

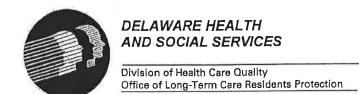
STATE SURVEY REPORT

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Office of Long-Term Care Residents Protection

NAME OF FACILITY: Sunrise Assisted Living in Wilmi	ington DATE SURVEY COMPLETED: Fel	oruary 19, 2025
STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
An unannounced Annual and Compla	aint	
Survey was conducted at this facility fr		141.1
February 17, 2025, through February	19,	1 11/25
2025. The deficiencies contained in this	re-	1/100
port are based on interview, record revi	iew	
and review of other facility documentat	ion	1 126
as indicated. The facility census on the f	First	TOP ALL Deficiel
day of the survey was seventy-two (72).	The	
survey sample totaled ten (10) reside	ents	HLL
plus three (3) additional subsampled re		/ .
dents.		DOT NIDV
		1 () (+ 1 C/O
Abbreviations/definitions used in this st	ate	
report are as follows:		
Acetablular Fracture – A break in your	hip	1
socket that usually requires surgery;		
CDC – Centers for Disease Control;		
DelVax - Delaware's state immunizat	ion	1
registry that serves as a database to cont	ain	
the immunization records of Delaware re	esi-	
dents;		
Dementia – a condition that affect to	the	
brain's ability to think, remember, a	and	
function normally;		
DON – Director of Nursing;		
DOS – Director of Sales;		
ED - Executive Director;		
HALO - A metal brace that circles and	at-	
taches to your skull. It is used to keep t	the	
bones in your cervical spine (neck) fro	om	
moving;		
LPN - Licensed Practice Nurse;		
Pubic Rami Fracture — A crack or break i	n a	
person's pelvis;		
RCD - Resident Care Director;		
RN – Registered Nurse;		
Service Agreement - allows both parties	in-	
volved (the resident and the assisted liv	ing	1
facility) to understand the types of care a	and	
services the assisted living provides. The	ese	

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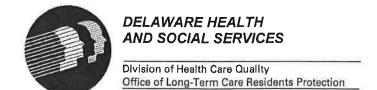


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NAME OF FACILITY: Sunrise Assisted Living in Wilmington DATE SURVEY COMPLETED: February 19, 2025

SECTION STA	TEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
STA		ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED A. No residents were affected by the deficiency. B. All residents have the potential to be affected by this practice. E14 and E16 will receive the mandatory annual dementia training. C. A root cause analysis determined a lack of training for all staff. All current and new staff will receive the mandatory training via the Learning Channel/Relias or in a classroom setting. D. The Executive Director/Designee will conduct weekly audits until compliance is at 100%. Then a random sample of staff will be audited monthly x2 and the results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	Completion
	Based on interview, record review and view of other facility documentation, it we determined that for two (E14 and E16) of seven employees sampled for demensipation training, the facility failed to pivide evidence of the mandated annual mentia specific training. Findings include	vas out tia ro- de-	
	1. 11/9/09 - E14 (LPN) was hired. The omentia training in evidence was completed on 7/19/23. The facility failed to provide idence of the mandated yearly demensible training for the calendar year 20.	ed ev- tia	



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NAME OF FACILITY: Sunrise Assisted Living in Wilmington DATE SURVEY COMPLETED: February 19, 2025

Date_____

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	2. 4/23/12 - E16 (LPN) was hired. The dementia training in evidence was complete on 8/30/23. The facility failed to provide evidence of the mandated yearly dementispecific training for the calendar year 2024 2/19/25 – Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the training was not in evidence. 2/19/25 - Findings were reviewed with E at the exit conference beginning at approximately 1:50 PM.	d //- a 1. 1. 1.	
3225.7.0	Specialized Care for Memory Impairment	A. No residents were affected by the deficiency.	
3225.7.2	Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in a assisted living facility. The information disclosed shall explain the additional care that is provided in each of	B. All residents have the potential to be affected by this practice. C. A root cause analysis determined the community did not include written docu-	
	the following areas:	sons information related to preadmission, admission and discharge, assessment, care	
3225.7.3.3	Pre-Admission, Admission & Discharge the process and criteria for placementransfer or discharge from this specialize care;	planning and implementation, staffing plan, and training policies. During community tours the Sales Director has been providing this information	
3225.7.3.4	Assessment, Care Planning & Implementation: the process used for assessment an establishing and updating the service agreement and its implementation,	The Sales Director will be in-serviced by the	
3225.7.3.5 S/S – E	Staffing Plan & Training Policies: staffin plan, orientation, and regular in-servic education for specialized care.		
	This requirement was not met as evidence by:		

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ECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Based on interview and review of the facility's memory care information, the facilimaterials failed to disclose to the person seeking specialized care the above elements. Findings include:	ty changes will be made, if needed.	
	Review of the memory care materials d not contain the information for the Pre-A mission, Admission & Discharge.		8
	Review of the memory care materials of not contain the information for the Assessment, Care Planning & Implementation.		,
	Review of the memory care materials of not contain the information for the Staffi Plan and Training Policies.		
	2/18/25 - Per interview with E6 (DOS) at a proximately 1:30 PM, E6 confirmed t company's memory care information w lacking in those areas.	he	
	2/19/25 - Per interview with E1 (ED) at a proximately 1:30 PM, E1 confirmed to memory care information needed and date to include this information. E1 stated during a tour of the facility, the person seeking specialized care for memory in pairment were informed verbally of the elements.	he pp- ed on m-	
	2/19/25 - Findings were reviewed with at the exit conference beginning at approimately 1:50 PM.		
225.8.0	Medication Management	A. No residents were affected by the defi- ciency. R5 and R6 have been cognitively and	
225.8.6	Within 30 days after a resident's admissi and concurrent with all UAI-based asse		
S/S – D			



