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

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

STATE SURVEY REPORT

NAME OF FACILITY: AL- Dover Place

DATE SURVEY COMPLETED: December 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from December 10, 2024, through December 19, 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 fifty-two (52). The survey sample totaled twenty-five (25) residents. Abbreviations/definitions used in this State Report are as follows: ARWD – Assistant Resident Wellness Director ED – Executive Director; DA – Dietary Assistant; DD – Dietary Director; DM – Director of Maintenance; LPN – Licensed Practical Nurse; MC - Memory Care; MRR – Medication Regimen Review; MT – Medication Technician; MCPD – Memory Care Program Director; RN – Registered Nurse; RCD – Resident Care Director; RCM – Resident Care Personnel; RWD – Resident Wellness Director; MG- milligrams – unit of measurement; Buspirone – anti-anxiety medication used to treat anxiety and extreme nervousness; Risperidone – antipsychotic medication, used to treat mental disorders related to psychosis; SA (Service Agreement) – allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living pro-vides. These include lodging, board, housekeeping, personal care, and supervision services;		

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	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 assist-ed living facility shall be re-quired to use the UAI to evaluate each resident on both initial and ongoing basis in accordance with these regulations.		
S/S E			
3225.0	**Assisted Living Facilities**		
3225.8.0	**Medication Management**		
3225.8.1	**An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:**		
3225. 8.1.5.3	**Review of each resident's medication regimen with written reports noting any identified irregularities or areas of concern.** Based on record review and interview it was determined that for three (R2, R9 and R10) out of five residents reviewed for medication management, the facility failed to complete written reports noting identified areas of concern identified on the resident's medication regimen reviews. Findings include: The facility policy on medication management last updated 2018 indicated, that the [pharmacy] recommendations regarding a particular resident are also maintained in the resident's file. 1.Review of R2's clinical record revealed: 2/5/24 – An MRR (Medication Regimen Review) in R2's clinical record documented recommendations made to nursing and the prescriber.	3225.8.1.5.3 – Medication Management A) R2, R9, and R10 were not negatively impacted by this deficient practice. A Pharmacy consult was completed on 12/29/24 and any irregularities were identified and followed up on. B) All residents have the potential to be affected by this deficient practice. No others were identified. C) RCA reveals that the pharmacy consult was completed per regulation; however, the MRR response by the provider could not be located in our archived records. RWD completed an in-service on 1/9/25 on Medication Management policy with nursing staff. (Exhibit 1) All MRR recommendations will be retained in the paper chart and not thinned or archived.	2/17/2025

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3225.8.3.5	5/3/24 - An MRR in R2's clinical record documented recommendations made to nursing and the prescriber. 12/16/24 11:47 AM - During an interview E2 (RWD) confirmed that the facility was unable to provide evidence of the written reports for the recommendations made in R2's 2/5/24 and 5/3/24 MRR. 2. 2/5/24 – An MRR in R10's clinical record documented recommendations made to nursing and the prescriber. 12/11/24 3:12 PM – The surveyor requested the written reports from pharmacy that detailed the recommendations made. 12/16/24 11:47 AM - During an interview E2 (RWD) confirmed that the facility was unable to provide evidence of the written reports for the recommendations made in R10's 2/5/24 MRR. 3. Review of R9's clinical records revealed: 5/3/24 – The facility's former contracted pharmacy (C1) completed a MRR for R9 which indicated an identified irregularities or recommendation for nursing staff. 12/16/24 11:00 PM – A review of the facility's May 2024 Consultant Pharmacist Report lacked evidence that C1's pharmacy recommendation on 5/3/24 for nursing staff was documented. 12/16/24 11:47 AM – In an interview, E2 confirmed that there was no recommendation report from the pharmacist [C1] on the May 2024 Consultant Pharmacist Report. 12/19/24 2:53 PM – Findings were reviewed with E1 and E2 during the Exit Conference.	D) Pharmacy will conduct quarterly consult as scheduled. RWD will review and retain the MRR in the paper chart after the MD/NP responds to any recommendations. QAPI meetings monthly to ensure any recommendations are signed by provider and changes from provider put in place.	

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3225.8.3 3225.8.3.1	**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.** **Medication stored by the assisted living facility shall be stored and controlled as follows:** **Medication shall be stored in a locked container, cabinet, or area that is only accessible to authorized personnel;** Based on observation and interview it was determined that the facility failed to ensure medications stored were only accessible to authorized personnel and that medications were disposed of in accordance with facility policy. Findings include: The facility policy on medication management last updated 2018 indicated, "All medications are required to be kept in a locked area. Only community certified staff authorized to administer medications has access to locked medications. Medications must be properly disposed. Medications may be disposed of in a drug buster container. Disposal of medication may be documented on a Medication Destruction Form." 9/13/24 – The pharmacy review to demonstrate that storage of medications meets regulation and facility standards documented the pharmacist documented, "pulled a few medications with expired prescription labels from all carts." The review did not document inspection of medication storage closets. 12/10/24 9:19 AM – 10:30 AM – Three medication carts were inspected for compliance with medication storage. E8 (LPN) reported that excess medications and medications for disposal were held in the medication carts until disposal	3225.8.3.1 – Medication Management A) No residents were negatively affected by this alleged deficient practice. Medication is locked in the carts and is only accessible to authorized personnel. All expired or discontinued medications are disposed of in a drug buster. B) All residents may be negatively affected by this practice. Surveyor audited all medication carts and supply closets. No expired or discontinued medication was identified. C) RCA revealed that medication may have been in a storage closet at some unknown historical date and time. RWD provided an in-service to Nursing staff on medication storage and disposal on 1/9/25. (Exhibit 1) D) RWD or designee will audit medication carts weekly x3 and then monthly x2 to ensure continued compliance at 100%. Audits to be reviewed at QA for compliance. (Audit A)	2/17/2025

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	and that the facility had no medication storage room. 12/12/24 1:40 PM – During an interview E7 (LPN) was asked if medications of deceased residents were ever donated, E7 replied, "We had permission from the ED before, under a different corporate and pharmacy." E7 stated the facility made "two" donations "To the clinic, MD1 (Mission Doctor) took them". When asked if there was any documentation regarding the donations E7 stated, "there was at the time, but I don't know where it is now. The pharmacy now does their own donations. This was before [E1 (ED) and possibly before [E2 (RWD)]. E7 denied donating medications to the homeless and stated that she gave the medications directly to MD1 for the clinic. 12/12/24 2:15 PM – 2:45 PM – E1 (ED) and the surveyor toured the facility and observed all supply storage areas made known to the survey team. 12/12/24 2:50 PM – During an interview E7 (LPN) was shown a photograph of storage closet with medications and confirmed that it was a storage closet inside E3's office who was not scheduled to work that day. E7 denied placing medications in the storage closet and stated she did not have a key to that closet. 12/12/24 2:52 PM – E1 accompanied the surveyor to attempt to open the storage closet in E3's office and E1 was unable to open the door. E1 stated that he would consult with maintenance or call a lock smith. E5 (Maintenance Director) immediately confirmed the maintenance department did not have a key to the storage area in E3's office.		

