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: Foulk Living

DATE SURVEY COMPLETED: September 10, 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 September 9, 2024, through September 10, 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 thirty-six (36). The survey sample totaled nine (9) residents. Abbrevlations/definitions used in this state report are as follows: Contract – A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations; DelVAX -A confidential online computer system used statewide by doctors, nurses, schools to keep track of their patient/student's immunizations; DON – Director of Nursing; ED - Executive Director; EMR – Electronic Medical Record; LPN – Licensed Practical Nurse; MT – Medication Tech; NP – Nurse Practitioner; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; RA – Resident Assistant; RN – Registered Nurse; 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; SLRE (Senior Living Resident Evaluation);		

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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 assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.	**Corrective action:** All residents in the Memory Care Unit must receive information regarding the physical environmental features of a secured unit, as well as the staffing plan and training policies. No residents or individuals were impacted by this deficiency according to regulation 3225.7.0, which mandates specialized care for memory impairment. The facility has implemented corrective actions to ensure substantial compliance with state-required rules and regulations in all outlined categories.	10/23/2024
3225	**Assisted Living Facilities**		
3225.7.0	**Specialized Care for Memory Impairment**		
3225.7.1	**Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations herein.**		
3225.7.2	**Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.**	**Identification of Other Residents:** All residents have the potential to be affected by this deficiency. To address this, the following corrective actions will be taken to ensure the protection of all residents.	
3225.7.3	**The information disclosed shall explain the additional care that is provided in each of the following areas:**	**System Changes:** •The facility did not previously review the staffing plan, orientation, or regular in-service education for specialized care. Moving forward, the facility will incorporate these aspects into marketing materials, including a signature page for the Power of Attorney (POA) or family members to sign at the time of admission. •The marketing materials will also include details about the physical environment and design features, including security systems that are appropriate for supporting the functioning of adults with memory impairment.	
3225.7.3.5	**Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care.**		
3225.7.3.6	**Physical Environment: the physical environment and design features, including security systems, appropriate to support the functioning of adults with memory impairment;**		
S/S - E	This requirement was not met as evidenced by:		

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	Based on interview and review of the facility's memory care information, the facility materials failed to disclose to the persons seeking specialized care some of the regulation required information. Findings include: Review of the materials did not contain the information for physical environment features of a secured unit or the staffing plan, training, and the frequency of training for staff. 9/10/24 – Per interview with E1 (ED) at approximately 3:30 PM, E1 confirmed the memory care information was lacking those specifics. 9/10/24 – Findings were reviewed with E1, E2 (SNF DON), E3 (Temp AL DON) and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	•This information will encompass specifics about the operations and care provision for residents with memory impairment. **Evaluation of Success:** •An audit will be conducted by the Executive Director (ED) or designee to monitor the marketing materials and the acknowledgment of receipt signature page. •Audits will take place weekly for four weeks and then monthly for three months or until 100% compliance is achieved. •The results of these audits will be submitted to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and necessary follow-up actions.	
3225.9.7 S/S - D	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** This requirement was not met as evidenced by: Based on record review, interview, and review of State DelVAX website, it was determined that for three (R6, R7 and R9) out of	**Corrective Action:** The vaccination status for the three residents identified at time of survey (R6, R7, and R9) has been successfully updated in the electronic health record (PCC). **Identification of Affected Residents:** All residents may potentially be impacted by this identified deficiency. Corrective actions outlined below will ensure that all residents are adequately protected. **System Changes:** •Immunization documentation for all current residents will be updated with the latest information obtained from family members and the DelVax website. •A vaccine clinic will be scheduled to offer the Pneumococcal vaccine to all eligible residents.	10/5/2024

