DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

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
	An unannounced Annual and Complaint Survey was conducted at this facility from February 17, 2025, through February 19, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was seventy-two (72). The survey sample totaled ten (10) residents plus three (3) additional subsampled residents. Abbreviations/definitions used in this state report are as follows: Acetablular Fracture – A break in your hip socket that usually requires surgery; CDC – Centers for Disease Control; DelVax - Delaware's state immunization registry that serves as a database to contain the immunization records of Delaware residents; Dementia – a condition that affect the brain's ability to think, remember, and function normally; DON – Director of Nursing; DOS – Director of Sales; ED - Executive Director; HALO - A metal brace that circles and attaches to your skull. It is used to keep the bones in your cervical spine (neck) from moving; LPN - Licensed Practice Nurse; Pubic Rami Fracture – A crack or break in a person's pelvis; RCD - Resident Care Director; RN – Registered Nurse; 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		4/1/25 for ALL Deficiencie

Provider's Signature Rebecca White NHA Title Executive Director Date 3/14/25

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	include: lodging, board, housekeeping, personal care, and supervision services.	A. No residents were affected by the deficiency.	
3225	**Assisted Living Facilities**	B. All residents have the potential to be affected by this practice. E14 and E16 will receive the mandatory annual dementia training.	
3225.5.0	**General Requirements**	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.	
3225.5.12 S/S – D	**An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for two (E14 and E16) out of seven employees sampled for dementia specific training, the facility failed to provide evidence of the mandated annual dementia specific training. Findings include: 1. 11/9/09 - E14 (LPN) was hired. The dementia training in evidence was completed on 7/19/23. The facility failed to provide evidence of the mandated yearly dementia specific training for the calendar year 2024.	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.	

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	2. 4/23/12 - E16 (LPN) was hired. The dementia training in evidence was completed on 8/30/23. The facility failed to provide evidence of the mandated yearly dementia specific 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 E1 at the exit conference beginning at approximately 1:50 PM.		
3225.7.0 **3225.7.2** **3225.7.3** **3225.7.3.3** **3225.7.3.4** **3225.7.3.5** **S/S – E**	**Specialized Care for Memory Impairment** **Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.** **The information disclosed shall explain the additional care that is provided in each of the following areas:** **Pre-Admission, Admission & Discharge: the process and criteria for placement, transfer or discharge from this specialized care;** **Assessment, Care Planning & Implementation: the process used for assessment and establishing and updating the service agreement and its implementation,** **Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care.** This requirement was not met as evidenced by:	A. No residents were affected by the deficiency. B. All residents have the potential to be affected by this practice. C. A root cause analysis determined the community did not include written documentation for the memory impairment persons information related to preadmission, admission and discharge, assessment, care planning and implementation, staffing plan, and training policies. During community tours the Sales Director has been providing this information verbally. This information will be updated in writing for those seeking specialized care for memory impairment. The Sales Director will be in-serviced by the Executive Director on documentation for memory impairment persons. D. Weekly audits will be conducted by the Executive Director/Designee until compliance is at 100%. Then monthly x2 and the	

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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 the above elements. Findings include: Review of the memory care materials did not contain the information for the Pre-Admission, Admission & Discharge. Review of the memory care materials did not contain the information for the Assessment, Care Planning & Implementation. Review of the memory care materials did not contain the information for the Staffing Plan and Training Policies. 2/18/25 - Per interview with E6 (DOS) at approximately 1:30 PM, E6 confirmed the company's memory care information was lacking in those areas. 2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the memory care information needed an update to include this information. E1 stated during a tour of the facility, the person seeking specialized care for memory impairment were informed verbally of these elements. 2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM.	results will be presented to the QAPI Committee for further review and appropriate changes will be made, if needed.	
3225.8.0 3225.8.6 S/S – D	**Medication Management** **Within 30 days after a resident's admission and concurrent with all UAI-based assess-**	A. No residents were affected by the deficiency. R5 and R6 have been cognitively and physically assessed by an RN and are able to self-administer medications.	

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	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.	B. All residents have the potential to be affected 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 **3225.9.6** **S/S – D**	**Infection Control** **The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended**	A. R4 no longer resides at the community. R6, R7, R9, and R10 will be offered the	

