit out by R3 during the last neurocheck at 10:00 PM. Review of R3's Neurological Evaluation Flow Sheet after the fall revealed: - At 6:30 PM and 7:00 PM, E7 (LPN) documented "W" (W=weakness) under the section Unusual/New Observations. - From 6:30 PM through 10:00 PM, E7 documented that R3 was lethargic; both left and right eyes had equal pupil size and reacted to light under the section Pupils; R3 had movement in her right upper limb under the section Motor Movement Evaluation. - At 11 PM, E8 (LPN) documented that R3 was lethargic; pupils section was blank; and	designee will audit 5 random residents MARs to identify any missed medications or treatments (goal: 0 missed medications or 100% followed up if missing) weekly x 4 weeks then monthly x 2 months. 2. Monitoring: Resident Services Coordinator (RN) or licensed nurse designee will audit 5 random hospice resident records to ensure hospice RN assessments are completed timely and appropriately as needed (goal: 0 missed/100% timely completed assessments as needed) weekly x 4 weeks then monthly x 2 months. iii. Potential for missed wound management/ treatments, consultation with wound care specialist, and RN Assessment of wounds. 1. Monitoring: Resident Services Coordinator (RN) or licensed nurse designee will audit 5 random residents' TARs to	

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	R3 did not have movement in her right upper limb. 5/30/24 at 12:47 AM – The hospital record documented that R3 had an "unwitnessed fall at 1830 (6:30 PM) right eye trauma, vomiting blood." The physical exam documented "... confused. C-collar placed...Significant right-sided periorbital (around the eye) ecchymosis (bruising)... Pupils equal and reactive... Extraocular eye movement testing is limited by patient's ability to follow commands... Extremities: Patient with tenderness of the... right upper extremity particularly at the shoulder. Holding arm closely to her side... While in the exam room getting settled, the patient did have multiple episodes of coffee ground emesis, and this was confirmed with... testing... Scan did show multiple traumatic injuries... multiple facial fractures...right upper arm fracture...small intracranial bleed....". 5/31/24 – In response to R3's 5/29/24 fall with significant injuries, the facility initiated the following actions: - on 5/31/24, facility nurses were educated on "When to call [E1 (ED) and E2 (RSC)]." - from 5/31/24 through 6/10/24, facility staff were educated regarding the facility's post-fall evaluation, head injury signs and symptoms, neurochecks, and notification of change of condition. - from 5/31/24 to 6/11/24, facility nurses completed a written head injury posttest. - on 6/3/24, a Leadership Call in Log was initiated to ensure notification of any falls and follow-up was completed. - on 6/4/24, facility nurses were educated on completion of the Delaware Interagency Patient Transfer form when sending a resident out emergently to the hospital.	identify any missed wound management or treatments (goal: 0 missed medications or 100% followed up if missing) weekly x 4 weeks then monthly x 2 months. 2. Monitoring Resident Services Coordinator (RN) or licensed nurse designee will audit 5 random resident records to ensure timely RN assessment of wounds and consultation with wound care specialist if necessary (goal: 100% timely RN assessment of wounds and consultation with wound care specialist if necessary) weekly x 4 weeks then monthly x 2 months. iv. Potential for failed reporting after fall. Monitoring: Executive Director/Resident Services Coordinator (RN) or licensed nurse designee will audit current in-house resident records to ensure fall incidents are identified and those meeting the requirement are reported to the Delaware Division of Health	

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	- on 6/6/24, facility implemented an Incident Audit Tool to monitor the facility's incident process and completion. 6/4/24 at 10:15 AM – During an interview, E9 (Physician) stated that she received a call from E7 (LPN) on 5/29/24 between 6:30 PM and 7:00 PM as the on-call service takes over at 7:00 PM. E9 stated that she was told the vital signs were okay and the resident has a small hematoma on her forehead. E9 stated that she told E7 to do neurochecks and to call back with any other changes. E9 confirmed that no further calls were received by the on-call service during 3-11 PM shift. 6/4/24 at 5:38 AM – During an interview, E8 (LPN) stated that she was told during shift report about R3's fall and then went to perform a neurocheck. E8 stated that she found R3 lying in bed with her right eye swollen shut, hematoma to her head, vomited dark red blood, R3 grimaced in pain when right arm was touched; and she wasn't at her baseline (talkative) as her answers were short. E8 called the physician's on-call service and received an order to send her to the ER. E8 also stated that she called E2 (RSC). 6/5/24 at 3:14 PM – During an interview, E7 (LPN) stated that E14 (CG) notified her that R3 had an unwitnessed fall. E7 stated that she evaluated R3 on the floor, including checking vital signs and range of motion. E7 stated that R3 was turned to the right side and had a right hematoma (big lump on the side of her head), eye was swollen, bruising, and R3 said "she didn't feel so good." E7 stated that she and E14 (CG) picked R3 up under the armpits as R3 was weak and they were supporting her as	Care Quality (DHCQ) (goal: 100% resident fall incidents will be reported appropriately and timely to DHCQ) weekly x 4 weeks then monthly x 2 months. v. Potential for injury if patient moved after potential injury. Executive Director or designee will audit incident reports to validate that if a head injury is suspected, EMS was activated and residents were not moved as possible until EMS arrives. (goal: 100% of residents who have unwitnessed fall with suspected head injury are not moved unless they move themselves and EMS was activated) This will be conducted weekly x 4 weeks, then monthly x 2 months vi. Potential to miss monitoring needs due to shift to shift communication. Monitoring: Executive Director or designee will audit the 24-hour report, incident reports (including reportable, investigation and statements), concern/grievances, communication logs, new orders weekly to ensure residents are free of abuse, neglect, mistreatment, exploitation, or medication diversion and monitoring needs are identified (goal: 0 missed instances of abuse, neglect, mistreatment, exploitation, or medication diversion and	

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	they helped walk her back to her bedroom. After R3 was placed back into bed, E7 stated that she checked vital signs, range of motion and R3 had no complaint of pain. E7 stated that she called E9 (Physician) and left a voicemail. E7 stated that E9 called back and E7 reported that R3 had a hematoma, eye swelling, discoloration, neurochecks started and that the resident stated she did not feel good. E7 stated that the physician said okay and did not give any further orders. E7 stated at 7:30 PM, R3 was quiet, and she had to physically open her eye due to the swelling to perform the pupil check. E7 stated at 10:30PM, she attempted to administer Tylenol, crushed in applesauce, to R3, but she spit it out, felt nauseated, but did not throw up. E7 stated that she administered R3's Keppra and Lipitor at 5 PM (dinnertime) crushed in applesauce. E7 stated that she left a message for R3's representative. When asked about how she checked R3's range of motion of her upper extremities, E7 stated that R3 was able to do range of motion of R3's elbows. E7 stated that she did not check range of motion of R3's shoulders. 6/5/24 at 4:04 PM – During an interview, E14 (CG) stated she heard a loud boom and observed R3 face down. E14 asked if R3 was okay and R3 replied "head hurt." E14 stated that the walkie (communication device used by staff) was dead, so she had to run to get the nurse. E14 stated that E7 checked R3's vital signs in a seated position on the floor, observed a lump on forehead (right side) and discoloration happened almost immediately then helped R3 to the bedroom. E14 stated that range of motion was not done on the floor, only in the bed. E14 stated that they picked R3 up under the arms and grabbed her pants and guided	monitoring needs are identified timely) weekly x 4 weeks then monthly x 2 months. vii. Potential for missing a change in condition and need for emergent care. Monitoring: RSC/Nurse will review 24-hour report on houses and progress notes to identify changes in condition and follow-up (goal: All changes in condition and follow-up are reported to MD or appropriate staff for follow-up) weekly x 4 weeks then monthly x 2 months viii. Potential for missed incident report and thorough investigation. Monitoring: Executive Director or designee will conduct an audit of 100% of fall occurrences to identify completed investigations according to the facility Resident Protection Protocol (goal: 100% of audited investigations follow the resident protection protocol) weekly x 4 weeks, then monthly x 2 months. ix. Potential for missed collaborative services (PT). Monitoring: Resident Services Coordinator (RN) or licensed nurse designee will audit 5 random resident records to ensure physician orders for consults are followed as ordered (goal: 100% of consult orders are implemented) weekly x 4 then monthly x 2 months.	