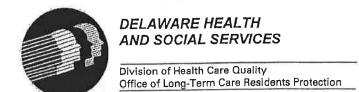
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NAME OF FACI	LITY: Sunrise Assisted Living in Wilming	ton DATE SURVEY COMPLETED: Febr	uary 19, 2025
SECTION STA	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	ments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication. This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for two (R5 and R6) out of two residents who were self-administering their medications, the facility failed to provide evidence of the RN assessment of the resident's ability to do so. Findings include: 1. 11/30/23 – R5 was admitted to the facility. The facility lacked evidence of an RN assessment of the resident's cognitive and physical ability to self-administer their medications. 2. 11/6/20 – R6 was admitted to the facility. The facility lacked evidence of an RN assessment of the resident's cognitive and physical ability to self-administer their medications. 2/19/25 - Findings were reviewed with E1 (ED) at the exit conference beginning at approximately 1:50 PM.	fected by this practice. C. A root cause analysis determined an RN did not do an assessment for self-administration of medications upon admission as required. The Resident Services Director will be in-serviced on this regulation by the Executive Director/Designee. D. Weekly audits will be conducted by the Resident Care Director/Designee until compliance is at 100%. Then monthly x2 and the results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	
3225.9.0	Infection Control		
3225.9.6 S/S – D	The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended	R6, R7, R9, and R10 will be offered the	



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	ENT OF DEFICIENCIES ECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	the Immunization Practice Advisor		
	mmittee of the Centers for Disease Cor		
	l, unless medically contraindicated. A		
	idents who refuse to be vaccinate		
	ainst influenza must be fully informe		
	the facility of the health risks involved		
L.	e reason for the refusal shall be doc	I C A POOT COLLEG SHOWER REFERENCE THE	
me	nted in the resident's medical record	nurse(s) did not either document the vac-	
}		to (1) - I - to a -to-on an algebra of The Deal	
	s requirement was not met as evidence	dent Services Director and nurses will be in-	
by:	30		
		serviced on this regulation.	
	sed on record review, interview and re	I I) Weekly stidits will be conducted by the	
	w of other facility documentation, it was	Basidant Cara Director/Designed until com-	
	termined that for three (R2, R5 and R	//	
	t of ten residents sampled, the facili	., ., ., ., ., ., ., ., ., ., ., ., ., .	
	led to provide evidence of the 2024 infl za vaccination or a declination of such.	mittee for further review and appropriate	i i
enz	za vaccination of a declination of such.	changes will be made, if needed.	
1,	12/27/18 – R2 was admitted to the fac	_	
	R2 received the influenza vaccination		
	10/24/23. The facility lacked evidence		
	2024 Influenza vaccination or a declin	. I	
	n of such.		
110	n or such.		
2.	11/30/23 – R5 was admitted to the fac	il-	
	. R5 received the influenza vaccination		
,	3/9/23. The facility lacked evidence of		
	24 Influenza vaccination or a declination		
	such.		
1			
3.	11/20/24 - R7 was admitted to the fac	il-):
ity	. R7 received the influenza vaccination	on	
on	12/26/23. The facility lacked evidence	of	
a 2	2024 Influenza vaccination or a declin	a-	
tio	n of such.		
		<	
2/:	19/25 - Per interview with E1 (ED) at a	p-	
1 .	oximately 1:30 PM, E1 confirmed the va	1 I	
	ation record or declination was not in e	V-	
	ence.	The state of the s	TI.

Title ______ Date ___



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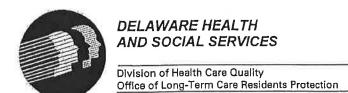
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NAME OF FACILITY:	Sunrise Assisted	Living in Wilmington
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2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM. 3225.9.0 Infection Control 3225.9.7 The 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 other facility documentation, it was determined that for five (R4, R6, R7, R9 and R10) out of ten residents sampled, the facility failed to provide evidence of the vaccination against pneumococcal pneumonia, a vaccination series completion or a vaccination declination. Findings include:	SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
"Pneumococcal Vaccine Timing for Adults- Adults >/= 65 years old Complete pneumo- coccal vaccine schedules PCV13 only at any age- Option A: >/= 1 year, give PVC20,	3225.9.0 3225.9.7	2/19/25 - Findings were reviewed with at the exit conference beginning at approximately 1:50 PM. Infection Control The assisted living facility shall have on five evidence of vaccination against pneum coccal pneumonia for all residents old than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapse and as recommended by the Immunization Practice Advisory Committee of the Ceters for Disease Control, unless medical contraindicated. All residents who refuse to be vaccinated against pneumococcipneumonia 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 evidence by: Based on record review, interview and review of other facility documentation, it was determined that for five (R4, R6, R7, R9 and R10) out of ten residents sampled, the facility failed to provide evidence of the vaccination against pneumococcal pneumonia a vaccination series completion or a vaccination declination. Findings include: "Pneumococcal Vaccine Timing for Adult Adults >/= 65 years old Complete pneumococcal vaccine schedules PCV13 only and the provide evidence of the vaccination series complete pneumococcal vaccine schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedules PCV13 only and the provide evidence of the vaccination schedu	A. R4 no longer resides at the community. R6, R7, R9, and R10 will be offered the pneumococcal pneumonia vaccine. B. All residents have the potential to be affected by this practice. C. A root cause analysis determined the nurse(s) did not either document the vaccine(s) as being given or declined. The Resident Services Director and nurses will be inserviced on this regulation. D. Weekly audits will be conducted by the Resident Care Director/Designee until compliance is at 100%. Then monthly x2 and the results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	•