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	12/12/24 5:35 PM – E1 stated he received a key from E6 (Maintenance Technician) who first had to travel home to retrieve the key then return to the facility. E1 then accompanied the surveyor to the storage closet located in E3's office. The closet contained white shelves, with labels of various medication supplies. There were medication supplies such as oxygen tubing, oxygen mask and thermometer probe covers inside the closet. There were no medications in the closet. E1 confirmed the storage closet identical to the closet pictured. 12/16/24 12:31 PM - During an interview E3 confirmed observation of medications in the storage closet in her office but was unaware of their origin or when they were discarded. E3 stated, "I had seen some medications, but I don't know where they came from or when they were removed". When asked if there were medication destruction forms for R20's medications, E3 stated, "We don't record disposals of medications". 12/17/24 2:52 PM – In an interview, E1 confirmed that only E3 had a key to the storage closet in her office because "A gift card was stolen from E3 so she needed a space. E2 (RWD) then reported the storage closet in E3's office was for both personal storage and facility storage." 12/19/24 2:53 PM – Findings were reviewed with E1 and E2 during the exit conference.		
3225.8.4	**Residents who self-administer medication shall be provided with a lockable container or cabinet. This requirement does not apply to medications which are kept in the immediate control of the individual resident, such as in a pocket or in a purse. Facility policies must require that**	3225.8.4 – Medication Management	2/17/2025

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	medications be secured in a locked container or in a locked room. Based on observation, and interview it was determined that for one (R3) out of one resident reviewed for self-medication administration, the facility failed to provide a resident who self-administered medications, with a locked container. The facility policy on medication management last updated 2018 indicated, "Residents that self-administer medications are also required to keep their medications in a locked and secured area accessible only by them. Review of R3's clinical record revealed: 11/4/24 – The UAI assessment completed for R3 documented the resident was oriented to person, place, time and memory adequate and independent for medication management. 11/4/24 – A resident self-administration assessment documented that R3 was safe to self-administer medications. 11/6/24 - The Resident Handbook included in R3's resident agreement indicated that residents would be provided with a lockable storage cabinet in your apartment for storage of medications and personal items. 11/6/24 – R3 moved into the facility. 12/11//24 1:30 PM – During an interview in R3's apartment the resident reported that there was no lockable container or cabinet for medication storage. R3 stated, "I keep my medicine in my pouch, or on the counter." R3 then pointed to the empty pharmacy bag with a label for R3's prescription cholesterol medication.	A) R3 was not negatively impacted by this alleged deficiency and self-administers medication safely. B) All residents that self-administer medication may be negatively affected by this alleged deficient practice. No others were identified. C) RCA reveals R3 keeps her 2 medications in her pouch in her walker. A lock box was provided for use if desired and R3 keeps her door locked. The regulation requires that "medications be secured in a locked container OR in a locked room." The pharmacy bag on the counter was "empty" as indicated by surveyor. There was not any unsecure medication in the resident room. Resident reported to RWD the bag on the counter was waiting for her daughter to refill the medication. D) Quarterly assessments are completed by the RWD or designee on residents that self-administer medication to ensure safety and regulatory compliance and will be reviewed during monthly QAPI to include ensuring medications are properly secured.	

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S/S D 3225. 11.0 3225.11.4	12/11/24 1:46 PM - During an interview E2 (RWD) accompanied the surveyor to R3's apartment and confirmed that R3 did not have a lockable cabinet or container for medications. R3 reported usually keeping medication in "her pouch and on the counter" and that she was unable to find the cholesterol medication that was usually on the counter. E2 stated she would follow up with R3's daughter to see if the medication needed to refill with the pharmacy. 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2. **Resident Assessment** **The resident assessment shall be completed in conjunction with the resident.** Based on record review and interview it was determined that for one (R11) out of five residents reviewed for resident assessment the facility failed to ensure that the UAI assessment was completed in conjunction with the resident. Findings include: Review of R11's clinical record revealed: 5/17/23 - A Mini Mental State Exam scored R11 as a "23"; 23 or lower is indicative of cognitive impairment. January 2024 – April 2024 – Review of progress notes in R11's clinical record documented the resident yelling, throwing items, and becoming agitated at another resident. 3/22/24 – R11 was involved in a resident-to-resident altercation when R11 pushed R14 to the floor causing a fall.	3225.11.4 – Resident Assessment A) R11 was not affected by this alleged deficient practice. The UAI/assessment was completed on 5/4/24 with the resident in attendance and was signed by the POA. B) All residents have the potential to be affected by this alleged deficient practice. No others were identified. C) RCA reveals assessments are conducted with the resident and/or responsible party in attendance. D) ED will monitor RWD and ARWD to ensure that the resident and/or responsible party is present for assessments weekly x3 then monthly x2. ED reviewed this regulation with RWD and ARWD to ensure continued compliance at 100%.	2/17/2025