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	her back to her room and laid her on the bed. E14 stated that R3 said she did not feel well and she and E7 talked about it. E14 stated that R3 was still moaning and reported it immediately to the nurse. 6/11/24 at 2:13 PM – An Immediate Jeopardy was called in the presence of E1 (ED), E2 (RSC), E3 (mobile DON), E12 (RHWS) and E18 (State Monitor). The facility's abatement included, but was not limited to: - 6/11/24 at 2:40 PM – Interdisciplinary team meeting regarding the IJ. Physician(s) for R2 and R3 were notified of the findings. - 6/11/24 – E2 (RSC) completed a clinical evaluation of R2 and R3 with no new head injuries noted and physician was notified. - 6/11/24 – Full house audit to identify any residents with potential head injury and single neurological evaluation of each resident performed. - 6/11/24 at 3:30 PM – Medical Director was made aware that residents who have a suspected head injury will be sent out via Emergency Medical Services. 3. The facility's policy and procedure entitled "Wound/Skin Condition", dated 6/2021, stated, "... A wound/skin evaluation is initiated when a resident wound or skin condition is identified during... a resident's stay. The wound/skin evaluation is documented in the Clinical Evaluation..., using the Body Evaluation Tool, and with a nursing entry in the resident's health record. Arden Courts... ensures that no resident would a wound and/or skin condition beyond a stage II or unstageable are approved... and/or retained in the community unless end of life... A weekly progress note	x. Potential for missed Hospice notification/lack of facility/hospice care collaboration. Monitoring: Resident Services Coordinator (RN) or licensed nurse designee will audit hospice visit notes to ensure the frequency of visits and the care needs of the residents are met by the provider as noted in the Hospice plan of care and the facility service plan (goal: 100% hospice residents receive the care and service-frequency of visits by hospice staff as defined in the hospice plan of care) weekly x 4 weeks then monthly x 2 months. xi. Missed UAI assessments. Monitoring: Executive Director or designee will audit 5 random resident records for a completed UAI (goal: 100% up to date with plan for signing if needed) weekly x 4 weeks then monthly x 2 months. xii. Not using standard pain scale for pain assessment. Monitoring: Monitoring: Resident Services Coordinator (RN) or licensed nurse designee will audit current resident MARs to ensure daily monitoring of pain using the PAIN-AD scale is utilized for evaluation (goal: 100% of residents will have pain monitored routinely with follow-up of timely administration of	

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	is documented in the resident's Health Record. Consultation with outside disciplines, i.e.... Wound Care Specialist, and physician, is the responsibility of the RSC... 11. On-going documentation to include all of the above plus progress or lack of progress of the wound, use of specialty devices... 12. Ensure wound and wound care is included in the current service plan... vascular wounds...". R16 clinical record revealed: 3/3/22 – R16 was admitted to the facility with diagnoses that included, but were not limited to, dementia, aFib, morbid obesity, hypertension and congestive heart failure. a) 2/13/24 – E24 (LPN) documented in the physician's binder that R16 had "edema to BLE (bilateral lower extremities), please eval (evaluate)... Continues with Lasix as ordered." E9 (physician) initialed the note and dated 2/14/24 as reviewed. 2/21/24 at 7:48 PM – A nurse's note by E7 (LPN) documented, "It was brought to my attention that patient's legs are swollen and very red. They are blanchable n/s (no signs) of pain or discomfort to patient. Patient is being observed for any further redness, swelling to legs." The facility failed to notify the physician of R16's change of condition. 2/29/24 at 9:50 PM – A nurse's note by E7 (LPN) documented, "Patient complains of pain in legs red and swollen blanchable Tylenol given for pain." The facility failed to notify the physician of R16's change of condition.	physician ordered medications as needed) weekly x 4 weeks then monthly x 2 months. xiii. Lack of post fall monitoring. Resident Services Coordinator (RN) or licensed designee will conduct an audit of falls to identify post-fall monitoring of residents not transferred from the facility, activation of EMS for evaluating residents who sustain an unwitnessed fall or fall with suspected head injury or other obvious injury (goals: 100% of residents with falls not requiring transfer from the facility will have post-fall monitoring completed per protocol. 100% of residents with a suspected head injury OR unwitnessed fall will be sent to ER appropriately) weekly x 4 weeks then monthly x 2 months. Findings will be reviewed by the QAPI Committee. 5) Date of Compliance: 08.14.24	

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	3/5/24 at 8:35 PM – A nurse's note by E7 (LPN) documented, "[R16's family member] notified nurse of red itchy legs. She was informed that the doctor will be in tomorrow to examine and follow up will be given...". The facility failed to notify E9 (physician) of R16's change of condition. 3/6/24 – E10 (LPN) documented in the physician's binder that R16 had "B/L (bilateral) edema both legs, c/o (complained of) pain when touched redness, (zero) warmth." 3/6/24 at 3:05 PM – A nurse's note documented that R16 was seen by E9 (physician) and new order for additional diuretic medication for two weeks. There was no documented physician progress note for the 3/6/24 visit in R16's clinical record for the Surveyor to review. 3/12/24 – E10 (LPN) documented in the physician's binder that R16's "family remains concerned about residents (sic) legs she needs further tx (treatment)." E9 (physician) initialed the note and dated 3/27/24, fifteen days later on her next visit. 3/13/24 at 2:07 PM – A nurse's note documented, "... orders send resident to ER (emergency room) d/t (due to) B/L (bilateral) leg edema and swelling to r/o (rule out) cellulitis...". 3/13/24 – E10 (LPN) documented in the physician's binder that R16 was admitted to the hospital for cellulitis BLE (bilateral lower extremities), and pressure ulcer left heel, boggy.		