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NAME OF FACILITY:	Sunrice Accieted	Living in Wilmingt	on
MANUE OF PACILITY.	Sullise Assisted	LIVING III VVIIIIIIII	

DATE SURVEY COMPLETED: February 19, 2025

Date _____

MANIE OF FACILITY, Cumbo Accided Eving in Williamses.			
SECTION ST	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
SECTION	1. 8/1/22 - R4 was admitted to the facility The facility lacked evidence of a pneum coccal vaccination or of a declination such at R4's admission or after. 2. 11/6/20 - R6 was admitted to the facility R6, now aged 72, received the pneumococcal vaccine on 6/22/18. The facility was unable to provide any documentation of the completing the pneumococcal vaccing schedule by receiving an updated vaccing per the CDC schedule or a declination such. 3. 11/20/24 – R7 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination such at R7's admission or after. 4. 11/21/23 - R9 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination such at R9's admission or after. 5.11/21/22 - R10 was admitted to the facility. R10, now aged 85, received the pneumococcal vaccined to the pneumococcal vaccined to the facility. R10, now aged 85, received the pneumococcal vaccined to the pneumococcal vaccined to the facility. R10, now aged 85, received the pneumococcal vaccined to the pneumococcal vaccined to the facility. R10, now aged 85, received the pneumococcal vaccined to the facility. R10, now aged 85, received the pneumococcal vaccined to the facility.	ANTICIPATED DATES TO BE CORRECTED y. Do- of y. Co- n- R6 ne ne of il- u- of iil- u- of iil- u- of	Date
	mococcal vaccine on 3/22/19. The facil was unable to provide any documentation of R10 completing the pneumococcal vacine schedule by receiving an updated vacine per the CDC schedule or a declination of such.	on oc- oc-	
	2/19/25 - Per interview with E1 (ED) at a proximately 1:30 PM, E1 confirmed the vacination records or declinations were not evidence.	nc-	
	2/19/25 - Findings were reviewed with at the exit conference beginning at approimately 1:50 PM.	The state of the s	¥

Provider's Signature ______ Title _____

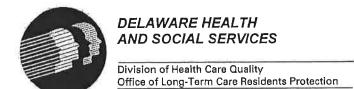


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NAME OF FACILITY: Sunrise Assisted Living in Wilmington DATE SURVEY COMPLETED: February 19, 2025

SECTION STA	SPECIFIC DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.12.0 3225.12.1	Services The assisted living facility shall ensure	A. No residents were affected by the deficient practice.	
	that:	B. All residents have the potential to be affected by this practice.	
3225.12.1.3 S/S – F	Food service complies with the Delaware Food Code	C. A root cause analysis determined the Food Service Coordinator was not ensuring	
-,-	Delaware Food Code 3-501 Temperature and Time Control	the cooks were completing the food temperature logs daily. The Food Service Coordinates and an always the coordinates and an always the coordinates are always to coordinates are always the coordinates are always to coordinates are always to coordinates are always	
	3-501.16 Time/Temperature Control for	dinator and cooks will be in-serviced on this regulation by the Executive Director.	
	Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public	D. Weekly audits will be conducted by the Executive Director/Designee until compliance is at 100%. Then monthly x2 and the	
	health control as specified under §3- 501.19, and except as specified under (B)	results will be presented to the QAPI Committee for further review and appropriate	
	and in (C) of this section, TIME/TEMPER- ATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or	changes will be made, if needed.	
	above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54°C (130°F) or above.	3	
	This requirement is not met as evidenced by:		
	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:		
	2/17/25 11:35 AM — The facility failed to provide a 3-month (starting from mid-November 2024 to the current date) food temperature log.		



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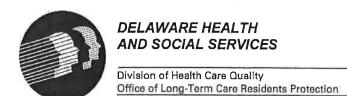
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DATE SUBVEY COMPLETED: February 19, 2025

NAME OF FACILITY:	Sunrise Assisted Living in Wilming	<u>on</u> DATES	URVEY COMPLETED: Febr	uary 19, 2025
	NT OF DEFICIENCIES	CORRECTION C	ATOR'S PLAN FOR OF DEFICIENCIES WITH TES TO BE CORRECTED	Completion Date
the fa 3-mo 5-50: (A) R for R used due a LISHI structor corfor R shall item clear Base dete vide off volume site of dum prop stern firms 2/17 E1 (E	25 3:37 PM – E1 (ED) confirmed that acility did not have the record of the onth food temperature log. 1.15 Outside Receptacles eceptacles and waste handling units EFUSE, recyclables, and returnables with materials containing FOOD resigned used outside the FOOD ESTABMENT shall be designed and consted to have tight-fitting lids, doors, overs. A storage area and enclosure EFUSE, recyclables, or returnables be maintained free of unnecessary s, as specified under § 6-501.114, and on observation and interview, it was rmined that the facility failed to prosafe sanitary environment to guard ermin. Findings include: /25 12:15 PM - The Surveyor had a with E4 (MC) to the trash collecting outside the facility. The lid of the pster was broken and not closed erly, also two side doors of the dump were left open. The findings were consecutive with E4 on site.	deficien B. All resid be affec C. A root c the Mai not chec ensure i dition an turn we dumpste two side nance C viced or utive Di D. Weekly the Exec until con monthly present for furth changes	lents were affected by the t practice. ents have the potential to sted by this practice. ause analysis determined intenance Coordinator did ock the lid of the dumpster to it was in good working connected two side doors, which in re open. The lid to the er has been replaced. The er are closed. The Maintenance will be in-servector. In this regulation by the Exected this regulation by the Exected this regulation by the Exected this will be conducted by cutive Director/Designee in pliance is at 100%. Then y x2 and the results will be ed to the QAPI Committee ther review and appropriate is will be made, if needed.	
3225.13.3 The cian(ice Agreements resident's personal attending physi- (s) shall be identified in the service ement by name, address, and tele- ne number.	deficient pro reside at the agreements	ents were affected by the actice. R3 and R4 no longer e community. The service have been updated with an's address and phone	