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3225.11.5	5/4/24 – A UAI assessment completed by E2 (RWD) for R11 documented in section four psychological/social cognition information a "No" in response to history of danger to others, and 'no' to disruptive, assaultive, demanding behaviors. 12/17/24 11:21 AM – During an interview, E2 confirmed that R11's UAI assessment completed on 5/4/24 did not document R11 as a danger to others or R11's history of behaviors that resulted in resident-to-resident incidents. E2 stated, "No" I don't believe [R11] is a danger, I expect some aggression and some paranoia." 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2. **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 record review, it was determined that for one (R18) out of five sampled residents reviewed, the facility failed to ensure that a UAI was updated when a resident had a significant change in condition. Findings include: Review of R18's clinical records revealed the following: 4/19/23 – Prior to admission, the initial UAI documented that R18 had Alzheimer's dementia with major depression, dizziness/vertigo, independent with mobility using a rollator and transfers self. R18 denied pain "0", oriented to person, place and with no history of disruptive, socially inappropriate, assaultive, and demanding behaviors. R18 did not refuse or resist care.	3225.11.5 – Resident Assessment A) Unable to correct the deficiency as R18 no longer resides in the community. B) All residents have the potential to be affected by this deficient practice. No other residents have a significant change of condition as defined by regulation. C) RCA reveals that RWD did not complete a change of condition UAI secondary to ascertaining that the resident did not have a change in needs for assistance with eating, dressing, bathing, or ambulation. ED educated the RWD/ARWD on change of condition to include a change in behaviors or need for pain management. D) Resident condition changes will continue to be reviewed in stand up meeting daily and discussed with the team to determine if any resident requires a change in condition update to their UAI/Service agreement which will be completed promptly if	2/17/2025

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	4/30/23 – R18 was admitted to the facility with diagnoses including dementia. 5/19/23 – R18's 30 – day UAI documented "No Change". 12/6/23 – A physician progress note documented that R18 was seen for right knee pain "in front and back"... "She [R18] has obvious deformities to b/l (bilateral) knees right worse than left..." 1/4/24 – An orthopedic consult note documented that [R18] reported having pain in posterior aspect of the knee for a couple of months and occurring constantly...aching and discomforting pain...also experiencing limping, pain after activity, weakness and presented WBAT (weight bearing as tolerated). There was a lack of evidence that the facility identified that R18 had a significant change with mobility and pain management after admission and they subsequently failed to complete a significant change UAI. This failure resulted in R18's Service Agreement not being revised. 1/5/24 – R18 was seen by a psychologist. 1/17/24 - A physician progress note documented, "...it appears that patient [R18] and her roommate (unidentified resident in the next room)...became very friendly and connected to others difficult (sic) for them to separate per staff...given her [R18] advanced dementia (sic) , does breakdown and does have a (sic) increased amount of agitation...May require Memory Care Unit...Will refer to (Memory Care Center)." 1/18/24 2:20 PM – A nurse progress note documented, "Clinicals/referral faxed to (facility) requesting in – patient care for [R18] needing medication adjustment..."	indicated and reviewed during monthly QAPI to ensure continued compliance.	

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	2/28/24 – A facility Wellness Visit note documented "[R18] refuses showers, resistant when staff attempts sink bath. Change in condition: Yes..." There was a lack of evidence that the facility identified that R18 had a significant change with behavior and medication management after admission and they subsequently failed to complete a significant change UAI. 12/17/24 10:58 AM – During an interview, E3 (RCD) stated that with R18's increasing knee pain and progressing dementia and behavior outburst, a significant change UAI should have been done. E3 further stated, "I am not sure if it was actually completed. E2 (RWD) may know." 12/17/24 11:37 AM – In an interview, E2 (RWD) confirmed that she did not complete a significant change UAI for R18. 12/19/24 2:53 PM – Findings were reviewed with E1 (ED) and E2 (RWD) during the Exit Conference.		
S/S D **3225.13.0** **3225.13.1**	**Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement. This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for two (R16 and R18) out of five	3225.13.1 - Service Agreements A) Unable to correct this deficiency as R16 and R18 no longer reside in the community. B) All residents have the potential to be affected by this deficient practice. No others were identified. All resi-	2/17/2025

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	sampled residents reviewed, the facility failed to ensure that a signed copy of the Service Agreement was received by R16 and R18's POA (Power of Attorney). Findings include: 1.Review of R16's clinical records revealed: 6/27/24 – Prior to admission, a facility Service Agreement Form documented, "...This Care Service Agreement was approved on 6/27/24... Resident or designee: 'reviewed over phone POA' (initials for FM2)." 7/11/24 – R16 was admitted to the facility with diagnoses including dementia. 12/16/24 11:50 AM – In an Interview, E2 (RWD) stated that she went over the details of R16's Service Agreement with FM2 over the phone since he was out of state at that time on 6/27/24. 12/19/24 10:56 AM – During a telephone interview, FM2 (POA) stated that he was out of state at that time when the Service Agreement was completed. FM2 further stated that he went to the facility sometime on the 2nd week of July to sign more admission paperwork with E1 (ED). FM2 confirmed that he did not receive a signed copy of the Service Agreement completed on 6/27/24. 2.Review of R18's clinical records revealed: 4/19/23 – An initial Assessment and Negotiated Service Plan Summary documented, "Mobility/transfer/escort – rollator, fell in bathroom no injuries..." a. 1/11/24 – A facility incident report documented that R18 had an unwitnessed fall. 1/15/24 -A facility incident report documented that R18 had an unwitnessed fall.	dents have a signed service agreement and a copy was provided to the POA. C) RCA reveals that R18 was discharged from the community prior to the POA meeting with the RWD for a copy of the service agreement as the POA was out of state. R16 was provided with a signed copy; POA just does not recall. The service agreement form will be updated to include an area for resident/POA to initial indicating a copy was received. D) Service agreements will be audited to ensure that all responsible party signatures indicate a copy was received at review. This will be done weekly x3 and monthly x2 and reviewed in QAPI to ensure continued compliance. (Audit B)	

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	1/17/24 - Handwritten notes on the original 4/19/23 Assessment and Negotiated Service Plan Summary had the following scribbled: high fall risk, fall precautions, frequent rounding, non-skid shoes, walker – in place, Q (every) 1 hr (hour) checks, PT (Physical Therapy), refuses assist from RCP at times. 12/17/24 1:44 PM – During an interview, E2 (RWD) stated that she wrote the hand written notes on the 4/19/23 service agreement form to update resident care need status and interventions to address R18's issues on falls. E2 further confirmed that she did not complete and update a new Assessment and Negotiated Service Plan Summary form. b. 1/17/24 2:11 PM – A nurse progress note documented, "Care plan meeting with daughter [FM1], E1 (ED), E3/E2 (RCD/RWD) and E18 (NP)...[R18] has dementia that is progressing with increased anxiety, agitation and behaviors noted. [R18] is also a high risk for injury related to falls. Discussed options for safety and overall quality of life to include family providing 1:1 private care, transfer to secure memory unit or possible in-patient treatment for medication management..." 12/17/24 1:44 PM – During an interview, E2 (RWD) stated that she wrote the handwritten notes on the 4/19/23 service agreement form to update resident care need status and interventions to address R18's issues on increasing behavior. E2 further confirmed that she did not complete and update a new Assessment and Negotiated Service Plan Summary form. 12/19/24 11:54 AM – In a telephone interview, FM1 (POA) stated that R18 had increasing issues with her knees, had falls and worsening demen-		