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	nine residents reviewed for pneumococcal vaccines, the facility failed to provide evidence of the residents' pneumococcal vaccine. Findings include: "Pneumococcal Vaccine Timing for Adults-Adults >/= 65 years old Complete pneumococcal vaccine schedules... "U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 1. 6/5/15 – R6, now aged 83 years, was admitted to the facility. 9/9/24 – A search on the DelVAX website (State of Delaware, Division of Public Health, Immunization Record) revealed R6 received the PVC23 pneumococcal vaccine on 7/21/21 and R6 received the PCV20 vaccine on 10/16/23. While the DelVax website confirmed the vaccinations were up to date, the facility failed to provide evidence of such in R6's medical record or other facility documentation. 2. 3/31/23 – R7, now aged 93 years, was admitted to the facility. 9/9/24 – A search on the DelVAX website revealed R7 received the PVC13 pneumococcal vaccine on 4/4/17. While the DelVax website confirmed the PCV13 vaccination was received, the facility failed to provide evidence of such in R7's medical record. The facility failed to provide evidence of any documentation of R7 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine or a declination of such. 3. 2/29/24 – R9, now aged 86 years, was admitted to the facility. 9/9/24 - A search on the DelVAX website contained no information of vaccinations as R9 was admitted from another state.	•Nurses will receive training on the requirement that all patients aged 65 and older must be assessed for their pneumococcal vaccination status during routine healthcare visits and at the time of admission. If a resident is unvaccinated or due for a booster, the Power of Attorney (POA) or family member will be given the required information and a consent form. If the consent is secured, the appropriate pneumococcal vaccine will be ordered and administered by the nurse in accordance with CDC guidelines. **Success Evaluation:** •An audit will be conducted to verify that updated vaccination information for all current residents is documented in the electronic health record (PCC). •Audits will occur weekly for four weeks, followed by monthly audits for three months or until 100% compliance is achieved. •The audit results will be reported to the QAPI Committee by the Executive Director or their designee.	

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	The out of state Rehab unit in which the resident was transferred from, indicated R9 received the PCV13 vaccination on 1/1/18, over 6 years ago and the PPV23 on 10/1/18, over 5 years ago. The facility failed to provide evidence of any documentation of R9 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine or a declination of such. 9/10/24 – Per interview with E2 (SNF DON) and E3 (Temp AL DON) at approximately 3:30 PM, E2 and E3 confirmed they have access to the DelVAX site. E3 confirmed the vaccination records or declinations of vaccinations were not entered or scanned into the residents EMR. 9/10/24 – Findings were reviewed with E1 (ED), E2, E3 and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.		
3225.10.0 3225.10.10 S/S - B	**Contracts** **No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.** Based on record review and review of other facility documentation, it was determined that for four (R4, R6, R7 and R9) out of four residents sampled for contract dates, the facility obtained a signed contract prior to the full assessment UAI was completed or the SA was executed. 1. 7/26/24 - R4 was admitted to the facility. The UAI was completed on 7/26/24 and the SA was executed on 7/26/24. The contract	**Corrective Action:** This issue represents past non-compliance. Contracts must be signed only after the completion of the admission UAI-based (Uniform Assessment Instrument) and Service Agreement. The contracts for four residents (R4, R6, R7, and R9) have already been signed and cannot be retroactively corrected. **Identification of Other Residents:** All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure protection for all residents moving forward. **System Changes:** For all new admissions to Assisted Living/Memory Care: •The UAI will be completed, and Service Plan Agreement will be executed prior to date of admission.	10/05/2024