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	For approximately three weeks, the facility failed to recognize R16's change of condition that started on 2/21/24 and continued through 3/13/24 when she was sent to the ER for intravenous antibiotic treatment for cellulitis. b) 3/17/24 - R16 was readmitted to the facility with wound treatment to her posterior leg as daily dressing change of oil emulsion, gauze, ABD and kerlix per the hospital discharge. 3/17/24 (Sunday) at 10:06 PM – A nurse's note by E25 (LPN) documented, "... Assessment completed... Treatment to LLE [left lower extremity] completed. Bandages removed. Area has a black necrotic wound to the back of her left leg. Treatment completed per Drs (Doctors) orders. Resident complained of some discomfort during treatment...". The facility lacked evidence of an RSC's assessment of R16's necrotic wound and left heel pressure ulcer upon readmission. Review of the March 2024 TAR (Treatment Administration Record) had R16's wound treatment transcribed as "Cleanse LLE (left lower extremity) c (with) NNS (normal saline solution). Pat dry. ~~Apply oil emulsion~~, gauze + (plus) ABD dsg (type of dressing) daily/PRN (as needed) until healed...". It was unclear as to why "Apply oil emulsion" was crossed out. From 3/18/24 through 3/31/24, R16's wound treatment was not done on five (5) out of fourteen (14) scheduled days. 3/18/24 at 7:00 PM – A nurse's note by E10 (LPN) documented, "... Observed purulent		

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	drainage coming from wound, resident c/o (complained of) minor pin (sic) when cleansed with NSS (normal saline solution). Area is warm to touch, and reddened... Resident removed dressing, and observed picking at it with her fingers. This nurse intervened asking the resident not to pick at it. The area was cleansed a second time with NSS and CDD." 3/19/24 at 1:28 PM – A nurse's note by E10 (LPN) documented, "... continues on ABT (antibiotic) for cellulitis to the left lower leg. Leg is warm to touch, observed purulent drainage. Cleansed with NSS and applied a CDD (clean dry dressing) for protection...". 3/20/24 at 1:17 PM – A nurse's note by E10 (LPN) documented, "... LLE erythematous, visible purulent drainage observed along with slight odor. Minor pain and discomfort, administered Tylenol 650mg @ 1230... Wound cleansed CDI (clean dry intact)." The facility failed to notify E9 (Physician) of E10's observations of R16's wound. 3/20/24 at 2:59 PM – A nurse's note by E10 (LPN) documented, "... Still waiting call from [R16's family member] with information regarding appointment with wound care specialist. No further information has been provided at this time. Will f/u (follow up) with [R16's family member] tomorrow 3/21/24." 3/20/24 at 9:26 PM – A nurse's note by E7 (LPN) documented, "... Clear draining with slight smell noted to wound accompanied by slight pain/discomfort Tylenol given @ (at)1730 (5:30 PM). Dressings changed due to patient picking at dressing...".		

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	The facility failed to notify E9 (Physician) of R16's wound observations. 3/21/24 at 2:50 AM – A nurse's note by E10 (LPN) documented, "During rounds this nurse noticed resident removed the dressing to the LLE. She stated it was itching... Cleansed area with NSS left OTA (open to air)." There was no evidence that oil emulsion treatment was reapplied. The facility failed to notify E9 (Physician) about R16's itching. 3/21/24 at 2:31 PM – A nurse's note by E10 (LPN) documented, "... Awaiting return call regarding wound care appointment." 3/21/24 at 9:35 PM – A nurse's note by E7 (LPN) documented, "... Patient continues to pick at sore on leg...". 3/22/24 at 6:17 AM – A nurse's note by E10 (LPN) documented, "... Dressing to LLE replaced at 0600 (6:00 AM) due to resident removing previous one. Showed signs of pain and discomfort offered Tylenol, resident accepted... LLE... area warm to touch, and erythematous (red)... Still awaiting call from [R16's family member] regarding appointment with wound care specialist." Despite multiple attempts by nursing staff that were waiting for R16's family member to schedule the wound care appointment, the facility's RSC failed to consult with the Wound Care Specialist according to the facility's policy and procedure. 3/22/24 at 2:45 PM – A nurse's note by E2 (RSC) documented, "... continues on ABT (antibiotic)... Resident removed DSG (dressing) soon after applied...".		

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	3/26/24 at 7:00 AM – R16 received the last dose of the antibiotic for the cellulitis. 3/27/24 – A physician progress note by E9 documented, "... hospitalized 3/13/24 through 3/17/24... for cellulitis of the left lower extremity... Patient was evaluated by infectious disease and was on IV antibiotics which was later changed to oral Keflex. Patient also was noted to have a left nonhealing wound for which podiatry was consulted... dressing noted in the left ankle/foot... Plan:... Cellulitis... Patient to continue treatment with Keflex 500 mg 3 times a day for 7 days and was advised outpatient follow-up with podiatry. Unstageable heel wound. Patient advised follow-up with podiatry... Pain. Patient has been on acetaminophen 650mg as needed...". There were no documented nurse's notes from 3/28/24 until 4/5/24 regarding R16's wound or legs. 4/5/24 at 2:11 PM – A nurse's note by E2 (RSC) documented, "... N/O (new order) Keflex 500mg BID (twice a day) x7 days DX Cellulitis LLE. Paint LLE with betadine leave open to air TID (three times a day). Sight (sic) cleanses DSG applied this AM, resident removed DSG and was touching wound...". Review of R16's wound treatment to the left posterior leg were: - from 4/1/24 to 4/4/24, no wound treatment was done. - on 4/5/24 and 4/6/24, nursing staff signed off that they cleansed wound with normal saline solution, pat dry and applied gauze and ABD dressing daily. - despite a new wound treatment order obtained on 4/5/24 to use betadine, the treatment was not started until 4/7/24.		

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	The facility failed to ensure that R16 was monitored and received care and services, including treatment for her left lower extremity wound and re-occurring cellulitis as she was sent to the ER on 4/7/24 for an unrelated reason and received intravenous antibiotic for re-occurring cellulitis and wound care. c) 4/15/24 – During R16's hospitalization, the resident was evaluated and admitted to hospice services. Per hospice records, R16 "... Nursing reports patient moans and complains of pain in her wound during movement and wound care... Plan discussed with [R16's family member]. Hopeful to get patient's pain managed with wound care and discharge back to Arden Courts with hospice services... Left lower extremity cellulitis requiring Santyl and wound care... admitted to General Inpatient level of care... uncontrolled pain; multisystem failure requiring skilled intervention/assessments; system management that requires frequent medication adjustments, and/or skilled nursing assessment and intervention... Medications to be continued: - Eliquis 5mg PO BID; - Cephalexin 500mg PO TID; - Santyl application daily; - Lasix 40mg PO BID; - Metoprolol 12.5mg PO BID (Hold for SBP <120 or HR <60BMP); ... - Senna 2 tabs PO Q AM; - Standard (hospice) Comfort Pack...". 4/19/24 (Friday) at 2:47 PM – A nurse's note by E10 (LPN) documented, "... returned back to facility at 3:15 PM... Reached out to (E9, facility Physician) ... resume all medications as scheduled. Wound to left leg had a dressing in place C/D/I...".		

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	4/19/24 – E10 (LPN) documented in the physician's binder that R16 returned to the facility and was on [name] hospice. E9 (physician) initialed the note and dated 4/24/24. 4/19/24 at 7:59 PM – Per hospice note, H5 (RN) saw R16 and documented, "... short period of hyperventilation... occasional moan or groan... pain score 2... mild pain... none [Morphine] since arrival to facility... Pt reported pain 'not bad,' and 'all over'... Has PRN orders for Ativan... Reviewed current medication regimen, interactions and side effects with... Caregiver... Supervisor call back requested by [E20, facility LPN] to clarify pt hospice status... Advised staff nurse that RNCM (Registered Nurse Case Manager) visits once/week, and aide visits generally M-F (Monday-Friday). Hospice Nurse reviewed the current plan of care and delineation of services with the facility staff during this visit. Yes... Wound care not provided: Covered... Pulse ox and BP low (80% on room air, 88/60). [E20] (facility nurse) made aware. Another Nurse/Med Tech (?) reported little report received, No D/C documents including DNR, stated also that she 'was told that hospice was not going to be following pt at Arden Court.' [E20] requested supervisor callback to clarify... Suggested Morphine be given for pt RR (respiratory rate) 26...". Review of the April 2024 MAR revealed that Morphine was not administered to R16 on 4/19/24 per the suggestion of the hospice RN. It should also be noted that R16's other routine medications, as indicated in the 4/15/24 hospice documentation, were not resumed upon readmission to the facility, including Eliquis, Lasix, Metoprolol with parameters and Senna. A		