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3225.13.6	tia. FM1 further confirmed that she did not receive a signed copy of the Assessment and Negotiated Service Plan Summary form while R18 was a resident at the facility. **The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated. This requirement was not met as evidenced by:** Based on record review, interview and review of the facility policies and procedures, it was determined that for three (R11, R9 and R19) out of five sampled residents, the facility failed to complete and revise the service agreements when the needs of the residents changed. Findings include: The facility policy on resident service plans last updated 2018, indicated, "The resident service plan is based on the resident assessment form information." The facility policy on resident evaluation and assessment last updated 2018 indicated, "Use the resident assessment form as the basis for the resident service plan. 1.Review of R11's clinical record revealed; 1/4/23 - A service agreement was completed for R11. 5/4/23 - A UAI assessment was completed for R11. 12/17/24 - 10:58 AM – During an interview E3 (RCD) confirmed the UAI assessment and service agreement should be completed at the same	3225.13.6 – Service Agreement A) Unable to correct the deficiency for R19 as he does not reside in the community. Not able to complete a service agreement for R9 or R11 retroactively. B) All resident have the potential to be affected by this deficient practice. No corrective action required as all service agreements are current. All residents now have a current service agreement on file. C) RCA reveals that the service agreement for the identified deficiency for R11, R9, and R19 could not be located in the archived records. ED educated RWD and ARWD on need to update service agreement for any identified significant change of condition per regulation. Service agreement audit was completed by RWD and ARWD. D) A sample of 10 service agreements will be audited to determine if revision is needed by RWD or designee weekly times 3 and then	2/17/2025

Provider's Signature DocuSigned by: Kyle Whelan 60B43C60FBC1427... Title Executive Director Date 1/23/25

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	time and that the facility does not have a UAI assessment that corresponds with the 1/4/23 service agreement that was completed for R11. 12/17/24 11:34 AM – E2 (RWD) confirmed that the UAI assessment and service agreement should both be done "around the same time". 2. Review of R9's clinical records revealed: 7/19/23 – Prior to admission, the initial UAI documented that R9 had dementia, was independent with mobility and transfers self. There was lack of evidence that the facility completed R9's initial Service Agreement. 8/18/23 – R9 was admitted to the facility. 8/19/23 - R9's 30-day UAI documented "No Change". 12/6/23 1:30 PM – A facility incident report submitted to the State agency documented that R9 grabbed the arm of another resident [R19], and he began to punch the hand of R19. R9 was redirected away from R19. Changes made to the care plan included encourage activities and decrease stimulation. There was lack of evidence that the facility completed R9's Service Agreement to include the interventions for staff to encourage activities and decrease stimulation to address R9's aggressive behavior. 12/27/23 – A nurse progress note documented, "Care plan meeting with family... [R9] continues to void and defecate in public areas. Staff to redirect, frequent toileting in place, use distraction techniques, and encourage activities..." There was lack of evidence that the facility completed R9's Service Agreement to include the new interventions for staff to re-direct, frequent	monthly times 2 until 100% compliance is achieved. (Audit B) Results will be reviewed at QA monthly.	

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	toileting in place, use distraction techniques, and encourage activities to address R9's behavior of voiding and defecating in public areas. 4/10/24 – The annual UAI documented that R9 was independent with mobility and transfers self with behaviors of urinating and defecating in public places. There was lack of evidence that the facility completed R9's Service Agreement to evaluate the interventions for staff to re-direct, frequent toileting in place, use distraction techniques, and encourage activities to address R9's behavior of voiding and defecating in public areas. 12/17/24 2:52 PM – In an interview, E2 (RWD) confirmed and stated that R9's service agreements in congruent with the UAI review periods could not be found in R9's records. In addition, E2 confirmed that the latest service agreement for R9 was only completed on 7/22/24. 3. Review of R19's closed clinical records revealed: 1/13/22 – R19 was admitted to the facility with diagnoses including dementia, restlessness and agitation. 6/1/22 – A facility Behavior Strategy Plan for R19 documented a behavioral concern, "Aggressive behavior – cursing, physical aggression to staff and other residents...Potential Stimulus Triggering Behavior: Dementia, Cognitive loss...Potential Strategy to Control Stimuli: Remain calm when speaking to the resident, assist to a quiet area, do not confront or accuse the resident of wrong doing, do not argue, give resident personal space, give time for resident to calm down, distraction techniques...Goals: Staff will provide an		

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S/S E	effective approach to help minimize negative resident behaviors." 2/17/23 – R19's Assessment and Negotiated Service Plan Summary (Service Agreement) documented that R19 was a resident in the Memory Care (MC) unit, used a manual wheelchair and self-propelled on short distances. R19 participated in exercise program and social activities. 5/27/23 – An Annual UAI documented that R19 had Alzheimer's dementia, anxiety disorders, major depression with agitation at times and required frequent redirection. R19 had a history of disruptive, assaultive physical aggression and was resistant to ADL care and refused medication. There was lack of evidence that the facility revised R19's Service Agreement to address R19's aggressive behavior. 6/22/23 – A Significant Change UAI documented that R19 had a history of disruptive, socially inappropriate, assaultive and demanding behaviors and continued to refuse care by staff. There was lack of evidence that the facility revised R19's Service Agreement to address R19's physically aggressive behavior. 1/10/24 1:15 PM – A facility incident report submitted to the State Agency documented that R19 swung his arm and made contact with the other resident [R9]. No injuries noted. Care plan changes included monitor behaviors and encourage activities. There was lack of evidence that the facility revised R19's Service Agreement to include the interventions of monitoring behaviors and encouraging activities.		