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	was signed on 7/25/24, prior to the assessments being completed. 2. 12/29/23 - R6 was admitted to the facility. The UAI was completed on 12/29/23 and the SA was executed on 12/28/23. The contract was signed on 12/28/23, prior to the UAI being completed. 3. 3/31/23 - R7 was admitted to the facility. The UAI was completed on 4/3/23 and the SA was executed on 4/3/23. The contract was signed on 3/31/23, prior to the assessments being completed. 4. 2/29/24 - R9 was admitted to the facility. The UAI was completed on 3/4/24 and the contract was signed on 2/29/24, prior to the assessment being completed. 9/10/24 – Findings were reviewed with E1 (ED), E2 (SNF DON), E3 (Temp AL DON) and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	•The contract will only be signed after both the UAI and Service Plan Agreement have been completed and signed by the resident or their Power of Attorney (POA). **Evaluation of Success:** •The Executive Director (ED) or designee will audit the records of all newly admitted residents to ensure that the UAI and Service Agreement are completed and signed before the contract is signed. •Audits will be conducted weekly for four weeks, then monthly for three months or until 100% compliance is achieved. •The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary.	
3225.11.0 **3225.11.2** **S/S - E**	**Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.** This requirement was not met as evidenced by:	**Corrective Action:** This deficiency reflects past non-compliance. A resident seeking admission must have an initial UAI- based (Uniform Assessment Instrument) resident assessment completed by a registered nurse (RN) on behalf of the assisted living facility no more than 30 days prior to admission. The assessments for four residents (R4, R6, R7, and R9) have already been completed and cannot be retroactively corrected. **Identification of Other Residents:** All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure that all residents are protected moving forward.	10/05/2024

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	Based on record review, interview, and review of other facility documentation, it was determined that for four (R4, R6, R7 and R9) out of nine sampled residents for UAI completion, the facility failed to provide evidence that a UAI was completed within 30 days prior to admission. Findings include: 1. 7/26/24 - R4 was admitted to the facility. The initial UAI was completed on 7/26/24, the day of admission. 2. 12/29/23 - R6 was admitted to the facility. The initial UAI was completed on 12/29/23, the day of admission. 3. 3/31/23 - R7 was admitted to the facility. The initial UAI was completed on 4/3/23, after R7 was admitted. 4. 2/29/24 – R9 was admitted to the facility. The initial UAI was completed on 3/4/24, after R9 was admitted. 9/10/24 – Per interview with E2 (SNF DON) and E3 (Temp AL DON) at approximately 3:30 PM, E3 stated the UAI information was not in evidence. 9/10/24 – Findings were reviewed with E1 (ED), E2, E3 and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	**System Changes:** For all new admissions to Assisted Living/Memory Care, both the UAI and the service plan agreement must be completed prior to date of admission. An initial UAI-based resident assessment will be conducted by a registered nurse (RN) on behalf of the assisted living facility no more than 30 days prior to admission, and the assessment must be signed by the resident or their Power of Attorney (POA). **Evaluation of Success:** •The Executive Director (ED) or designee will conduct audits of all newly admitted residents to ensure that the UAI resident assessments are completed by an RN no more than 30 days prior to admission and signed by the resident or POA. •Audits will be conducted weekly for four weeks and then monthly for three months or until 100% compliance is achieved. •The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary.	
3225.11.3 **S/S - D**	**Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.** This requirement was not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that for one (R6) out of six sam-	**Corrective Action:** This issue represents past non-compliance. A prospective resident must have a medical evaluation completed by a physician within 30 days prior to admission. The medical evaluation for R6 has already been completed and cannot be retroactively corrected. **Identification of Other Residents:**	10/05/2024

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	pled residents for a Physician's medical evaluation, the facility failed to provide evidence that an evaluation was completed within 30 days prior to admission. Findings include: 12/28/23 - R6 was admitted to the facility. The Physician's evaluation was completed on 10/16/23, over 30 days prior to admission. 9/10/24 - Per interview with E3 (Temp AL DON) at approximately 3:30 PM, E3 confirmed that R6's medical evaluation was completed outside of the 30 days prior to admission. 9/10/24 – Findings were reviewed with E1 (ED), E2 (SNF DON), E3 and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure that all residents are protected moving forward. **System Changes:** For all new admissions to Assisted Living/Memory Care, a medical evaluation must be completed by a physician within 30 days prior to admission. **Evaluation of Success:** •The Executive Director (ED) or designee will conduct audits of all newly admitted residents to ensure that medical evaluations have been completed by a physician within 30 days prior to admission. •Audits will be conducted weekly for four weeks and then monthly for three months or until 100% compliance is achieved. •The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary.	
3225.11.4 **S/S - E**	**The resident assessment shall be completed in conjunction with the resident.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for six (R1, R4, R5, R6, R7 and R8) out of nine sampled residents, the facility failed to provide evidence that the UAI was signed by the resident confirming their agreement with the assessment. Findings include:	**Corrective Action:** This issue involves past non-compliance. A resident seeking admission must have an initial UAI-based (Uniform Assessment Instrument) resident assessment signed by the resident confirming their agreement with the assessment. The assessments for six residents (R1, R4, R5, R6, R7, and R8) have already been completed and cannot be retroactively corrected. **Identification of Other Residents:** All newly admitted residents have the potential to be affected by this issue.	10/05/2024