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	handwritten notation of "D/C 4/20/24" was documented after each medication on the April 2024 MAR with no indication of who discontinued R16's routine medications. 4/20/24 at 10:14 AM – Per hospice note, H6 (RN) documented, "... no pain... bedbound... ADLs requiring assistance: bathing, dressing, grooming, toileting... What days will the hospice nurse assess wounds and/or provide wound care? Tuesday. What days will the facility nurse provide wound care? Sunday, Monday, Wednesday, Thursday, Friday, Saturday. Does the patient have a hospice aide? Yes. What days will the hospice aide provide ADL care? Tuesday, Wednesday and Friday... Name and credentials of facility staff the hospice nurse reviewed the current plan of care and delineation of services with: Reviewed with facility nurse [E20 (agency LPN)] ...". 4/20/24 at 6:56 PM – A nurse's note by E20 (LPN) documented, "...c/o left leg pain treatment done to left leg (sic) has new order for comfort medication waiting for meds from pharmacy none delivered...". 4/21/24 at 6:53 PM – A nurse's note by E20 (LPN) documented, "... has new order for comfort medication waiting for meds from pharmacy none delivered. Hospice to bring medications...". 4/22/24 (Monday) at 1:33 PM – Per hospice records, H3 (RN) documented, "... Medication Review Complete: Yes... Wound Assessment... bedbound (sic) total assist with ADLs including being fed... incontinent of bowel and bladder... venous ulcer left lower calf not open, necrotic		

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	black eschar. Facility doing betadine soaks to the necrotic area... Facility RN reports they have all scripts for meds they need. Morphine should be arriving to facility today. Discussed plan of care with [R16's family member]. Facility reports no changes in care or medication (sic) no new needs at this time." 4/22/24 at 2:52 PM – A nurse's note by E10 (LPN) documented, "... All meds received from pharmacy, currently awaiting Morphine oral solution to arrive via pharmacy...". The facility failed to ensure that R16 received her prescribed Morphine medication from the hospice pharmacy. 4/23/24 – Per hospice records, there was no visit by a hospice RN to assess R16's wound per R16's plan of care. The facility failed to ensure that R16's wound was assessed by the hospice RN per R16's plan of care. 4/24/24 at 10:31 PM – A nurse's note by E7 (LPN) documented, "This nurse was notified by Caregiver that patient had a S/P (sic) while attempting to use the bathroom on her own while she stepped away... Patient complained of pain to her rib area when repositioning her back into her wheelchair... PRN Tylenol given for pain. MD notified Family notified." The facility failed to ensure that hospice was notified of R16's fall and rib pain. 4/25/24 at 1:47 PM – A nurse's note by E10 (LPN) documented, "... resident experiences minor pain and discomfort at times.		

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	LLE observed and appears necrotic, slight redness surrounding the wound...". 4/29/24 at 10:24 PM – A nurse's note by E7 (LPN) documented, "Patient complaints of burning and discomfort while urinating." The facility failed to ensure that hospice was notified. 4/30/24 at 12:44 PM – Per hospice records, H1 (SW) documented, "... SW mainly spoke to the nurse [E10]. She stated that the pt has stabilized right now. She has not been given any comfort medications. She does have some pain when cleaning her wound but its (sic) minor pain and she reports not wanting morphine...". 4/30/24 – Per hospice records, there was no visit by a hospice RN. The facility failed to ensure that R16's wound was assessed by the hospice RN per R16's plan of care. 5/3/24 at 7:12 AM – A nurse's note by E8 (LPN) documented, "... Wound site warm, red and painful to touch." 5/3/24 at 1:26 PM – Per hospice records, H3 (RN) documented, "... Patient has a venous stasis ulcer to her left posterior calf which she has had for some time. She has been on antibiotics in the past which has helped it be free of infection but then it tends to become infected again. Upon assessment today it does appear to be infected. It is red and hot and painful to touch barely touching it causes the patient to jump. Patient denies pain. Facility state she has been refusing pain medication like		

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	Morphine. When patient was on the inpatient unit, she was receiving Morphine with positive effect... Facility states that they just wanted to discharge her to the hospital. They don't want to try antibiotic because they've (sic) stated they've (sic) tried it in the past and it helps but then the infection comes back, and they don't feel like they are capable to handle the wound infection and her pain. Discussed with [R16's family member] and Team Director and [hospice physician] who approved of the move to inpatient unit for pain control. Patient is on triage list for both units... I updated [R16's family member] and Arden Courts Nurse [E10 (LPN)]. [E10] ... is going to reach out to the facility doctor [E9] to start the patient on a PO (oral) antibiotic so the patient has some relief prior to moving to the unit since she is on triage. Facility does not feel like they can care for the patient. [R16's family member] does not want her [R16] going back to Arden Courts once she goes to the inpatient unit. [Hospice physician] approved of move to IPU (inpatient unit) for pain control...". 5/3/24 at 2:48 PM – A nurse's note by E10 (LPN) documented, "Resident LLE erythematous, warm, and painful to touch. Offered pain medication to resident @0830 (8:30 AM) she politely declined. Responded 'I don't need anything. It's not that bad'. This nurse reached out to... hospice requesting a nurse to come out to further assess resident... hospice assessed resident. [name of hospice physician] agreed to have resident sent out (IPU – inpatient unit) she is currently on a waiting list for the inpatient unit... Reached out to [E9 (facility physician)] to receive a TVO (telephone verbal order) order for a PO (oral) ABT (antibiotic) until she's transferred."		

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	5/3/24 at 3:50 PM – A nurse's note by E10 (LPN) documented, "TVO [E9] N.O. for Keflex 500mg TID x 7 days DX: Cellulitis." 5/4/24 at 7:39 AM – A nurse's note by E8 (LPN) documented, "Tx completed. Wound red and painful to touch. Hospice aware." Review of R16's April 2024 and May 2024 MARs revealed that the resident was never administered any pain medications despite having orders for both Morphine and Tylenol from 4/19/24 readmission through 5/4/24 when she was discharge to hospice's IPU for diagnosis of uncontrolled pain. Review of R16's April 2024 and May 2024 TARs revealed that the resident's wound treatment with betadine three times a day from 4/19/24 through 5/4/24 was not completed for 14 out of 46 scheduled opportunities. The facility failed to ensure that R16 received pain medications for her re-occurring cellulitis and necrotic wound; failed to ensure that the hospice RN assessed R16's wound weekly per the hospice plan of care; and failed to ensure R16's wound treatment was being consistently done. 5/4/24 at 2:50 PM – A nurse's note by E10 (LPN) documented, "This nurse received a call... regarding a p/u (pickup) time for resident who (sic) be transferred to IPU... for pain management d/t (due to) cellulitis of the LLE... scheduled for 1500 (3:00 PM)." 6/14/24 at 10:30 AM – During a combined interview, findings were reviewed with E2 (RSC) and E3 (Mobile DON). No further information was provided to the Surveyor.		