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3225.14.0 **3225.14.1**	12/17/24 2:52 PM – In an interview, E2 (RWD) confirmed and stated that R19's service agreements in congruent with the UAI review periods could not be found in R19's records. 12/19/24 2:53 PM – Findings were reviewed with E1 (ED) and E2 (RWD) during the Exit Conference. **Resident Rights** **Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein.** **§ 1121. Resident's rights. (b) It is the public policy of this State that the interests of the resident must be protected by a declaration of a resident's rights, and by requiring that all facilities treat their residents in accordance with such rights, which must include the following: (1) Each resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement was not met as evidenced by:** Based on observation and interview, it was determined that food service employees utilized gloves while in the dining room violating resident's dignity in their home environment. Findings include: 12/10/24 11:27 AM through 11:35 AM - During a dining observation in the facility's main dining room, E14 (DA) and E17 (DA) were observed	3225.14.1 – Resident Rights A) No residents in the dining room were negatively affected by this deficient practice. Not able to correct this deficiency as it is historical. B) All residents have the potential to be affected by this deficient practice. None were identified. C) RCA reveals that the DD followed food code that permits wearing of gloves in the dining room since food items were directly being handled. DD educated dietary staff to not wear gloves in the dining room. D) Weekly audit times 3 and monthly audits times 2 to be completed by DD until 100% compliance is reached. Results to be reviewed in monthly QA. (Audit C)	2/17/2025

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S/S D 3225.16.0 3225.16.2	wearing gloves in the dining room while delivering plated food and beverages to the tables. 12/10/24 11:37 AM – E16 (DD) confirmed the finding and stated, "It's because of opening crackers when serving soup." Both E14 (DA) and E17 (DA) were not opening crackers during the observation. 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2 (RWD). **Staffing** **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.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for two (R18 and R22) out of two residents sampled for falls, the facility failed to ensure that the initial post fall assessments were completed by the Registered Nurse. Findings include: 1. Review of R18's clinical record revealed: 1/11/24 – A facility Resident Incident Report documented that R18 had an unwitnessed fall.	3225.16.2 – Staffing A) R18 and R22 were not negatively affected by this deficient practice. Unable to perform a post fall assessment retroactively. B) All residents have the potential to be negatively affected by this practice. No other residents were identified. C) RCA reveals that leadership was not aware that an RN must complete a post-fall assessment. An in-service	2/17/2025

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S/S B 3225.19.0 3225.19.1	12/17/24 10:00 AM – Further review of the facility incident investigation report revealed that a post fall assessment was completed by E8 (LPN). 12/17/24 10:13 AM – In an interview, E8 confirmed that at the time of R18's fall on 1/11/24, E8 obtained R18's vital signs, checked for any signs of physical injury and completed the post fall assessment. 12/17/24 2:52 PM – Findings were discussed with E1 (ED) and E2 (RWD). 2. 7/4/24 – A facility incident report documented that R22 experienced a fall. The incident report, and its initial post fall assessment documentation was completed by E8 (LPN). 12/17/24 10:12 AM -During an interview E3 (RCD) confirmed that post fall assessments are completed by any nurse at the facility and E3 does not come in to complete post fall assessments. 12/17/24 11:39 AM – During an interview, E2 (RWD) stated, "Nurses complete an initial post fall evaluation that's what the form says, it's not an assessment then they call me and if need be I come in or if they need to send the resident out they are nurses and can determine that." 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2 (RWD). **Records and Reports** **The assisted living facility shall be responsible for maintaining appropriate records for each resident.** Based on record review and interview it was determined that for four (R3, R6, R9 and R19) out of twenty-five residents reviewed, the facility	was completed on 1/9/2025 with nursing staff on post-fall assessments by RWD. (Exhibit 1) An RN will complete all post-fall assessments. D) A sample of 10 fall incidents will be audited by RWD or designee for post-fall RN assessment completion weekly times 3 and monthly times 2 until 100% compliance is achieved. (Audit D) Audit will be reviewed at monthly QA meeting.	

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	failed to maintain appropriate records for each resident. 1. Review of R3's clinical record revealed: 11/4/24 – A resident medication self-administration assessment was completed for R3 with the next review date documented as 2/4/24. The surveyor was later provided a corrected copy with 2/4/24 crossed out with a line drawn and the corrected date of 2/4/25. 11/4/24 – An admission UAI assessment was completed for R3. 12/16/24 – Review of R3's, original paper 11/4/24 admission UAI assessment lacked evidence that the 30-day assessment was completed. The 30-day assessment area was left blank. Review of R3's EMR revealed the 30-day assessment was completed on 12/6/24. 2. Review of R6's clinical record revealed: 12/16/24 - Review of R6's immunization documentation lacked evidence of a date for R6's Pneumococcal vaccine consent form. The date area was blank. 12/16/24 11:47 AM – During an interview E2 (RWD) confirmed the findings. 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2 (RWD). 3. 12/12/24 11:45 AM – Review of R9 clinical records revealed a lack of evidence of R9's signed service agreements congruent to the following UAI review periods: 7/19/23 and 4/10/24. 4.12/12/24 11:50 AM - Review of R19's clinical records revealed a lack of evidence of R9's	3225.19.1 – Records and Reports A) R3, R6, R9, and R19 were not negatively affected by this deficient practice. Not able to correct the records retroactively. B) All residents have the potential to be negatively affected by this practice. No other residents were identified. C) RCA reveals that R3's assessment was completed timely via EMR on 12/6/24, the paper document was not signed by ARWD. R6's vaccine consent was signed; however, it was not dated. Immunization documentation and UAI's were reviewed and found compliant for signatures and dates. All documents will be signed and dated prior to being put in the chart. D) Some clinical records could not be located in the archived paper records. An administrative assistant has been scheduled to organize the medical records storage area. Quarterly records reviews will be done by administrative assistant and reviewed during monthly QAPI to ensure continued compliance.	2/17/2025