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	by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record. 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 (R2, R5 and R7) out of ten residents sampled, the facility failed to provide evidence of the 2024 influenza vaccination or a declination of such. 1. 12/27/18 – R2 was admitted to the facility. R2 received the influenza vaccination on 10/24/23. The facility lacked evidence of a 2024 Influenza vaccination or a declination of such. 2. 11/30/23 – R5 was admitted to the facility. R5 received the influenza vaccination on 3/9/23. The facility lacked evidence of a 2024 Influenza vaccination or a declination of such. 3. 11/20/24 – R7 was admitted to the facility. R7 received the influenza vaccination on 12/26/23. The facility lacked evidence of a 2024 Influenza vaccination or a declination of such. 2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the vaccination record or declination was not in evidence.	pneumococcal pneumonia vaccine. Residents R2, R5, and R7 will be offered the Influenza 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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	2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM.		
3225.9.0 **3225.9.7** **S/S – E**	**Infection Control** **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: "Pneumococcal Vaccine Timing for Adults-Adults >/= 65 years old Complete pneumococcal vaccine schedules... PCV13 only at any age- Option A: >/= 1 year, give PVC20, Option B: >/= 1 year, give PPSV23." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.	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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	1. 8/1/22 - R4 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of 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 R6 completing the pneumococcal vaccine schedule by receiving an updated vaccine per the CDC schedule or a declination of such. 3. 11/20/24 – R7 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of 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 of such at R9's admission or after. 5.11/21/22 - R10 was admitted to the facility. R10, now aged 85, received the pneumococcal vaccine on 3/22/19. The facility was unable to provide any documentation of R10 completing the pneumococcal vaccine schedule by receiving an updated vaccine per the CDC schedule or a declination of such. 2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the vaccination records or declinations were not in evidence. 2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM.		

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3225.12.0 **3225.12.1** **3225.12.1.3** **S/S – F**	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** **3-501 Temperature and Time Control** **3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or 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.** 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.	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 Food Service Coordinator was not ensuring the cooks were completing the food temperature logs daily. The Food Service Coordinator and cooks will be in-serviced on this regulation by the Executive Director. 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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	2/17/25 3:37 PM – E1 (ED) confirmed that the facility did not have the record of the 3-month food temperature log. **5-501.15 Outside Receptacles** **(A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. A storage area and enclosure for REFUSE, recyclables, or returnables shall be maintained free of unnecessary items, as specified under § 6-501.114, and clean.** Based on observation and interview, it was determined that the facility failed to provide safe sanitary environment to guard off vermin. Findings include: 2/17/25 12:15 PM - The Surveyor had a tour with E4 (MC) to the trash collecting site outside the facility. The lid of the dumpster was broken and not closed properly, also two side doors of the dumpster were left open. The findings were confirmed with E4 on site. 2/17/25 – The findings were reviewed with E1 (ED) at approximately 3:37 PM during the environmental exit conference.	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 did not check the lid of the dumpster to ensure it was in good working condition and two side doors, which in turn were open. The lid to the dumpster has been replaced. The two side are closed. The Maintenance Coordinator will be in-serviced on this regulation by the Executive Director. 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.	
3225.13.0 **3225.13.3** **S/S – B**	**Service Agreements** **The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.**	A. No residents were affected by the deficient practice. R3 and R4 no longer reside at the community. The service agreements have been updated with the physician's address and phone	

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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 1/2/25 and 1/15/25 did not include the residents' personal Physician's address and phone number. 4. 8/1/22 - R4 was admitted to the facility. The Service Agreement dated 8/12/24 did not include the residents' personal Physician's address and phone number. 5. 11/30/23 - R5 was admitted to the facility. The Service Agreements dated 6/26/24 and 12/20/24 did not include the residents' personal Physician's address and phone number.	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.	

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	6. 11/6/20 – R6 was admitted to the facility. The Service Agreement dated 10/17/24 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 did not include the residents' personal Physician's address and phone number. 8. 7/3/21 - R8 was admitted to the facility. The Service Agreement dated 10/29/24 did not include the residents' personal Physician's address and phone number. 9. 11/21/23 - R9 was admitted to the facility. The Service Agreement dated 11/26/24 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 and 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. 2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM.		
3225.16.0 3225.16.2 S/S – E	**Staffing** **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.	

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	residents shall be employed and shall comply with applicable state laws and regulations. **State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties 2024...Post 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 Pulse Type: Regular T 97.8 - 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 in-service 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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	Fall resulted in an injury to the resident: bruise on right forearm". 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. 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 rounds and saw the resident lying on the floor on 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. 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. 8/1/22 - R4 was admitted to the facility. 8/13/24 at 5:18 PM - Per EMR documentation by E17 (LPN) noted: {sic} "Fall was unwitnessed in residents' room 08/13/2024 5:18 PM. Resident states that she was reaching for a pair of shoes in her closet and lost her balance and fell on her bottom. She denies hitting her head, denies		

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	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 l/arm P 92 - 8/13/2024 21:42 Pulse Type: Regular T 97.5 - 8/13/2024 21:42 Route: Forehead (non-contact) R 20 - 8/13/2024 21:42.No injury noted at time of fall. Resident has full range of motion with all extremities. Denies pain, no new skin tears noted. Resident was assisted up from the floor by 2 person assist. No other concerns voiced". 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. 3. 11/30/23 - R5 was admitted to the facility. 10/27/24 at 12:06 PM - Per EMR documentation by E18 (LPN) noted: {sic} "Fall was unwitnessed in residents' room 10/27/2024 10:15 AM. Resident stated she slid out of bed when she was trying to get out of bed. She had no shoes on feet. Post fall evaluation: VS: BP 144/90 - 10/27/2024 12:07 Position: Sitting l/arm P 77 - 10/27/2024 12:07 Pulse Type: Regular T 97.0 - 10/27/2024 12:08 Route: Tympanic R 20 - 10/27/2024 12:09 No injury noted at time of fall". The post fall assessment was completed by E18, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.		