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	1. 11/6/21 – R1 was admitted to the facility. The annual UAI completed on 1/6/23 did not contain the resident's signature confirming their agreement with the assessment. 2. 7/26/24 – R4 was admitted to the facility. The initial UAI completed on 7/26/24 did not contain the resident's signature confirming their agreement with the assessment. 3. 4/8/22 – R5 was admitted to the facility. The annual UAI completed on 3/29/24 did not contain the resident's signature confirming their agreement with the assessment. 4. 12/29/23 – R6 was admitted to the facility. The initial UAI completed on 12/29/23 did not contain the resident's signature confirming their agreement with the assessment. 5. 3/31/23 – R7 was admitted to the facility. The annual UAI completed on 4/15/24 did not contain the resident's signature confirming their agreement with the assessment. 6. 3/8/19 – R8 was admitted to the facility. The annual UAI completed on 5/8/24 did not contain the resident's signature confirming their agreement with the assessment. 9/10/24 – Per interview with E2 (SNF DON) and E3 (Temp AL DON) at approximately 3:30 PM, E3 confirmed the EMR does not accept electronic signatures at the time. E2 stated the signed copy should be uploaded into the EMR and these were not in evidence. 9/10/24 – Findings were reviewed with E1 (ED), E2, E3 and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	The corrective actions outlined below will ensure that all residents are protected moving forward. **System Changes:** For all new admissions to Assisted Living/Memory Care, both the UAI and service agreement must be completed before the resident is physically admitted. An initial UAI-based resident assessment will be completed by a registered nurse (RN) on behalf of the assisted living facility no more than 30 days prior to admission, and the assessment must be signed by the resident or their Power of Attorney (POA). **Evaluation of Success:** •The Executive Director (ED) or designee will audit all newly admitted residents to ensure that the UAI-based resident assessments are signed by the resident or POA confirming their agreement with the assessment. •Audits will be conducted weekly for four weeks, then monthly for three months or until 100% compliance is achieved. •The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary.	

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3225.11.5 S/S - D	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for two (R6 and R7) out of nine sampled residents, the facility failed to provide evidence that a 30-day post admission UAI was completed. Findings include: 1. 12/29/23 - R6 was admitted to the facility. The initial UAI was completed on 12/29/23. The facility lacked evidence that a 30-day post admission assessment was completed. 2. 3/31/23 - R7 was admitted to the facility. The initial UAI was completed on 4/3/23. The facility lacked evidence that a 30-day post admission assessment was completed. 9/10/24 – Findings were reviewed with E1 (ED), E2 (SNF DON), E3 (Temp AL DON) and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	**Corrective Action:** This issue represents past non-compliance. AUI-based assessments must be updated. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition. The assessments for two residents (R6 and R7) have already been completed and cannot be retroactively corrected. **Identification of Other Residents:** All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure protection for all residents moving forward. **System Changes:** For all new admissions to Assisted Living/Memory Care, the UAI will be completed before the resident is physically admitted. AUI-based assessments will be updated. At a minimum, regular updates will occur 30 days after admission, annually and when there is a significant change in the resident's condition. **Evaluation of Success:** •The Executive Director (ED) or designee will conduct audits of all newly admitted residents to ensure that the UAI-based resident assessments are regularly updated within 30 days after admission, annually and when there is a significant change in the resident's condition. •Audits will be performed weekly for four weeks and then monthly for three months or until 100% compliance is achieved. •The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and any further action needed.	10/05/2024