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	6/17/24 at 10:25 AM – During a phone interview, E9 (Physician) stated that hospice would have reviewed and ordered all of R16's medications. 6/17/24 at 12:16 PM – During a phone interview, E20 (agency LPN) stated that R16 was having a lot of pain and yelling out. E20 stated that the Morphine came from the hospice. E20 stated that hospice was non-compliant and R16's family member was offered another hospice provider but declined. The facility failed to: - ensure that R16 was provided with consistent care and treatment for her bilateral leg edema, ongoing cellulitis and her necrotic wound including consultation with a Wound Care Specialist; - ensure that R16 received consistent pain management; and - ensure that R16 received hospice services, including delivery of medications and assessments by the hospice RN, in accordance with her hospice plan of care. As a result of these multiple failures, R16 was harmed. 4. R17's clinical record revealed: 4/18/24 – R17's UAI assessment documented that R17 required: - supervision, cueing and coaching with mobility and bed mobility; - standby assistance during transfers; and - pain management was not applicable. 4/23/24 – R17's Service Plan documented that the resident stated she has no pain, and her physician was listed as P1 (Physician) with phone number listed.		8/7/24

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	4/23/24 – R17 was admitted to the facility for a 40-day respite stay with a diagnosis of dementia. 4/23/24 at 2:44 PM – A nurse's note documented that R17 uses a rolling walker for ambulating and transfers with assistance. 4/27/24 (untimed) – Review of the [name of resident area] Communication Log revealed the following: "[R17] had her walker and lose (sic) her balance and fallen on the floor. [R17] dose (sic) have a skin tear on her left leg. She dose (sic) feel pain on her leg." 4/30/24 – The facility's Physician Binder documented that R17 had a "Cyst to R (right) cheek." 5/1/24 – E9's (Physician) progress note documented, "... Asked by nursing staff to see patient due to wound noted on the right cheek. Patient also with pain in the right lower extremity... Patient seen in wheelchair today... PLAN: ... Right lower extremity wound. Questionably squamous cell cancer... Ambulatory dysfunction. Patient seen in wheelchair today. Patient has been able to walk independently with her walker. Patient with history of right hip replacement. Will follow-up...". It should be noted that E9 evaluated R17's right lower extremity instead of the left lower extremity. 5/2/24 at 3:09 PM – A nurse's note documented, "Resident experiencing pain and discomfort on the left leg. Upon assessment resident c/o (complained of) having pain the left knee, and hip (abrasion observed). Attempted PROM (passive range		

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	of motion) resident yelled out in pain. With the assistance of another staff member, he began to stand her up to pull up her pants, she could barely tolerate standing, she was placed in to a wheelchair where she sat safely. MD notified an x-ray was ordered of the left leg and hip to R/O (rule out) FX (fracture). [R17's family member] notified about findings...". 5/2/24 at 3:18 PM – A nurse's note documented the claim number for an x-ray to left hip and leg. 5/3/24 at 2:40 PM – A nurse's note documented, "Pending x-ray to the left hip and leg... Denies any pain or discomfort to the area. Resident requires a 2 person assist d/t (due to) pain and discomfort to the left leg and hip." 5/3/24 at 5:15 PM – A telephone verbal order was received to send R17 out to the emergency room for further evaluation and treatment. 5/3/24 at 6:28 PM – R17's x-ray results revealed left hip fracture. "The above findings were immediately relayed to the patient's healthcare provider by the Relay STAT call team at the time of dictation." It should be noted that six (6) days past since R17 fell on 4/27/24 with trauma to the left leg until the left leg x-ray occurred. 5/3/24 at 10:49 PM – A nurse's note documented, "Resident x ray resulted DX: L hip FX, MD notified, orders to have resident sent out via 911 to [name of] hospital. [name of R17's family member] contacted by this nurse regarding findings.		

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	It should be noted that at no time from 4/27/24 through 5/3/24 when R17 was sent to the hospital was R17 assessed for pain using an appropriate pain scale nor was it documented in the clinical record. R17 was not ordered any pain medications during this time. 5/4/24 at 10:59 PM – The facility reported R17's fall with injury to the State Agency 23 hours later, outside of the 8-hour reporting requirement. The facility reported, "Resident was standing in front of the nurses station with her walker. The care giver (sic) stated she was just standing there and fell. MD was notified new orders to monitor for pain if pain worsen call MD. Pain did not not (sic) subside MD was notified new order to send to ER." It should be noted that there was no physician's order to monitor for R17's pain as reported to the State Agency on 5/4/24. 5/7/24 – A facility incident report was completed by E3 (Divisional Mobile ADNS). - 4/27/24 at 8:35 PM: the incident occurred in the hallway. - 5/1/24 at 10:00 AM: E9 (Physician) saw R17. - 5/2/24: x-ray was ordered. - 5/3/24: R17 was transferred to the emergency room. - 5/3/24 at 10:49 PM: R17's family member was notified. Attached statements included: 5/7/24 and 5/8/24 – E19 (CG) statement: "On 4/27/24, around 8:35 PM, I was sitting at the nurse's station on [name of area] and [R17] was standing on the other side of the station and she just fell. I got up and went to assist the resident off the floor. I		6/14/24

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	don't remember how she was laying on the floor. I paged the nurse, but she did not come. I assisted the resident off the floor. I notified the nurse x2, at the end of my shift that this resident was complaining of pain. On 4/28/24, I asked [E10 (LPN)] to help me get R17 out of bed (she is a two-person transfer0. I notified [E10] that the resident had fallen the previous day. It was obvious with movement the resident was in pain." 5/7/24 (untimed) – E20 (agency LPN) statement: "Around 10pm [E19 (CG)] told me that the resident that fell was having pain. I knew that [initials of another resident] ... had fallen earlier in the shift, and I went to check on her. I did not know that [R17] had fallen till the next day when one of the nurses at the facility notified me." 5/8/24 (untimed) – E21 (CG) statement: "On 4/27/24, I was walking down [name of area] hallway and there were residents standing outside the nurse's station. I saw [R17] reach for another resident. She fell one way and her walker fell the other way. I don't remember but think she was laying on the floor on her side. I notified [E19]. 5/8/24 at 8:30 AM – E10 (LPN) statement: "On 4/28/24 I asked [E19 (CG)] why [R17] was in a wheelchair. I was informed that the resident had fallen on the previous day. I texted the nurse from the previous day, [E20 (agency LPN)] to asked (sic) her about the fall. [E20] told me that she was aware that another resident had fallen but did not know [R17] had fallen. When I checked [R17], she winched with minimal pain. On 4/29 [E22 (CG)] asked me to assist in transferring [R17] and she again appeared to have pain. When I tried ROM on her left leg, she screamed in pain. On 5/1/24, [E9		

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	(Physician)] saw the resident but no new orders. On 5/2/24, the resident was experiencing pain and discomfort in left leg. When attempted ROM, resident yelled out I (sic) pain. I notified the physician and obtained an order for an X-ray of leg and hip. [R17's family member] notified of findings. 5/3/24 X-ray completed and indicated fracture of left hip. Physician notified and order obtained to transfer resident o (sic) hospital. [R17's family member] notified of fracture and transfer to hospital." 5/8/24 – The facility's 5-day follow-up reported: "Root Cause Analysis: Patient fall due to dementia r/t poor safety awareness. Result of Investigation: ... on 4/27/24 at approximately 0835 (8:35 PM) patient was observed standing on the other side of the caregivers station and fell while reaching for another resident. Witness statements report that patient was laying on her side, but unsure of which side. Patient assisted off floor and nurse was called. On 4/28/24 patient was noted with minimal pain. PCP assessed patient on 5/1/24 with no new orders. 5/2/24 patient experiencing pain and discomfort, PCP notified and order for x-ray of the left hip and leg was placed. Results received on 5/3/24 indicating left hip fracture. Patient was promptly sent to [name of] hospital. [Name of family member] contacted. Eyewitness interview statements reviewed that patient was note in physical contact with residents or staff prior to and during fall....". 6/12/24 at 8:30 AM – During an interview, E19 (CG) stated that she stands by her written statement. E19 stated that she told E20 (LPN) that R17 fell.		