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3225.19.3 3225.19.5	signed service agreements congruent to the following UAI review periods 5/27/23 and 6/22/23. 12/12/24 12:00 PM – During an interview, E1 (ED) stated, "We may not have [R9] and [R19]'s records because that was the time when the facility changed ownerships and there were some documents from back then that we don't have access now." 12/12/24 12:10 PM – In an interview, E2 (RWD) stated that the residents' paper charts are thinned every three months. E2 also stated, "...There were a lot of documents filed in boxes and archived and that it would be hard to retrieve them. We keep looking but I am not sure if what we have is what you need." 12/17/24 2:52 PM – Findings were discussed with E1 and E2. **The assisted living facility resident clinical records shall be retained for a minimum of 5 years following discharge or 3 years after death before being destroyed.** Based on record review and interview it was determined that the facility failed to retain clinical records, for one (R11) out of 25 residents reviewed. Findings include: 12/17/24 12:15 PM – Surveyor requested documentation regarding supervision/monitoring of R11 from March 2024 through July 2024. 12/17/24 12:21 PM – During an interview E4, (MCPD) stated that the facility was unable to provide evidence of monitoring prior to October 2024. E4 stated that monitoring documentation is only kept for ninety days. 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2 (RWD).	3225.19.3 – Records and Reports A) R11 was not negatively impacted by this deficient practice. R11 is on a	2/17/2025

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3225.19.6 **3225.19.7** **3225.19.7.1** **3225. 19.7.1.1**	**Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:** Based on record review and interview it was determined that for two (R11 and R21) out of eleven residents reviewed for abuse, the facility failed to ensure an incident report was completed with investigative documentation and retained by the facility. The facility policy on investigating accidents and injuries last updated 2018 indicated, "Document all accidents and injuries on an incident report form and in the resident record." 5/29/24 7:30 PM - A progress note in R11's clinical record documented, "RCP reported resident lightly tapped other resident on back of head due to other resident bumping into her in MC common area no injuries on other party nor pain. Agitation due to being lightly bumped into and being surprised by it...Will continue to monitor." There was no incident report submitted to the State Agency regarding this incident. 5/29/24 7:34 PM – A progress note in R21's clinical record documented, "RCP reported resident bumped into another resident and was lightly tapped on the back of the head." 12/16/24 4:13 PM – During an interview E2 (RWD) confirmed that the facility did not have evidence of an incident report or investigative documentation regarding the resident-to-resident altercation involving R11 and R21 that occurred on 5/29/24. 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2 (RWD).	secure memory care unit and receives supervision at all times and safety checks while in her room. Unable to locate document requested by surveyor in archives. B) All residents have the potential to be negatively impacted by this deficient practice. C) RCA reveals that E4 was in error. All records are to be maintained for 5 years. All progress notes were provided to the surveyor that document daily supervision in dining room and activity room. RWD educated nursing staff on record retention per regulation. All records will be archived in the medical records room for 5 years and will be screened by nursing staff prior to storing/archiving. D) Quarterly records reviews will be done by administrative assistant and reviewed during monthly QAPI to ensure continued compliance. 3225.19.5 – Records and Reports A) R11 and R21 were not negatively affected by this deficient practice. Unable to correct this deficiency retroactively. B) All residents have the potential to be negatively impacted by this deficient practice. C) RCA reveals that nursing staff requires education on state reportable incident. In-service was completed on 1/9/2025 by RWD on the need to document all injuries/accidents on an incident form via eMAR and state reportable incidents. (Exhibit 1) D) RWD or designee will screen incidents for reports of resident-to-resident physical altercation or any reports of abuse daily and complete an	2/17/2025

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3225.19.7.1.1.2 S/S D	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Abuse as defined in 16 Del.C. §1131.** **Physical abuse.** **Resident to resident with or without injury.** Based on record review and interview it was determined that for two (R11 and R21) out of eleven residents reviewed for abuse, the facility failed to ensure that a resident-to-resident incident was reported to the state agency. 5/29/24 7:30 PM - A progress note in R11's clinical record documented, "RCP reported resident lightly tapped other resident on back of head due to other resident bumping into her in MC common area no injuries on other party nor pain. Agitation due to being lightly bumped into and being surprised by it...DON aware." 5/29/24 7:34 PM – A progress note in R21's clinical record documented, "RCP reported resident bumped into another resident and was lightly tapped on the back of the head." 12/16/24 4:13 PM – During an interview E2(RWD) confirmed that the facility did not report the resident-to-resident incident involving R11 and R21 that occurred on 5/29/24. 12/17/24 9:34 AM – During an interview E15 (LPN) confirmed that he notified E2(RWD) of the resident-to-resident incident involving R11 and R21 on 5/29/24. E15 stated he did not report the incident because R11's physical contact with	incident report and notify the department in 8 hours if not previously reported. RWD or designee to screen 5 incident reports for resident-to-resident aggression or any abuse weekly times 3 then monthly times 2 until 100% compliance is achieved. (Audit E) Will be reviewed monthly in QAPI meeting. 3225.19.6 Records and Reports A) R11 and R21 were not negatively affected by this deficient practice. Not able to report the incident retroactively. B) All residents have the potential to be negatively impacted by this deficiency. No other incidents of resident-to-resident aggression were identified. C) RCA reveals that nursing staff require education on what incidents are state reportable. RWD provided in-service to nursing staff on 1/9/2025 regarding state reportable incidents. D) RWD or designee to screen 5 incident reports for resident-to-resident aggression or any abuse weekly times 3 then monthly times 2 until 100% compliance is achieved. (Audit E) Will be reviewed monthly in QA meeting.	2/17/2025

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16 Del. Code, Chapter 11, Subchapter II Rights of Residents§ 1121. Resident's rights.	R21's head was "Very light, but in case anything escalated or happened again. I thought it important to document it and let leadership know." 12/17/24 2:52 PM – Findings were reviewed with E1 (ED) and E2 (RWD). **(30) Each resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep.** Based on observation, interview, record review and review of other documentation as indicated it was determined that for three, (R14, R21, and R22) out of eleven residents reviewed for abuse the facility failed to ensure that the residents on the memory care unit were free from physical abuse. R14, R21, and R22 received physical abuse inflicted by R11. The incidents of physical abuse that occurred resulted in both R14 and R22 falling to the floor, placing both residents at risk for physical injury. Findings include: Abuse is defined "16 Delaware Code, Chapter 11, Subchapter III: (1) "Abuse" means the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and includes all of the following: a. Physical abuse. – "Physical abuse" means the unnecessary infliction of pain or injury to a patient or resident. "Physical abuse" includes hitting, kicking, punching, slapping, or pulling hair. If any act constituting physical abuse has been proven, the infliction of pain is presumed.	1121.30 – Resident Rights (30) A) R11, R21, R22 remain safe in community. Unable to correct deficiency as it is historical. B) All residents have the potential to be negatively impacted by this deficient practice. No other residents identified. C) RCA reveals that nursing staff require further education on the de-escalation of aggressive behavior in a resident with dementia. In-service was completed on 1/9/2025 by RWD for nursing staff on managing resident aggression. (Exhibit 1) All resident-to-resident aggression or any abuse will be promptly reported to the MD, Family, and department to ensure appropriate clinical interventions are in place after an episode of aggression. ED educated RWD on	2/17/2025