Title _



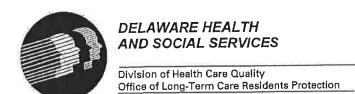
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NAME OF FACILITY: Sunrise Assisted Living in Wilming
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This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for ten (R1, R2, R3, R4, R5, R6, R7, R8, R9 and R10) out of ten sampled residents, the facility failed to provide evidence that the service agreement included the residents' personal Physician's address and phone number. Findings include: 1. 6/9/23 - R1 was admitted to the facility. The Service Agreements dated 9/4/24 and 9/24/24 did not include the residents' personal Physician's address and phone number. 2. 12/27/18 - R2 was admitted to the facility. The Service Agreements dated 3/1/24, 5/15/24 and 11/3/24 did not include the residents' personal Physician's address and phone number. 3. 1/14/25 - R3 was admitted to the facility. The Service Agreements dated 3/1/24, 5/15/24 and 11/3/24 did not include the residents' personal Physician's address and phone number.	ST SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
ity. The Service Agreements dated 1/2/25 and 1/15/25 did not include the residents' personal Physician's address and phone	ST	This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for ten (R1, R2, R3, R4, R5, R6, R7, R8, R9 and R10) out of ten sampled residents, the facility failed to provide evidence that the service agreement included the residents' personal Physician's address and phone number. Findings include: 1. 6/9/23 - R1 was admitted to the facility. The Service Agreements dated 9/4/24 and 9/24/24 did not include the residents' personal Physician's address and phone number. 2. 12/27/18 - R2 was admitted to the facility. The Service Agreements dated 3/1/24, 5/15/24 and 11/3/24 did not include the residents' personal Physician's address and phone number. 3. 1/14/25 - R3 was admitted to the facility. The Service Agreements dated 1/2/25 and 1/15/25 did not include the residents'	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED number for R1, R2, R5, R6, R7, R8, R9, R10. B. All residents have the potential to be affected by this practice. C. A root cause analysis determined a lack of knowledge the physician address and phone number are to be included on the service agreement. The Executive Director/Designee will in-service licensed nurses on this regulation. D. Weekly audits will be conducted by the Executive Director/Designee until compliance is at 100%. Then monthly x2 and the results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	Completion

Provider's Signature	Title	Date	



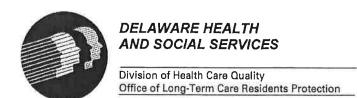
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ECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	6. 11/6/20 – R6 was admitted to the facility. The Service Agreement dated 10/17/2 did not include the residents' personal Physician's address and phone number.		
	7. 11/20/24 - R7 was admitted to the facility. The Service Agreements dated 10/12/24 and 11/21/24 dld not include the residents' personal Physician's address are phone number.	e	
	8. 7/3/21 - R8 was admitted to the facility The Service Agreement dated 10/29/24 d not include the residents' personal Physi- cian's address and phone number.	id	
	9. 11/21/23 - R9 was admitted to the faci ity. The Service Agreement dated 11/26/2 did not include the residents' personal Physician's address and phone number.		
	10. 11/21/22 - R10 was admitted to the facility. The Service Agreements dated 7/3/24 and 12/14/24 did not include the residents' personal Physician's address as phone number.		
	2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the Service Agreement form being used by the facility does not contain the Physician's address and phone number.	ne l	
A	2/19/25 - Findings were reviewed with Estate the exit conference beginning at approximately 1:50 PM.		
3225.16.0	Staffing		
3225.16.2 S/S – E	A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the	A. R4 and R13 no longer reside at the community. R1, R5, R7 and were not affected by the deficient practice.	
-	20.000 00	Title Date	

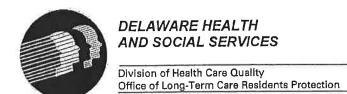


STATE SURVEY REPORT

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NAME OF FACILITY:	Sunrise	Assisted I	iving in	Wilmington

STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
residents shall be employed and shall comply with applicable state laws and regulations. State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practica nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties 2024Post Fall Assessment & Documentation- RN" Updated 4/10/24. This requirement was not met as evidenced by: Based on record review, interviews and other facility documentation, it was determined that five (R1, R4, R5, R7 and R13) out of thirteen residents reviewed for accidents, the facility failed to ensure that nursing services met professional standards as evidenced by having LPNs complete the post fall assessment and documentation which violates the Delaware State Board of Nursing Scope of Practice. Findings include: 1. 6/9/23 - R1 was admitted to the facility 9/20/24 at 10:45 PM - Per EMR documentation by E12 (LPN) noted {sic}" Fall was witnessed in residents' room 09/20/2024 8:05 PM. Recliner was in high position Resident slid out of chair was about to fall and care manager caught her. A bruise appeared on right arm. Post fall evaluation: VS: BP 120/53 - 9/20/2024 22:46 Position: Sitting r/arm P 68 - 9/20/2024 22:46 Position: Sitting r/arm P 68 - 9/20/2024 22:47 Route: Tympanic R 18 - 9/20/2024 22:47	B. All residents have the potential to be affected by this practice. C. A root cause analysis determined a lack of knowledge of this regulation. The Executive Director/Designee will inservice licensed nurses on this regulation. The Resident Care Director will ensure that only an RN can complete a post fall assessment. D. Weekly audits will be conducted by the Executive Director/Designee until compliance is at 100%. Then monthly x2 and the results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	