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	6/17/24 at 12:16 PM – During an interview, E20 (agency LPN) stated that she was not aware that R17 fell until another nurse called her. E20 stated that R17 should not have been picked up off the floor until a nurse assessed her. For R17, the facility failed to do the following: - failed to ensure a nurse responded to the resident after the fall; - failed to ensure that facility staff did not move the resident after the fall until a nurse responded; - failed to recognize that R17 required emergent care and treatment at the hospital; - failed to recognize and initiate an appropriate pain scale and document R17's pain level; - failed to notify P1 (R17's physician) and obtain a physician's order for pain management; and - failed to ensure that E9 (facility physician) evaluated R17's correct extremity when in the facility. As a result of all these failures, R17 was harmed. 5. R18's clinical record revealed: 9/14/23 – The signed admission UAI assessment documented that R18 required: - occasional physical assistance for mobility; - one-person physical assistance for bed mobility and transferring; - used a walker for mobility; - fall risk assessment "N/A" (Not applicable); and - pain management (checked) Not applicable.		

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	The facility lacked evidence of a signed Service Plan for R18 in coordination with the 9/14/23 UAI assessment. 9/15/23 – R18 was admitted to the facility with diagnosis of Alzheimer's disease. 2/14/24 at 3:27 PM – A facility incident report by E7 (LPN) documented, "This nurse was notified by caregiver that resident was on the floor. Upon repositioning resident to the bed patient was assessed by the nurse (sic) no sign of injury noted... Patient's vitals were obtained, and patient was repositioned back in bed...". E9 (physician) and R18's family member were notified. 2/16/24 at 7:13 AM – A nurse's note by E24 (LPN) documented, "Resident was observed to be on his knees next to his bed. He would normally stand and pivot for staff, but he declined to do so. He could not bare (sic) weight. Writer performed PROM he did not flinch but could not stand. Call made to NP... and she ordered x-ray of both knees...". 2/16/24 at 1:04 PM – A late entry nurse's note by E10 (LPN) documented, "During this shift this nurse observed resident to be experiencing pain and discomfort to the BLE. He c/o (complained of) pain during repositioning, and even standing. The discomfort he experienced made it difficult for him to eat. He refused both breakfast, and lunch... However, he appeared to show signs of aches and pains... N.O (new order) in place for Tylenol 325mg tab by mouth every 4 hours as needed for pain. Called [R18's family member] LM (left message) to have her call this nurse back."		

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	2/17/24 at 6:53 PM – A nurse's note by E25 (LPN) documented, "... Appetite poor during meals... Resident has c/o pain to BLE/Neck... Resident was given Tylenol for pain to BLE. [Name of x-ray company] has been called several times today with no resolution to why tech has not shown-up (sic) to perform services ordered per DRs orders. Reached out again @ 3:45 to speak to supervisor. Supervisor was suppose to call this nurse back." 2/17/24 at 11:06 PM – A nurse's note by E25 (LPN) documented, "Resident now has a stat order for x-ray to both knees. Spoke with [name of x-ray company] again. Customer service rep stated they will not come out until tomorrow morning. DR. notified." 2/18/24 at 1:42 PM – The facility's incident report by E2 (RSC) documented, "Care aide called this nurse via phone and stated that the resident was found on the floor in another resident's room on 2/14/24 at around 9pm (sic). Resident was transferred back to his room via wheelchair, because he wouldn't stand. The aide stated that she then notified the nurse that the resident had fell (sic) on the shift." 2/18/24 at 3:29 PM – A nurse's note by E10 (LPN) documented, "Resident continues to experience pain and discomfort to BLE... Awaiting [name of x-ray company] to come and complete x ray (sic)." 2/18/24 at 7:50 PM – R18's x-ray results revealed mild osteoarthritis in left and right knees. 2/19/24 at 1:36 AM – A nurse's note by E24 (LPN) documented, "... NP issued order for		

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	patient to go to the ER for further evaluation. [R18's family member] in agreement with POC (plan of care). Upon shift change he was observed to vomit green bile looking liquid with a foul smell. Moaning and flinching upon being repositioned. X-ray results back; there is osteoarthritis to right knee... reported to have poor PO (oral) intake... Writer called hospital and gave report." 2/19/24 at 7:23 AM – A nurse's note by E24 (LPN) documented, "Resident was observed with his torso on the bed, but his right knee was on the floor. Bed was in the lowest position. He normally has good bed mobility, but he could not move. It took 2 staff members to reposition him." It was unclear if this was a late entry nurse's note. 2/21/24 at 2:56 PM – A nurse's note by E10 (LPN) documented, "Resident remains in the hospital DX: left hip fx (fracture), gallbladder." For R18, the facility failed to do the following: - failed to ensure nursing staff reported R18's fall to the next shift for continued monitoring for a change of condition in addition to completing the facility's incident report; - failed to recognize that R18 required emergent care and treatment at the hospital; - failed to recognize and initiate an appropriate pain scale and document R18's pain level; As a result of all these failures, R18 was harmed. 6. R1's clinical record revealed:		

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	2/13/24 – R1's UAI assessment documented the following: - R1 was unable to toilet self or self manage incontinence and requires formal bowel/bladder incontinence program. Handwritten "does know when to go." - R1 required supervision, cueing and coaching. Handwritten "leg freezing; walking w/ (with) rollator ->needs supervision; needs walker brought to him." - R1 required one-person physical assistance for transferring. - R1 required complete assistance for grooming and bathing. Handwritten "1 person phys (physical) assistance." - Also noted that R1 "sundowns 8-8:30 PM... Agitation w/ sundowning...". - Under fall risk assessment, the following conditions may increase the resident's risk of falls: orthostatic hypotension, gait problem, impaired balance, confusion, Parkinsonism, fell in the last 30 days ("handwritten multi falls at least... 1-x (times) 2 daily"), and fell in last 31-180 days. - Under pain management section, R1 was documented as having intermittent pain to bilateral hips and Tylenol medication for pain relief. - Under treatments/therapies currently receiving, Rehab (physical therapy and speech therapy) was circled. 2/15/24 – R1's Service Plan documented the following: - "... Usually sundowns from 8P (PM) to around 11 PM. He wants to 'go home' he will needs (sic) monitoring and redirection... - Provide resident with safe environment... Ensure assistive device... is within reach... - Resident needs... assistance with toileting activities...		