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	The facility policy on abuse prohibition last updated 2018, indicated "We will not tolerate any form of abuse, neglect, or exploitation. Protect residents from abuse, neglect, or exploitation by anyone, including...other individuals." Review of R11's clinical record revealed: 5/17/23 - A Mini Mental State Exam scored R11 as a "23"; 23 or lower is indicative of cognitive impairment. 5/17/23 – A Wellness Baseline assessment documented that R11 had medical diagnoses that included dementia. 1/27/24 3:34 PM – A progress note in R11's clinical record documented, "Patient has been having increased agitation today, yelling and screaming out to other residents." 2/7/24 1:39 PM - A progress note in R11's clinical record documented "Seen by provider for increase of outburst toward residents and staff. New order increase anti-anxiety medication to three times a day. 2/15/24 3:39 PM - A progress note in R11's clinical record documented, "Resident threw a chair through the dining room during breakfast. Intermittent outburst of yelling." 2/22/24 3:48 PM - A progress note in R11's clinical record documented, "[R11] tending to be a bit 'bossy' with other residents." 2/25/24 2:17 PM - A progress note in R11's clinical record documented, "Patient has had increased yelling outburst to correct other residents in dining area." 3/18/24 6:47 PM - A progress note in R11's clinical record documented, "Resident had some agi-	"Resident notification of changes" policy. (Exhibit 2) D) RWD or designee will ensure all staff are up to date on dementia care training and identifying and reporting abuse. Will be reviewed in monthly QAPI to ensure continued compliance.	

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	tation during activities and meals today. Resident was able to be redirected away from other residents." 3/22/24 2:51 PM – A progress note in R11's clinical record documented, "Resident became agitated this morning and was yelling at other residents." 3/22/24 7:24 PM – An incident report was submitted to the State Agency that alleged, "[R11] states she was scared by [R14] in the hallway. [R11] pushed [R14] causing a fall to the floor, skin tear to right palm and laceration to right side of head." 3/22/24 – E19 (RCP) documented in a written statement, "I got a little more than halfway down the hall. I can hear [R14] cry out in pain and say, "what you do that for"? I then hear [R11] say "oh no" I rushed and turned and see [R14] already on the floor. I called for a nurse then I turned to see if I could find another RCP. As I was walking away I heard [R11] say "You can't just startle people like that and be so close. I didn't mean to push you I was scared." 3/27/24 – A follow up incident report submitted to the State Agency documented, "[R22] has healing skin tears as a result of R11 pushing him. This was an isolated incident of aggressive behavior. Medication reviewed and no new orders. Were changes made to care plan: No. Were system changes put into place: No." Review of R11's clinical record revealed prior incidents of agitation, yelling and aggressive behavior towards other residents on 1/27/24, 2/7/24, 2/15/24, 2/25/24 and 3/22/24 prior to R11's incident that involved R14. 3/29/24 – E22 (NP) documented in a psychiatric evaluation of R11, "Staff reported [R11] has		

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	been yelling at residents and becoming agitated. Patient appears unaware that she has been displaying agitation and yelling at other residents. Plan is to continue on current medication regimen and to add an antipsychotic medication in the afternoon at 4:00 PM as her behaviors seem to appear as she is sundowning." 3/29/24 – A physician's order was written for R11 to receive risperidone 0.25mg in the afternoon. 4/10/24 3:31 PM - A progress note in R11's clinical record documented, "Resident agitated today, was yelling at another resident and attempted to pick up walker and swing at resident. Staff were able to intervene and redirect without difficulty. Resident to see mental health provider this week." 4/10/14 - A physician's order was written for R11 to receive an increase in the antipsychotic to risperidone 0.25mg twice a day. 4/12/24 2:07 PM - A progress note in R11's clinical record documented, "Patient saw psychologist this A.M. for increased agitation and will increase her antipsychotic medication to twice a day." 5/2/24 – E18 (NP) documented in a progress note in R11's clinical record, "Staff reported that patient has been yelling at residents and becoming agitated. Staff stated she picked up her walker and attempted to swing it at another resident." 5/4/24 – A UAI assessment completed by E2 (RWD) for R11 documented "No" in response to history of danger to others, and 'no' to disruptive, assaultive, demanding behaviors.		

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	5/4/24 – A service agreement completed for R11 documented the resident required general supervision. 5/29/24 7:30 PM - A progress note in R11's clinical record documented, "RCP reported resident lightly tapped other resident on back of head due to other resident bumping into her in MC common area no injuries on other party nor pain. Agitation due to being lightly bumped into and being surprised by it...Will continue to monitor." There was no incident report submitted to the State Agency regarding this incident. 5/31/24 – E18 (NP) documented in a progress note in R11's clinical record, "Today patient is being seen for medication management and to reassess for any unmanaged symptoms. She has not been having any extreme negative behaviors. She has been less irritable...". 7/4/24 8:02 PM – An incident report submitted to the State Agency alleged, "[R11] rammed the rollator into [R22], and patient lost his balance and fell to the floor." 7/4/24 – E20 (AA) documented in a written statement, "[R22] had grabbed [R11's] walker to move it out of the way so he could get to the door. [E21 a(RCP)] and I told [R22] to let go off the walker, so he lightly pushed it back towards her. [R11] then aggressively pushed her walker at [R22] so hard he fell to the floor. R11 then said, 'Oh it wasn't that hard of a hit he didn't need to fall." 7/8/24 - A physician's order was written for R11 to receive an increase in the antipsychotic to risperidone 0.5 mg twice a day. 7/9/24 4:30 PM – A follow up incident report submitted to the State Agency documented, "[R22] was attempting to look out the window		