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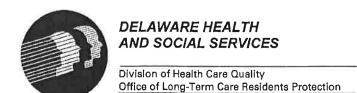
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Provider's Signature _____ Title _

DATE SURVEY COMPLETED: February 19, 2025

Date__

NAME OF FACIL	.ITY: Sunrise Assisted Living in Wilmin	gton DATE SURVET CONFELTED. Feb	duly lo, zozo
SECTION STA	TEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
SECTION	Fall resulted in an injury to the resident: bruise on right forearm". The post fall assessment was completed E12, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 10/11/24 at 11:58 AM - Per EMR documentation by E16 (LPN) noted: {sic} "Fall was unwitnessed in residents room 10/11/2024 4:38 AM. She was trying to move from her bed to her chair. The CM entered the resident's room for her roun and saw the resident lying on the floor of her back with the wheelchair and walker next to her. The resident stated she was trying to get out of the bed and back into chair. She forgot to press her call bell for help. Post fall evaluation: VS:BP 116/66-10/11/2024 11:59 Position: Other P 73-10/11/2024 12:00 Pulse Type: Regular T 98.0 - 10/11/2024 12:02 Route: Forehead (non-contact) R 20 - 10/11/2024 12:02. Ninjury noted at time of fall". The post fall assessment was completed E16, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 2. 8/1/22 - R4 was admitted to the facilit 8/13/24 at 5:18 PM - Per EMR document tion by E17 (LPN) noted: {sic} "Fall was u witnessed in residents' room 08/13/2026 5:18 PM. Resident states that she was reaching for a pair of shoes in her closet	ANTICIPATED DATES TO BE CORRECTED OY distribution of the control	Date
	and lost her balance and fell on her bottom. She denies hitting her head, denies		



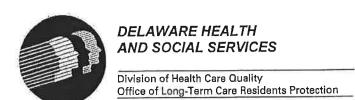
STATE SURVEY REPORT

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NAME OF FACILITY:	Sunrise Assisted	Living in Wilmington
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DATE SURVEY COMPLETED: February 19, 2025

	CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
pain of discomfort. She states she is embarrassed more than anything. Post fall evaluation: VS: BP 149/81 - 8/13/2024 21:41 Position: Sitting I/arm P 92 - 8/13/2024 21:42 Pulse Type: Regular T 97.5 - 8/13/2024 21:42 Route: Forehea (non-contact) R 20 - 8/13/2024 21:42.N injury noted at time of fall. Resident ha full range of motion with all extremities Denies pain, no new skin tears noted. R dent was assisted up from the floor by person assist. No other concerns voiced	d do s s. desi- 2	
The post fall assessment was complete E16, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3. 11/30/23 - R5 was admitted to the faity.		
10/27/24 at 12:06 PM - Per EMR documentation by E18 (LPN) noted: {sic} "Fawas unwitnessed in residents' room 10/27/2024 10:15 AM. Resident stated slid out of bed when she was trying to gout of bed. She had no shoes on feet. P fall evaluation: VS: BP 144/90 -	she get	
10/27/2024 12:07 Position: Sitting I/arr 77 - 10/27/2024 12:07 Pulse Type: Regu T 97.0 - 10/27/2024 12:08 Route: Tym- panic R 20 - 10/27/2024 12:09 No injury noted at time of fall".	ular	
The post fall assessment was completed E18, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.	- '	

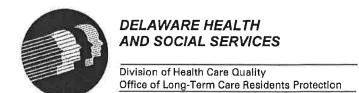


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DATE SURVEY COMPLETED: February 19, 2025

NAME OF	ACILITY: Sunrise Assisted Living in Wilmin	ton DATE SURVET COMPLETED. Febr	ualy 15, 2025
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	4. 11/20/24 - R7 was admitted to the facility. 12/6/24 at 10:30 AM - Per EMR documentation by E10 (LPN) noted {sic} "Fall was unwitnessed in residents room 12/06/2024 10:30 AM. Resident found on the floor in his room saying he fell he was laying on the mat with his legs bent and head towards the wall no pain at this time he was assisted up by staff and full set of vitals were taken. Post fall evaluation: VS BP 110/72 - 12/6/2024 12:15 Position: Lying I/arm P 80 - 12/6/2024 12:22 Pulse Type: Regular	is e	
	T 97 - 12/6/2024 12:22 Route: Forehead (non-contact) R 18 - 12/6/2024 12:22 No injury noted at time of fall". The post fall assessment was completed E10, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.	ру	
	12/23/24 at 2:34 AM - Per EMR documer tation by E8 (LPN) noted {sic} "Fall was unwitnessed in residents room 12/23/2024 12:45 AM. Resident stated that he rolled off the bed. Post fall evaluation: VS:BP 125/81 - 12/23/2024 02:35 Position: Lyin r/arm P 62 - 12/23/2024 02:36 Pulse Typ UTD - Unable to Determine T 98.1 - 12/23/2024 02:36 Route: Forehead (noncontact) R 20 - 12/23/2024 02:37. No injury noted at time of fall".	g e:	
	The post fall assessment was completed E8, not an RN as required by the Delawar	• 1	