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	- Observe for and report any signs of weakness, dizziness, loss of balance, falls, etc... - History of falls at home, sometimes 1-2 falls per night. We are implementing 15 minute checks, reminders, bringing him in on a trial basis in the event we can't decrease the falls. Interventions included, but were not limited to:... remind [R1] to use his rollator, make sure he is wearing non slip footwear. Monitor that needed assistive devices are within reach and praise the resident for use. Resident is on Safety Checks hourly...". 2/15/24 – R1 was admitted to the facility with dementia and Parkinson's Disease. A negotiated risk agreement was signed by R1's family member and the facility, which included: "Issue(s)/Concern(s): ... 2. Multiple Falls... To keep [R1] from injuring himself when he falls... In the event we are unable to minimize the amount of falls or injuries from falls we would need to end the trial stay and not be able to admit [R1] to the community as a permanent resident... Alternative approaches to minimize risk: ... To remind [R1] to use his rollator, make sure he is wearing appropriate footwear. Get a physical therapy assessment. Agreed-to course of action: ... [R1] will come in as a trial for 30 days... We will request a PT evaluation." Review of R1's clinical record and available incident reports reflected that R1 had the following 34 falls from 2/15/24 through 5/20/24:		

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	(Fall #1) 3/3/24 at 10:15 AM – A nurse's note documented that R1 had an unwitnessed fall and was noted with a "brush burn" to his right side of the head and dislocation of fourth and fifth finger on left hand. Neurochecks were incomplete. There was no incident report/investigation completed. (Fall #2) 3/5/24 at 6:00 PM – A nurse's note documented an unwitnessed fall with no injury. There was no incident report/investigation completed. (Fall #3) 3/20/24 at 11:30 AM – No incident report/investigation or nurse's note documented. Neurochecks were incomplete. 3/21/24 at 11:10 AM – An email between E2 (RSC), E1 (ED) and C1 (OT) documented that they received a "referral for services for PT, OT, ST. We have made multiple calls to [F1's family member] ... she was concerned about out-of-pocket cost... I am not sure if anyone communicates with [R1's family member]. I just wanted to provide you both with an update...". The facility failed to ensure that a PT evaluation was completed based on R1's negotiated risk agreement. (Fall #4) 3/21/24 at 11:30 PM – A nurse's note documented an unwitnessed fall with R1's left foot bleeding as a toenail had come off. There was no incident report/investigation or neurochecks were completed. (Fall #5) 3/23/24 at 11:30 AM – A nurse's note documented and unwitnessed fall		

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	with no injury. There was no incident report/investigation or neurochecks completed. (Fall #6) 3/23/24 at 4:00 PM – No incident report/investigation or nurse's note were completed. Neurochecks were incomplete. (Fall #7) 3/28/24 at 3:30 AM – A nurse's note documented a witnessed fall as R1 hit his head against refrigerator in [name of area] kitchen. There was no incident report/investigation or neurochecks completed. (Fall #8) 3/30/24 at 8:30 AM – No incident report/investigation was completed. Neurochecks increased in frequency. (Fall #9 and #10) 3/30/24 at 3:30 PM – No incident report/investigation was completed. At 1:28 PM, a nurse's note documented that R1 fell twice with no injuries with new orders to check blood pressure every shift for 3 days, bloodwork and urine analysis. (Fall #11) 3/30/24 at 6:41 PM – A nurse's note documented, "pt (patient) seen sitting on the floor by staff assisted by two persons... no Injuries noted (sic) pt noted with change in condition sighs (sic) of pain or discomfort noted...". No incident report/investigation for the unwitnessed fall. 3/30/24 at 8:12 PM – A nurse's note documented that R1 was sent to the ER due to change in mental status. 4/3/24 – Per hospice records, R1 was signed onto hospice services during his hospitalization.		

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	4/4/24 at 11:24 PM – A nurse's note documented that R1 was readmitted to the facility with a bruise to his sacrum and left hand. 4/5/24 – The UAI assessment was updated to reflect that R1 signed onto hospice services as it had a handwritten note of the name of the hospice. However, the UAI was incomplete (missing R1's date of birth, date of admission, assessment type, source of information, mobility assessment, hospice services were checked "No", vision and hearing not assessed, nutrition/hydration/diet missing information, sleep patterns were not completed, fall risk assessment was not completed, pain management was "Not Applicable", medications were not listed nor attached as it was written "See MAR". 4/5/24 – The Service Plan was updated and documented, "... [R1] returned from the hospital last evening after being sent out for change in condition. RSC (E2) completed a new assessment on 4/3/24 and deemed him able to return to the community on the evening of 4/4/24... being followed by... hospice." Review of R1's Service Plan lacked evidence of any other updates to his initial service plan, including falls, pain, etc., other than his code status change. 4/5/24 – Per hospice records obtained by the Surveyor, H1 (SW) documented, "... unable to fully communicate; wheelchair bound; trying to get up but is a fall risk; continues to try to tip his wheelchair." H2 (LPN) documented that safety instructions were provided for falls, transfers bed to chair with maximal assistance, ADLs requiring assistance included: bathing, dressing,		

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	grooming and toileting, and the patient does not have a hospice aide. H2 documented that the current plan of care and delineation of services with the facility staff were reviewed during this visit with E2 (RSC). 4/12/24 – Per hospice records, H3 (RN) documented that R1 was able to stand and pivot from bed to wheelchair and required total assist with ADLs, including feeding. (Fall #12) 4/21/24 at 3:50 PM – The incident report documented an unwitnessed fall with swelling and pain to right elbow. Hospice made aware of fall. However, the facility's neurochecks started at 12:00 Noon on 4/21/24. It was not clear exactly what time R1 fell. In addition, neurochecks were not complete nor was the fall investigated. 4/22/24 – Per hospice records, H3 (RN) documented, "... ambulating around facility with walker. Patient's [R1's family member] reported the patient how (sic) to fall on Saturday (sic) she states she came to... visit... and found him face down on the floor in his room with the door closed so she was unaware of how long he was on the floor. She stated one of the aids (sic)... got him up, emergency services were not called. She just noted a bump on his elbow from the fall... assessment... feels to be more of a bruise...". 4/23/24 – Per hospice records, H1 (SW) documented, "... sitting on the edge of a chair. The staff reports that the pt has been running around the building. He cannot (sic) sit still and will try to get out to walk. He reportedly falls out of everything. Dur-		

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	ing the visit the pt was told to sit down correctly but it took him a while to do it... stated if it get (sic) too much to call hospice and the agitation can be managed...". (Fall #13) 4/23/24 at 4:00 PM – The incident report documented a witnessed fall with no injury. Neurochecks were not complete. In addition, there was no evidence that hospice was notified of the fall nor was the fall investigated by the facility. 4/24/24 – A history and physical by E9 (Facility Physician) documented that R1 was "... re-hospitalized 3/30/24 through 4/4/24 following a fall x 2 with increased blood pressure and altered mental status. Patient was treated for vitamin D deficiency hypomagnesemia hypokalemia. Patient also was noted to have... bursitis of both hips and hematoma in the gluteus muscle...". (Fall #14) 4/25/24 at 5:22 AM – A nurse's note documented an unwitnessed fall with no injury. There was no incident report/investigation completed. Neurochecks were not complete. 4/25/24 – Per hospice records, H3 (RN) documented, "... wife reports facility told her he had (sic) fall this AM without injury... Facility reports no changes in care or medication no new needs at this time...". (Fall #15) 4/26/24 at 12:54 PM – The incident report documented a witnessed fall with no injury. There was no evidence of an investigation or notification to hospice. (Fall #16) 4/27/24 at 1:30 PM – A nurse's note documented a witnessed fall with a		

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	cut to left pinky finger. There was no incident report/investigation of this fall or notification to hospice. (Falls #17 and #18) 4/27/24 at 7:59 PM – The incident report documented that "pt fell twice within an hour... noted bleeding from right pink (sic) finger it had been injured from the previous fall early today... called hospice to get assistance (sic) pt continues with neuro checks...". Neurochecks were incomplete and no evidence of a facility investigation. (Falls #19, #20, #21 and #22) 4/27/24 at 11:30 PM, 4/28/24 at 12:35 AM, 12:57 AM and 2:18 AM – on third fall, R1 complained of pain to right lower extremity. At 1:09 PM, physician was contacted, and order was given to send R1 out to the ER if he has another fall. R1 sent out after fourth fall in the bathroom. There was no evidence that R1's fall were investigated or hospice notification. 4/28/24 at 2:21 PM – A nurse's note documented that R1 was readmitted to the facility with a left arm (sic wrist) fracture. Hospice was notified of R1's return. 4/28/24 at 6:04 PM – Per facility's documentation, the State Agency was notified of R1's fall and transfer to the ER. The facility failed to report R1's fall to the State Agency within the required 8 hours. 4/28/24 – Per hospice records, H4 (RN) documented, "... evaluated effectiveness of pain control measures... no signs of pain during this visit. Patient has Tylenol ordered. Per facility nurse, [F1's family member] is not approving of Morphine for pain at this time. Placed call... to educate on		