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	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 his 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 l/arm P 80 - 12/6/2024 12:22 Pulse Type: Regular 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 by E10, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 12/23/24 at 2:34 AM - Per EMR documentation 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: Lying r/arm P 62 - 12/23/2024 02:36 Pulse Type: UTD - Unable to Determine T 98.1 - 12/23/2024 02:36 Route: Forehead (non-contact) R 20 - 12/23/2024 02:37. No injury noted at time of fall". The post fall assessment was completed by E8, not an RN as required by the Delaware		

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	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		

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	02:41 Pulse Type: Regular T 97.1 - 2/1/2025 02:41 Route: Forehead (non-contact) 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 by E16, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 2/13/25 at 7:45 AM - Per EMR documentation by E18 noted {sic} "Fall was unwitnessed in residents room 02/13/2025 7:45 AM. Staff found resident in a seating position 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". The post fall assessment was completed by E18, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 5. 5/23/24 - R13 was admitted to the facility. 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 slid out of his chair. Post fall evaluation: VS: BP 117/68 - 9/15/2024 12:13 Position: Sitting l/arm P 68 - 9/15/2024 12:14 Pulse Type: Regular T 98.2 - 9/15/2024 12:14 Route:		

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	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 l/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".		

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	The post fall assessment was completed by E18, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 1/14/25 at 7:39 AM - Per EMR documentation by E8 (LPN) noted {sic} "Fall was unwitnessed in residents room 01/14/2025 12:15 AM. Resident was laying on the floor at the foot of his bed near his dresser with his head facing the window. Resident unable to state where he was going or how he 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/discomfort. Assisted resident off the floor safely. 2 skin tears one on each lateral aspect 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 resulted in an injury to the resident:2 skin tears one each on the lateral side of each knee". The post fall assessment was completed by E8, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 1/27/25 at 7:15 AM - Per EMR documentation by E18 (LPN) noted {sic} "Fall was unwitnessed in residents room 01/27/2025 5:00 AM. Staff was doing rounds and found resident on floor next to bed. Resident did not have call pendent around his		

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	neck. Skin tear observed on back of left hand and redness on 2nd toe, scabs observed also to area. Medication care manager and care staff assisted him back to bed, vital signs done, this nurse rechecked B/P 110/60. Intervention: Have staff become familiar with my daily routine and attempt to anticipate and meet my daily needs. Post fall evaluation: VS: BP 110/60 - 1/27/2025 07:57 Position: Lying l/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 Delaware State regulation of the Board of Nursing Scope of Practice. 2/2/25 at 11:23 PM - Per EMR documentation by E12 (LPN) noted {sic} "Fall was unwitnessed 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 did not have call pendent around his neck". "Post fall evaluation : VS:BP 109/72 - 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 on right fore head one hour after fall".		

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	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. 2/19/25 - Per interview with E1 (ED) at approximately 1:30 PM, E1 confirmed the LPNs in the facility are performing the post fall 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.		
3225.18.0 **3225.18.6** **3225.18.6.2** **S/S – E**	**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. E4 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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	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.		
3225.19.0 **3225.19.6** **3225.19.7** **3225.19.7.1.3** **3225.19.7.1.3.1** **S/S – D**	**Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Emotional abuse.** **Staff to resident.** 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	A. R4 no longer resides at the community. B. All residents have the potential to be affected by this practice. C. A root cause analysis determined the Resident Care Director mistakenly forgot to report the fall with injury within 8 hours of the incident. The Executive Director/Designee will in-service the Resident Care Director on timely reporting of incidents. 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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	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 resident altercation to the State Agency until 8/8/24, a month after the incident occurred and not within the 8-hour reporting 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 records dating between 7/15/24-7/30/24 on reporting of incidents. E1 confirmed that E19 was no longer an employee in the facility. 2/19/25 - Findings were reviewed with E1 at the exit conference beginning at approximately 1:50 PM.		
3225.19.0 3225.19.7.7.2 S/S – D	**Records and Reports** **Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.** 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 residents for incidents, the facility failed to report a	A. R4 no longer resides at the community. B. All residents have the potential to be affected by this practice. C. A root cause analysis determined the Resident Care Director mistakenly forgot to report the fall with injury within 8 hours of the incident. The Executive Director/Designee will in-service the Resident Care Director on timely reporting of incidents.	

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	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.	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.	
3225.19.0 **3225.19.7.6** **S/S – D**	**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:	A. R3 and R13 no longer resides at the community. B. All residents have the potential to be affected by this practice. C. A root cause analysis determined the new Executive Director was unaware that resident deaths need to be report	

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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 approximately 10:30 AM, E1 confirmed these 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 E1 at the exit conference beginning at approximately 1:50 PM.	to the state agency. The Regional Clinical 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.	

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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, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

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