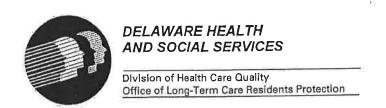
STATE SURVEY REPORT

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NAME OF FACILITY:	Sunrise	Assisted	Livina	in Wilmingt	on
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DATE SURVEY COMPLETED: February 19, 2025

SECTION	TATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	State regulation of the Board of Nursing Scope of Practice.		
	1/22/25 at 10:59 AM - Per EMR documentation by E16 (LPN) noted {sic} ": Fall was unwitnessed in residents room 01/22/2025 8:10 AM. The resident was heard calling out from his room. Walked in to observe him kneeling on the floor next to his bed, holding onto his halorail. No injuries observed. He was unable to explain why he was on the floor. Bed was in lowest position. He complained of foot pain and give PRN for it. Also complained of being hungry. He was given care and breakfast. Post fall evaluation: VS:BP 155/97 - 1/22/2025 11:00 Position: Lying r/arm P 64 - 1/11/2025 10:02 Pulse Type: Regular T 98.4 - 1/11/2025 10:02 Route: Forehead (non-contact) R 20.0 - 1/11/2025 10:02. No injury noted at time of fall".		
	The post fall assessment was completed by E16, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.		
	2/1/25 at 2:33 AM - Per EMR documentation by E16 (LPN) noted {sic} "Fall was unwitnessed in residents room 01/31/2025 8:30 PM. The resident was unable to inform of how he fell. The resident was observed lying on his right side on the fall mat. He was assisted back to bed. Skin tear observe on his right knee. Cleansed and covered. Denied pain or discomfort. No s/s of discomfort. Vitas Hospice notified. Daughter informed. Message to PCP. Post fall evaluation: VS:BP 120/72 - 2/1/2025 02:40 Position: Other P 73 - 2/1/2025		



STATE SURVEY REPORT

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Date___

SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	02:41 Pulse Type: Regular T 97.1 - 2/1/2025 02:41 Route: Forehead (non-cotact) R 17 - 2/1/2025 02:41. Fall resulted in an injury to the resident: Skin tear on right knee".		
	The post fall assessment was completed E16, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.	by	
*	2/13/25 at 7:45 AM - Per EMR document tion by E18 noted {sic} "Fall was unwitnessed in residents room 02/13/2025 7:4 AM. Staff found resident in a seating postion holding the Halo's, facing the wall by the recliner on his floor mat. Post fall evaluation: VS: BP 100/62 - 2/13/2025 15:14 Position: Sitting r/arm P 84 - 2/13/2025 15:14 Pulse Type: Regular T 98.6 - 2/13/2025 15:14 Route: Tympanic R 18 - 2/13/2025 15:14. No injury noted at time of fall".	i- / NI-	
	The post fall assessment was completed E18, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.	by	
	5. 5/23/24 - R13 was admitted to the facility.	il-	
	9/16/24 at 11:42 PM - Per EMR documentation by E12 (LPN) noted {sic} "Fall was unwitnessed in residents room 09/16/2024 9:30 PM. Resident said he was trying to get up in his wheel chair and sli out of his chair. Post fall evaluation: VS: 117/68 - 9/15/2024 12:13 Position: Sittin I/arm P 68 - 9/15/2024 12:14 Pulse Type Regular T 98.2 - 9/15/2024 12:14 Route:	ras d BP ng :	

Provider's Signature ______ Title _____



STATE SURVEY REPORT

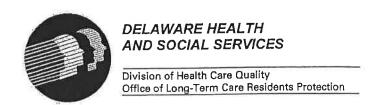
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NAME OF FACILITY: Sunrise Assisted Living in Wilmington	IAME OF FACILITY:	Sunrise Assisted	Living in	Wilmingto
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Office of Long-Term Care Residents Protection

DATE SURVEY COMPLETED: February 19, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Tympanic R 20.0 - 9/15/2024 12:14. No injury noted at time of fall".		
	The post fall assessment was completed by E12, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.		
	11/27/24 at 9:15 PM - Per EMR documentation by E9 (LPN) noted {sic} "Fall was unwitnessed in residents room 11/27/2024 6:00 PM. Resident unable to describe the event and how they felt just prior to falling. Post fall evaluation: VS: BP 135/74 - 11/20/2024 13:40 Position: Sitting r/arm P 65 - 11/27/2024 18:00 Pulse Type: Regular T 97.2 - 11/27/2024 18:00 Route: Forehead (non-contact) R 20 - 11/27/2024 18:00. No injury noted at time of fall".	×	
	The post fall assessment was completed by E9, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.		
	1/8/25 at 12:22 PM - Per EMR documentation by E18 (LPN) noted {sic} "Fall was unwitnessed in residents room 01/08/2025 8:37 AM. Resident was yelling out for help, when staff entered the room observed resident on floor on his back with his head in between the bed and night stand. Resident unable to say what happened. Post fall evaluation: VS: BP 122/68 - 1/8/2025 12:29 Position: Sitting I/arm P 72 - 1/8/2025 12:30 Pulse Type: Regular T 97.8 - 1/8/2025 12:30 Route: Tympanic R 18 - 1/8/2025 12:30. No injury noted at time of fall".		
Provider's Si	gnature 1	itle Date	

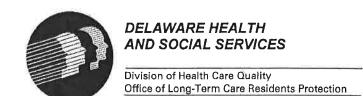


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NAME OF FACILITY: Sunrise Assisted Living in Wilmington DATE SURVEY COMPLETED: February 19, 2025