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	Services		10/05/2024
3225.12.0	**The assisted living facility shall ensure that:**	**Corrective Action:** The Administrator and Director of Food and Beverage have implemented corrective actions. All employees involved in food handling have been educated on proper procedures for compliance with the Delaware Food Code. This education included maintaining temperature logs for the refrigerator in the Assisted Living (AL) kitchen, ensuring all food items are properly dated, and discarding expired food items. **Identification of Other Residents:** All residents have the potential to be affected by improper food handling. To prevent this, the Director of Food and Beverage or designee will provide ongoing education to both current and newly hired staff, ensuring compliance with all food safety and storage requirements. **System Changes:** The root cause of the issue was identified as a failure by the dietary staff to store food in a sanitary manner. In response, the facility's process for kitchen sanitation has been updated. Weekly sanitation rounds will now be conducted by the dietician and the Director of Food and Beverage to ensure the Assisted Living kitchen and refrigerators are properly maintained. All concerns raised have been addressed. **Evaluation of Success:** •Audits will be conducted to ensure compliance with temperature log maintenance and food safety practices in the Assisted Living kitchen and refrigerators.	
3225.12.1	**Food service complies with the Delaware.**		
3225.12.1.3	**Food Code**		
S/S - E	**Delaware Food Code** Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.** 9/9/24 –During the survey of the facility at approximately 10:30 AM, it was observed that the refrigerator located in the AL kitchen had expired milk and yogurt still available for consumption. 9/9/24 – During an interview with E14 (Director of Food Services), at approximately 10:30		

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	AM, E14 confirmed the refrigerated items were past the expired date. 9/9/24 – During the survey of the facility at approximately 11:50 AM, it was observed that the refrigerator located in the memory unit contained pudding and chocolate cake that were not dated. 9/9/24 – During an interview with E1 (ED), at approximately 2:40 PM, E1 confirmed the food items were not dated. **4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a TEMPERATURE MEASURING DEVICE shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit.** 9/9/2024 –During the survey of the facility at approximately 11:50 AM, the refrigerator in the memory unit was observed to have a broken thermometer causing an inability to determine the temperature. 9/9/24 – During an interview with E1 (ED), at approximately 2:40 PM, E1 confirmed the thermometer was broken. 9/9/24 – Findings were reviewed with E1 and E14 at approximately 2:45 PM.	•These audits will take place weekly for four weeks, followed by monthly audits for three months or until 100% compliance is achieved. •The audit results will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and any necessary follow-up actions.	
3225.13.0 3225.13.1 S/S - D	**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,**	**Corrective Action:** This issue is identified as past non-compliance. A service agreement based on the needs identified in the UAI (Uniform Assessment Instrument) must be completed prior to or no later than the day of admission for each resident	10/05/2024