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	benefits of having PRN medications on board for pain management in case he was to develop more pain due to his ulnar fracture. Call not answered... Patient requires assistance with repositioning...". (Falls #23 and #24) 4/28/24 at 10:38 PM – A nurse's note documented that R1 "has multiple falls within 30 minutes... fell twice no injuries noted... Hospice nurse here to assess...". There was no incident reports or investigation completed. 4/29/24 at approximately 2:33 PM – Per hospice records, H3 (RN) documented, "... Fractured wrist over the weekend from fall, left lower to upper arm in splint. Facility states Pt had over 4 falls over the weekend. Facility Dr (doctor) started pt on Trazodone 50mg HS (at bedtime) for insomnia last Saturday. Per [name of hospice physician] start Pt on Lorazepam 0.5mg Q6hr prn for anxiety to help if pt agitated to prevent falls...". 5/3/24 – The facility submitted the five-day follow-up to the State Agency for the 4/28/24 fall with fracture. The facility documented that no changes were made to R1's care plan and determined that the root cause of the fall was "dementia related behaviors". It is unclear how this was determined when no investigation was conducted. (Fall #25) 5/4/24 at 7:12 AM – The incident report documented a witnessed fall with no injury. There was no evidence of an investigation. 5/7/24 at 1:10 PM – Per hospice records, a home health aide provided care.		

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	(Fall #26) 5/7/24 at 8:33 PM – The incident report documented that R1 was observed at 6:00 PM in the outside courtyard and observed R1 "lose his balance against the fence and slide to his knee". No injury noted. There was no evidence of an investigation. (Falls #27, #28 and #29) 5/7/24 at 11:40 PM and 5/8/24 at 1:00 AM and 2:52 AM – The incident reports documented witnessed falls while trying to exit seek. On the third fall, R1's right second toe was swollen and bruised. There was no evidence of an investigation. 5/8/24 at 12:13 PM – A nurse's note documented, "ED and this nurse spoke with [R1's family member]. Discussed residents (sic) numerous falls, altered cognition, and poor safety awareness. Explained we do not provide one on one service and we need to change focus from fall prevention to injury prevention. She agreed with the change in focus. We discussed helmets, elbow pads, knee pads, and hipsters. She agreed resident would remove pads and helmets but felt hipsters might work. She is going to contact Hospice and have them provide facility with hipsters." There was no evidence of any follow-up regarding hipsters. 5/8/24 – A progress note by E9 (facility Physician) documented, "... Asked by nursing staff to see patient due to bruising on the right second toe... Questionable secondary to injury from recent fall. No signs or symptoms of infection noted. No open wounds. No tenderness noted (sic) patient able to bear weight... Will cancel x-ray and follow-up...".		

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	5/8/24 at 1:40 PM – Per hospice records, H2 (LPN) documented, "... Received report from facility nurse... multiple falls overnight reported. Facility MD... canceled xrays on toe. No new orders... Extensive education on role of hospice education with facility nurse. Non-pharmacologic interventions and PRN anxiety medication use emphasized... Hospice ATC (around the clock) availability for any changes or concerns emphasized...". 5/8/24 – R1's Service Plan was updated and signed. Under ambulation and transferring section, the following was added: "Ensure assistive device Wheelchair is within reach. Encourage and praise consistent use, remind [R1] he is unable to walk, re-direct, [R1's family member] is reaching out to hospice to order hipsters." However, R1's Fall service plan was not updated as it still stated that R1 uses a rollator. There was no evidence that a UAI assessment was completed prior to updating R1's Service Plan. (Fall #30) 5/9/24 at 6:36 AM – The incident report documented an unwitnessed fall. R1 sustained a laceration to the forehead and complained of a headache. It was noted that after this fall there was no PRN (as needed) Tylenol available. Neurochecks were incomplete. There was no evidence that hospice or a physician was notified after this fall nor was an investigation completed. 5/9/24 at 8:16 AM – Per hospice records, a home health aide provided care. 5/10/24 at 12:29 PM – Per hospice records, H3 (RN) documented, "... ambulates with		

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	walker (sic) total assist with ADLs able to feed self... splint to left wrist from previous fall... [R1's family member] states pt is third on waitlist to move to [name of facility]... Facility reports no changes in care... no new needs at this time." 5/14/24 at 1:30 PM – Per hospice records, a home health aide provided care. 5/14/24 at 12:08 PM – Per hospice records, H1 (SW) documented, "... spoke to the pt, he reported pain in his right hip but he declined medication. SW spoke to staff who were getting ready for lunch about the pt. They reported that he usually does not mention pain but that he falls a lot...". 5/16/24 at 2:15 PM – Per hospice records, a home health aide provided care. (Fall #31) 5/17/24 at 9:23 AM – The incident report documented an unwitnessed fall. R1 had a cut to his forehead. It was unclear about the time of the fall as the incident report did not match the starting time of the neurochecks at 5:15 AM. There was no evidence of an investigation. 5/17/24 at 11:07 AM – Per hospice records, H3 (RN) documented, "... Facility states fall this morning no injury...". While the facility's incident report documented a cut to R1's forehead, this was not communicated to hospice. (Fall #32) 5/18/24 at 7:28 AM – The incident report documented an unwitnessed fall. R1 had an abrasion to left side mid back and complained of back pain. Tylenol was given. Neurochecks were not being performed per the facility's protocol (every 30 minutes x 4; then every hour x 4; then		

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	every 8 hours x 9). There was no evidence that hospice was notified nor an investigation was completed. (Fall #33) 5/19/24 at 12:23 PM – The incident report documented an unwitnessed fall with no injury. Neurochecks were not being performed per the facility's protocol, hospice was not notified or an investigation completed. (Fall #34) 5/20/24 at 1:57 AM – The incident report documented an unwitnessed fall. R1 complained of a headache and requested to go to bed. Ativan given for agitation. Neurochecks were initiated at 1:00 AM and 1:30 AM only. R1's respiratory rate was documented as 21 and 23 respectively. No neurochecks were documented at 2:00 AM and 2:30 AM. At 3:07 AM, R1 complained of pain to his right side and "flinched and grimaced about pain to his right side" when care was attempted. On call physician ordered to send R1 to the hospital. 5/20/24 - Per hospice records, R1 was diagnosed with multiple rib fractures. 6/14/24 at 10:30 AM – During a combined interview, findings were reviewed with E2 (RSC), E3 (Mobile DON) and E12 (RHWS). No further information was provided to the Surveyor. For R1, the facility failed to do the following: - failed to complete an incident report for seven falls; - failed to thoroughly investigate each fall and re-evaluate interventions for effectiveness;		

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	- failed to follow-through on the PT evaluation per the negotiated risk agreement; - failed to collaborate and ensure hospice was notified promptly for each fall. As a result of the continuous multiple facility failures, R1 was harmed.		

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(302) 421-7400

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