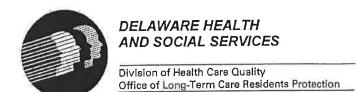
WAINE OF TA	CILITY: Sulling Assisted Living in Williams		
SECTION ST	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	The post fall assessment was completed b	у	1
	E18, not an RN as required by the Dela-		Ì
	ware State regulation of the Board of		
	Nursing Scope of Practice.		
	1/14/25 at 7:39 AM - Per EMR documenta	-	,
	tion by E8 (LPN) noted {sic} "Fall was un-		
	witnessed in residents room 01/14/2025		a
	12:15 AM. Resident was laying on the floo	r	
	at the foot of his bed near his dresser with	1	
	his head facing the window. Resident una		
	ble to state where he was going or how he	<u> </u>	
	fell out of bed. He stated that he dragged		
	himself from the side of the bed to the		
	foot of the bed near his dresser. Denies		
	hitting head. no signs that he did. AROM		
	mental status at baseline. Denies pain/dis	-	
	comfort. Assisted resident off the floor		
	safely. 2 skin tears one on each lateral as-		
	pect of knees. Post fall evaluation: VS:BP		
	120/55 - 1/14/2025 00:44 Position: Lying		
	l/arm P 65 - 1/14/2025 00:44 Pulse Type:		
	UTD - Unable to Determine T 97.7 -		
	1/14/2025 00:44 Route: Forehead (non-		
	contact) R 20.0 - 1/10/2025 21:34. Fall re-		N.
	sulted in an injury to the resident:2 skin		
	tears one each on the lateral side of each	P.	
	knee".		1
	The post fall assessment was completed by	NV	
	E8, not an RN as required by the Delaware	- 1	
	State regulation of the Board of Nursing	'	
	Scope of Practice.		
	Scope of Flactice.		
1	1/27/25 at 7:15 AM - Per EMR documenta	ı -	
	tion by E18 (LPN) noted {sic} "Fall was un-		
	witnessed in residents room 01/27/2025		
	5:00 AM. Staff was doing rounds and		
	found resident on floor next to bed. Resi-		
	dent did not have call pendent around his		



STATE SURVEY REPORT

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SECTION ST	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	neck. Skin tear observed on back of left		1
	hand and redness on 2nd toe, scabs ob-		
	served also to area. Medication care man-		
	ager and care staff assisted him back to		
	bed, vital signs done, this nurse rechecked		
	B/P 110/60. Intervention: Have staff be-		
	come familiar with my daily routine and at-		
	tempt to anticipate and meet my daily		
	needs. Post fall evaluation: VS: BP 110/60 -		1
	1/27/2025 07:57 Position: Lying I/arm P 76		
	- 1/27/2025 07:57 Pulse Type: Regular T		
	97.8 - 1/27/2025 07:57 Route: Tympanic R		
	20 - 1/27/2025 07:58. Fall resulted in an		
	injury to the resident: Skin tear on back of		
	left hand and redness with scabs to 2nd		
	toe on right foot".		
	The post fall assessment was completed by		
	E18, not an RN as required by the Dela-		
	ware State regulation of the Board of		
	Nursing Scope of Practice.		
	2/2/25 at 11:23 PM - Per EMR documenta-		
	tion by E12 (LPN) noted {sic} "Fall was un-		
	witnessed in residents room 02/02/2025		
	8:25 PM. Resident was not able to tell how		
	he fell. Nurse was taking medication into		
	room for resident, found resident on floor		
	next to bed on the window side. Resident	1	
	did not have call pendent around his		
	neck". "Post fall evaluation: VS:BP 109/72	1	e
	- 2/2/2025 12:01 Position: Lying r/arm P 44		
	- 2/2/2025 12:02 Pulse Type: Regular T		
	97.0 - 2/2/2025 12:02 Route: Tympanic R		
	20.0 - 2/2/2025 12:02. Fall resulted in an		
	injury to the resident: A bruise appeared	2 = =	
	on right fore head one hour after fall".		
		I	1



STATE SURVEY REPORT

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NAME OF FACILITY: Sunrise Assisted Living in Wilmington

Provider's Signature ______ Title ___

DATE SURVEY COMPLETED: February 19, 2025

_____ Date ____

SECTION STA	TEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.18.0 3225.18.6 3225.18.6.2 S/S – E	The post fall assessment was completed be E12, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the LPNs in the facility are performing the postfall assessments. E1 stated she will research options available for post-fall assessments going forward. 2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM. Emergency Preparedness Each facility shall submit with an application for a license and annual renewal of a license: Copies of the FEMA certificate of achievement which demonstrate that at least two active, full-time employees have completed FEMA training in ICS-100 and NIMS-700a in the past 24 months. This requirement was not met as evidenced by: Based on interview and review of other facility documentation, the facility lacked evidence of two fulltime staff members having the ICS-100 and NIMS-700a FEMA certification. Findings include: 2/18/25 - Per interview with E4 (MC) at approximately 1:30 PM, E4 confirmed that currently he is the only active fulltime employee who has the FEMA certification. Eastated the second person (the former ED) stated the second person (the former ED)	A. No residents were affected by the deficient practice. B. All residents have the potential to be affected by this practice. C. A root cause analysis determined the Maintenance Coordinator has a FEMA Certification and a new Executive Director had started just before the survey and did not complete the FEMA Certification course. The Executive Director will take the FEMA course and receive certification so there are 2 staff members with this certification. D. The course will be completed by the Executive Director and presented to the QAPI Committee for review.	