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	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 record review, interview, and review of other facility documentation, it was determined that for three (R4, R5 and R7) of nine sampled residents, the facility failed to complete a (SA) Service Agreement within the regulation timeframe, to provide evidence that the resident or family participated in the development of the agreement or that the resident/resident representative was provided a copy. Findings include: 1. 7/26/24 – R4 was admitted to the facility. The SA was completed on 7/29/24, three days after admission. The SLRE (Senior Living Resident Evaluation) was completed on 7/29/24, three days after admission which captured R4's LOC (Level of Care). The facility failed to obtain R4's signature on either assessment and did not provide evidence that the signed copy was given to the resident. 2. 4/8/22 – R5 was admitted to the facility. The SA in evidence was completed on 4/8/23. The facility failed to complete an annual SA or to obtain R5's signature on the SLRE. There was no evidence that the R5 participated in the development of the SLRE or that R5 received a copy. 3. 3/31/23 – R7 was admitted to the facility. The SA in evidence was completed on 4/24/23. The facility lacked evidence of a 2024 annual SA. The SLRE (Senior Living Resident Evaluation) was completed on 1/8/24 which captured R5's LOC (Level of Care). The	seeking entrance. The resident or family must participate in the development of the service agreement and the resident/resident representative must be provided a copy. The service agreements for three residents (R4, R6, and R7) have already been completed and cannot be retroactively corrected. **Identification of Other Residents:** All newly admitted residents have the potential to be affected by this issue. Corrective actions outlined below will ensure the protection of all residents going forward. **System Changes:** For all new admissions to Assisted Living/Memory Care, a service agreement based on the needs identified in the UAI will be completed prior to or no later than the day of admission. The resident's attending physician(s) will be documented in the service agreement, including their name, address, and telephone number. Documentation will support resident/resident representative participation in the development process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. **Evaluation of Success:** •The ED or designee will audit all newly admitted residents to ensure that a service agreement based on the UAI is completed and that the residents' personal attending physician(s) are properly identified by name, address, and telephone number. Documentation will support resident/resident representative participation in the devel-	

Provider's Signature _____ Title Executive Director Date 10/2/24

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	facility failed to complete an annual SA or to obtain R7's signature on the SLRE. There was no evidence that the R5 participated in the development of the SLRE or that R5 received a copy. 9/10/24 – Per interview with E2 (SNF DON) and E3 (Temp AL DON) at approximately 3:30 PM, E2 stated the facility obtains a Senior Living Resident Assessment which signifies the Level of Care needed and includes the SA elements. These assessments are usually signed by the resident and should be uploaded into the EMR. E3 stated residents do not usually receive a copy of the SA or level of care assessment. 9/10/24 – Findings were reviewed with E1 (ED), E2, E3 and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	opment process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. •Audits will be conducted weekly for four weeks, then monthly for three months or until 100% compliance is achieved. •The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and any necessary actions.	
3225.13.3 S/S - B	**The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** This requirement was not met as evidenced by: Based on record review, interview, and review of other facility documentation, it was determined that for five (R4, R6, R7, R8 and R9) out of nine sampled residents for the SA (Service Agreement) completion, the facility failed to provide evidence that the resident's personal attending Physician was identified on the SA. Findings include: 1. 7/26/24 – R4 was admitted to the facility. The SA completed on 7/29/24 did not contain R4's personal attending Physician's address or phone number. 2. 12/29/23 – R6 was admitted to the facility. The SA completed on 1/2/24 did not contain	**Corrective Action:** This issue is identified as past non-compliance. A service agreement based on the needs identified in the UAI (Uniform Assessment Instrument) must be completed prior to or no later than the day of admission for each resident seeking entrance. The resident or family must participate in the development of the service agreement and the resident/resident representative must be provided a copy. The service agreements for three residents (R4, R6, and R7) have already been completed and cannot be retroactively corrected. **Identification of Other Residents:** All newly admitted residents have the potential to be affected by this issue. Corrective actions outlined below will ensure the protection of all residents going forward.	10/5/2024

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	R6's personal attending Physician's address or phone number. 3. 3/31/23 – R7 was admitted to the facility. The SA completed on 4/24/23 did not contain R7's personal attending Physician's address or phone number. 4. 3/8/19 – R8 was admitted to the facility. The SA completed on 7/29/24 did not contain R8's personal attending Physician's address or phone number. 5. 2/29/24 – R9 was admitted to the facility. The SA completed on 3/4/24 did not contain R9's personal attending Physician's address or phone number. 9/10/24 – Per interview with E1 (ED) at approximately 3:30 PM, E1 confirmed the facility's electronic version of the SA does not contain the Physician's information other than the Physician's name. 9/10/24 – Findings were reviewed with E1, E2 (SNF DON), E3 (Temp AL DON) and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.	**System Changes:** For all new admissions to Assisted Living/Memory Care, a service agreement based on the needs identified in the UAI will be completed prior to or no later than the day of admission. The resident's attending physician(s) will be documented in the service agreement, including their name, address, and telephone number. Documentation will support resident/resident representative participation in the development process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. **Evaluation of Success:** •The ED or designee will audit all newly admitted residents to ensure that a service agreement based on the UAI is completed and that the residents' personal attending physician(s) are properly identified by name, address, and telephone number. Documentation will support resident/resident representative participation in the development process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. •Audits will be conducted weekly for four weeks, then monthly for three months or until 100% compliance is achieved. •The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and any necessary actions.	