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	and moved [R11's] walker, causing [R11] to become agitated. Both residents are on secure memory unit and have diagnosis of dementia with cognitive decline and behaviors. Increased agitation when personal objects are touched by another resident is a trigger. Residents were separated from each other and supervised to prevent further incidents from occurring. Medication review completed my Mental Health Provider and adjustments made...Changes to made to the care plan 'no'. Were system changes put into place? No." 9/4/24 – E22 (NP) documented in a psychiatric evaluation, "[R11] has intermittent episodes of becoming agitated but a significant decrease from how she was previously." 11/13/24 – E18 (NP) documented in a progress note in R11's clinical record, "Unfortunately, [R11] is at increased behaviors and recently treated for a urinary tract infection." 12/3/24 – E18 (NP) documented in a progress note in R11's clinical record, "Patient is seen today for dementia, aggression...Has become more agitated." 12/17/24 11:21 AM – During an interview, E2 (RWD) confirmed that R11's UAI assessment completed on 5/4/24 did not document R11 as a danger to others or R11's history of behaviors that resulted in resident-to-resident incidents. E2 stated, "No" I don't believe [R11] is a danger, I expect some aggression and some paranoia." 12/17/24 12:21 PM – During an interview E4, (MCPD) stated that R11's behaviors "Come in phases, it comes and goes". E4 confirmed that R11 received standard every two-hour monitoring done on the memory care unit and that spe-		

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	cific behavior monitoring or increased monitoring was not initiated for R11. Additionally, E4 was unable to provide evidence of monitoring prior to October 2024. E4 stated that monitoring documentation is only kept for ninety days. 12/17/24 2:52 PM – E2 (RWD) confirmed that R11 continued to receive the standard every two-hour general supervision on memory care and that the facility response to the resident-to-resident altercations that R11 was involved in was to "Document and review the medications. It's expected with that unit to have behaviors". 12/19/24 12:46 PM – During an interview E24 (MT) stated that when R11 is agitated the facility response is to "Mostly redirect. [R11] gets upset and tells other residents don't touch her walker or don't eat with their hands she gets frustrated because she is more aware." When asked if there is additional supervision or monitoring E24 stated, "No because she can come and go to her room, and we want to keep that independence." 12/19/24 12:53 PM - During an interview E12 (RCP) confirmed that R11 does not receive additional monitoring or supervision during periods of agitation, E12 stated, "No because it's so quick. We redirect and of course separate them. [R11] gets mad and defensive when people are close in her personal space, her acuity is different, and she gets mad. She spends most of her time in her room and I feel like she's slowing down some." 12/19/24 1:49 PM – During an interview E7 (LPN) clarified that when R11 was documented as "yelling" the resident was "Yelling across the room. Sometimes random thoughts. Sometimes at other residents telling them to stop doing things that she thinks is wrong, not to do		

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S/S E **Title 16 Health and Safety** **Subchapter IX. Criminal Background Checks; Drug Testing - PPECC** **§1191. Mandatory drug screening.**	things." When asked if she was aware of any additional monitoring or supervision when R11 exhibits aggressive behavior, E7 stated, "No, because she's redirectable." 12/19/24 2:30 PM – During an interview, R11 was unable to recall the prior incidents. R11 stated, "I don't know of any conflicts. If there was, I may have done something instinctually". 12/19/24 – During an interview with E21 (MT) stated, "[R11] is more lucid than everyone else and she gets frustrated. She will yell at them [other residents] and get agitated. If someone is walking by and they place their hand on her walker for balance she will push it away from them." When asked what R11 says when yelling, E21 stated, "She yells across the dining room if someone is eating with their hands. Anytime someone is doing something she doesn't think is right she gets agitated and yells." When asked if the resident seems to be aware she is pushing other residents E21 stated, "Yes, in the moment but then if she goes in her room, it's like her brain resets and she doesn't remember. She is very territorial about her belongings and people in her space." 12/19/24 3:49 PM – During an interview E20 (AA) confirmed the written statement documented on 7/4/24 and stated, "I remember [R11] pushing her walker into [R22], she was upset and said something about 'oh it wasn't that hard." 12/19/24 4:53 PM – Findings were reviewed with E1 (ED) and E2 (RWD) during the Exit Conference.		

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	(a)An employer may not employ any applicant without first obtaining the results of that applicant's mandatory drug screening. **(b)All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(c)The Department shall promulgate regulations regarding the pre-employment screening of all applicants for use of all of the following illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.** **(3) Opiates.** **(4) Phencyclidine ("PCP").** **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department, under regulations promulgated under this section.** **(d) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **(e) Any employer who fails to comply with the requirements of this section is subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation.** **This requirement was not met as evidenced by:** Based on interview and record review it was determined that for four (E5, E11, E14 and E15) out of four (4) employees reviewed the facility failed to complete required pre-employment drug screening. Findings include: 12/20/24 9:28 AM – A desk review of the facility's employee drug test results submitted by E1	1191– Health and Safety A) No residents were affected by this deficient practice. E5, E11, E14, and E15 will be tested for marijuana/cannabis. B) Screening will be completed by HR to identify any staff that did not complete mandatory drug screening that includes marijuana/cannabis. C) RCA reveals that leadership was in error for not testing new hires for cannabis. HR was educated by ED on the requirement for pre-employment testing requirements. D) HR to complete audit of new hires weekly times three then monthly times 2 for drug screening per regulations until 100% compliance is achieved. (Audit F) To be reviewed in monthly QA.	2/17/2025

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	(ED), revealed four (E5, E11, E14 and E15) employees out of four (4) reviewed did not have marijuana/cannabis included in their pre-employment drug screen testing regimen: E5 (Maintenance Director) – 6/17/24, no evidence of a marijuana drug test. E11 (Resident Assistant) – 7/9/24, no evidence of a marijuana drug test. E14 (Dietary Wait Staff) – 9/17/24, no evidence of a marijuana drug test. E15 (LPN) – 4/23/24 - no evidence of a marijuana drug test. 12/20/24 10:54 AM – Findings were communicated to E1 (ED) and E2 (RWD) via email correspondence.		

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