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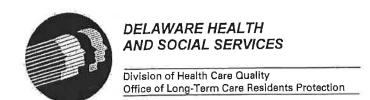
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NAME OF FACILITY: Sunrise Assisted Living in Wilmington

Office of Long-Term Care Residents Protection

DATE SURVEY COMPLETED: February 19, 2025

SECTION STA	TEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.19.0	was the other employee who maintained a FEMA certification. 2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed that there is only one employee who currently has the FEMA certification. E1 stated she is planning to complete the FEMA certification in the near future. 2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM. Records and Reports	A. R4 no longer resides at the commu-	
3225.19.6	Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.	B. All residents have the potential to be affected by this practice.C. A root cause analysis determined the Resident Care Director mistakenly for-	4
3225.19.7 3225.19.7.1.3	Reportable incidents include: Emotional abuse.	got to report the fall with injury within 8 hours of the incident. The Executive Director/Designee will in-service the	
3225.19.7.1.3.1	Staff to resident.	Resident Care Director on timely reporting of incidents.	
S/S – D	Based on record review, interview and review of other facility documentation, it was determined that for one (R4) out of thirteen sampled residents for incidents, the facility failed to report an altercation between a staff member and resident within the 8-hour reporting regulation. Findings include: 8/1/22 – R4 was admitted to the facility. 7/8/24 – E11 (LPN) witnessed an altercation between E19 (care manager) and R4 at approximately 12:40 PM. E11 stated E19	D. Weekly audits will be conducted by the Executive Director/Designee until compliance is at 100%. Then monthly x2 and the results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	



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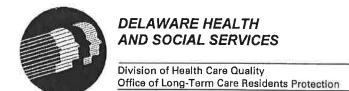
NAME OF FACILITY: Sunrise Assisted Living in Wilmington

Provider's Signature _____

DATE SURVEY COMPLETED: February 19, 2025

STA SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	was yelling, using profanity and name calling to R4. E11 reported this incident to the ED (no longer active) several weeks later. Per facility documentation, E19 was placed on suspension and subsequently her employment was terminated. The facility failed to report this staff to res		
	ident altercation to the State Agency until 8/8/24, a month after the incident occurred and not within the 8-hour reportin regulation.		=
	2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 was unsure of the incident as it was prior to her being hired. E1 was able to supply the staff training reords dating between 7/15/24-7/30/24 on reporting of incidents. E1 confirmed that E19 was no longer an employee in the facility.	e c-	
	2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approimately 1:50 PM.		
3225.19.0	Records and Reports	A. R4 no longer resides at the commu-	
3225.19.7.7.2 S/S – D	Injury from a fall which results in transfe to an acute care facility for treatment or evaluation or which requires periodic re- assessment of the resident's clinical sta-	R All residents have the notential to be	
	tus by facility professional staff for up to 48 hours.	C. A root cause analysis determined the Resident Care Director mistakenly for-	
	Based on record review, interview, facility incident report and the State Agency Reporting System, it was determined that for one (R4) out of thirteen sampled resident for incidents, the facility failed to report a	Director/Designee will in-service the Resident Care Director on timely re-	ő

Title _____ Date ___

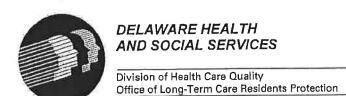


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NAME OF FACILITY: Sunrise Assisted Living in Wilmington DATE SURVEY COMPLETED: February 19, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.19.0 3225.19.7.6 S/S D	fall with injury to the State Agency Reporting System within 8 hours of the incident. Findings include: 3/9/23 – R1 was admitted to the facility. 6/4/24 – R1 sustained a fall hitting her head on the ground. R1 was transported to the ER for evaluation. The hospital findings were that R1 sustained a fracture of her left Acetabular and Pubic Rami and declined any surgical intervention. The facility reported the fall with injury to the State on 6/12/24, eight days after the incident occurred, not within the 8-hour regulation. 2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 was unsure of the incident as it was prior to her being hired. E1 stated the DON was on leave of absence and unable to clarify incident further of why the incident was not reported timely. 2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM. Records and Reports Death of a resident in a facility or within 5 days of transfer to an acute care facility. Based on record review, interview and the State Agency Reporting System, it was determined that for two (R3 and R13) out of two sampled residents for deaths, the facility failed to report to the State a resident's death. Findings include:		



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IAME OF FACILITY: Sunrise	Assisted Living in Wilmingto
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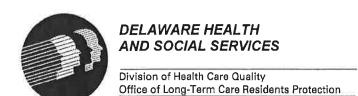
Provider's Signature _____

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1. 1/14/25 – R3 was admitted to the facility. 2/6/25 – R3 expired at the facility under Hospice care. The facility failed to report the death to the State. 2. 5/23/24 – R13 was admitted to the facility. 2/8/25 – R13 expired at the facility under Hospice care. The facility failed to report the death to the State. 2/18/25 - Per interview with E1 (ED) at all proximately 10:30 AM, E1 confirmed the two deaths did not get reported to the State. E1 stated she was unaware that deaths needed to be reported in the Assisted Living facility and reported them once the Surveyor called it to her attention. 2/19/25 - Findings were reviewed with E at the exit conference beginning at approximately 1:50 PM.	cal Nurse will in-service the Executive Director on reporting deaths. D. Weekly audits for the reporting of deaths will be conducted by the Executive Director/Designee until compliance is at 100%. Then monthly x2 and the results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	

_ Title _____

Date ____



STATE SURVEY REPORT

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Provider's Signature ______ Title _____