Provider's Signature [signature] Title Executive Director Date 10/2/24

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3225.14.0 **3225.14.1** **Del.C. Ch 11, Subchapter II - § 1121. Resident's rights.** **S/S - E**	**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.** **§ 1123. Notice to patient.** **(b) Copies of § 1121 of this title shall be furnished to the resident upon admittance to the facility; all residents currently residing in the facility; and the authorized representative under § 1122 of this title. The long-term care facility shall retain in its files a statement signed by each person listed in this subsection that the person has received a copy of § 1122 of this title.** This requirement was not met as evidenced by: Based on record review and interview, it was determined for five (R4, R6, R7, R8 and R9) out of five residents reviewed for the updated resident rights notification, the facility failed to ensure that the resident or resident representative was notified and had signed off on the updated resident rights form. Findings include: The Resident Rights form (updated September 2023) required each resident or resident representative to sign and date acknowledging the receipt of a copy of the Resident Rights. 1. 7/26/24 – R4 was admitted to the facility. The facility was unable to provide any documentation of R4 or R4's resident representative being notified and signing off on the updated Resident Rights form.	**Corrective Action:** The Resident Rights form, updated in September 2023, requires each resident or their representative to sign and date the form, acknowledging receipt of a copy of the Resident Rights. **Identification of Other Residents:** The updated Resident Rights were incorporated into the facility's Resident Agreement in May 2024. Therefore, all residents admitted after this date have received the most current version of the Resident Rights. However, it was identified that residents admitted before this update have not yet received the new Resident Rights information. **System Changes:** To ensure all residents are informed, the facility will distribute the updated Resident Rights form to all current residents or their representatives who were admitted prior to the May 2024 update. Each resident or representative will be required to sign and date the form to acknowledge receipt. **Evaluation of Success:** •Audits will be conducted weekly for four weeks to ensure that all residents or their representatives have received and acknowledged the updated Resident Rights. •Following the initial four weeks, audits will continue monthly for three months or until 100% compliance is achieved. •The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the Executive Director (ED) or their designee for review and action if needed.	10/23/2024

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

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

STATE SURVEY REPORT

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	2. 12/29/23 – R6 was admitted to the facility. The facility was unable to provide any documentation of R6 or R6's resident representative being notified and signing off on the updated Resident Rights form. 3. 3/31/23 – R7 was admitted to the facility. The facility was unable to provide any documentation of R7 or R7's resident representative being notified and signing off on the updated Resident Rights form. 4. 3/8/19 – R8 was admitted to the facility. The facility was unable to provide any documentation of R8 or R8's resident representative being notified and signing off on the updated Resident Rights form. 5. 2/29/24 – R9 was admitted to the facility. The facility was unable to provide any documentation of R9 or R9's resident representative being notified and signing off on the updated Resident Rights form. 9/10/24 – Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the updated Resident Rights were added to the facility's Resident Agreement earlier this year (May 2024), so anyone admitted after that date would have the updated version of the Rights. E1 stated the existing residents admitted prior to this Agreement update have not received the new Resident Rights information yet. 9/10/24 – Findings were reviewed with E1, E2 (SNF DON), E3 (Temp AL DON) and E4 (LPN) at the exit conference beginning at approximately 3:35 PM.		

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