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

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

STATE SURVEY REPORT

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: November 1, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from October 31, 2024, through November 1, 2024. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-eight (38). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this state report are as follows: DON - Director of Nursing; ED - Executive Director; MT – Med Tech; PCA – Personal Care Aide.	**3225.11.3 Resident Assessment** **Corrective Action:** A prospective resident shall have a medical evaluation completed by a physician within 30 days prior to admission. The medical evaluation for resident R8 has already been completed and cannot be retroactively corrected. **Identification of Other Residents:** All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure protection for all residents moving forward. **System Changes:** For all new admissions a medical evaluation will be completed by a physician within 30 days prior to admission. **Evaluation of Success:** The Director of Nursing and/or Designee will audit the records of all admissions prior to being admitted, ensuring a medical evaluation has been completed by a physician within 30 days prior to admission. Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved. The results of these audits will be reported to the Executive Director for review and further action if necessary.	12/10/2024
3225 **3225.11.0** **3225.11.3** **S/S - D**	**Assisted Living Facilities** **Resident Assessment** **Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.** This requirement was not met as evidenced by: Based on record review and review of other facility documentation, it was determined that for one (R8) out of eight sampled residents, the facility failed to provide evidence that a Physician's medical evaluation was completed within 30 days prior to admission. Findings include: 10/5/23 – R8 was admitted to the facility. The Physician's evaluation was completed on 8/12/23, greater than 30 days prior to admission.		

Provider's Signature Steven Yahn Title Executive Director Date 12/10/24

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	11/1/24 – Per interview with E2 (DON) at approximately 2:55 PM, E2 confirmed the medical evaluation was completed greater than 30 days prior to R8's admission. 11/1/24 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 3:05 PM.	**3225.12.1.3 2-101.11 Assignment** **Corrective Action:** There must be a PERSON IN CHARGE that is a Certified Food Protection Professional during all hours of operation. The Dining Service Director has implemented a schedule for all PERSONS IN CHARGE to obtain their CFPP (Certified Food Protection Professional). This cannot be retroactively corrected.	12/10/2024
3225.12.0	**Services**	**Identification of other residents:** All residents have the potential to be affected by improper food handling. Corrective actions below will ensure protection for all residents moving forward.	
3225.12.1	**The assisted living facility shall ensure that:**	**System Changes:** The root cause of the issue was identified as only two PERSONS IN CHARGE were certified in proper food handling. The Dining Services Director has implemented a schedule for all PERSONS IN CHARGE to obtain their CFPP. All COOKs and lead DINING ATTENDANTS are enrolled in the Accredited program and will be scheduled for their tests to ensure proper food handling and compliance with the Delaware Food Code.	
3225.12.1.3 **S/S - F**	**Food service complies with the Delaware Food Code** **Delaware Food Code** Based on observations, interview and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **2-101.11 Assignment. (A) Except as specified in ¶ (B) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation.** **2-102.12 Certified Food Protection Manager (A) At least one employee, the PERSON IN CHARGE at the time of inspection, shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM.** 10/31/24 – During the survey of the facility at approximately 1:15 PM, a review of the schedule for Dietary employees revealed that	**Evaluation of Success:** The Dining Services Director and/or designee will conduct monthly audits of department schedules to ensure a Certified Food Protection Professional is scheduled on duty every day, during working hours. Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved. Results of the audits will be shared with the Executive Director for review and compliance with the Delaware Food Code. The Dining Services Director and/or Designee will track all potential expiring certifications and schedule staff for recertification as needed.	

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	on October 21, 22, 28, and 29 of 2024, no employees who were a Certified Food Protection Manager were scheduled to work after 3:00 PM. 10/31/24 – Per interview with E1 (ED) at approximately 1:50 PM, E1 confirmed the schedule did not list a Certified Food Protection Manager on these days after 3:00 PM. **2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES.** 10/31/24 – During the survey of the facility at approximately 11:00 AM, E7 (Cook 1) was observed without a beard net while preparing lunch. 10/31/24 – Per interview with E1 (ED) at approximately 1:50 PM, E1 confirmed the beard net was not in place. 11/1/24 – During the survey of the facility at approximately 9:00 AM by another surveyor, E7 was observed in the kitchen without a beard net. **3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.**	**3225.12.1.3 2-402.11 Effectiveness** **Corrective Action:** All employees involved in food handling have been educated by the Dining Services Director on proper procedures for safety and compliance with the Delaware Food Code. This education included that all food handling employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLESERVICE and SINGLE USE ARTICLES. **Identification of other residents:** All residents have the potential to be affected by improper food handling. Corrective actions below will ensure protection for all residents moving forward. **System Changes:** All food handling employees have been educated on the importance of wearing the correct hair restraints when handling food. Daily monitoring of food handling employees will be completed by the Dining Services Director and/or Designee. **Evaluation of Success:** Audits will be conducted by the Dining Services Director to ensure compliance with food handling employees wearing the correct hair restraints when handling food. Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved. The results of these audits will be reported to the Executive Director for review and further action if necessary. **3225.12.1.3 3-305.11 Food Storage** **Corrective Action:** All employees involved in food handling have been educated by the Dining Services Director on proper procedures for safety and compliance with the Delaware Food Code. This education included	12/10/2024 12/10/2024

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	10/31/24 – During observation of the facility at approximately 11:00 AM, three bags of cereal and a bag of baking soda were left open exposing them to contamination. 10/31/24- During observation of the facility at approximately 11:00 AM in the preparation area, sprinkles, baking soda, and a bag of tortillas were not sealed properly exposing the contents. 10/31/24 – Per an interview with E7 (cook 1) at approximately 11:05 AM, E7 confirmed the items were left open. 10/31/24 – During observation of the facility at approximately 11:15 AM, the walk-in refrigerator had a large container of Kosher dill pickles stored on the floor and the walk-in freezer had a box of eclairs on the floor. 10/31/24 - Findings were reviewed with E1 (ED) at approximately 2:00 PM.	proper food storage, specifically ensuring food is protected from contamination where it is not exposed to splash, dust, or other contamination; and at least 15 cm (6 inches) above the floor. **Identification of other residents:** All residents have the potential to be affected by improper food storage. Corrective actions below will ensure protection for all residents moving forward. **System Changes:** All food handling employees have been educated on the importance of proper food storage. Daily monitoring of food handling employees will be completed by the Dining Services Director and/or Designee regarding food storage. **Evaluation of Success:** Audits will be conducted by the Dining Services Director to ensure compliance with proper food storage. Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved. The results of these audits will be reported to the Executive Director for review and further action if necessary.	
16 Del.C., Ch. 11, Subch. III **S/S - G**	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)** **12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **This is a past non-compliance deficiency.** Based on interview, staff statements, investigative and incident reports, record review and review of other facility documentation, it	**Past Non-Compliance**	**8/28/2024**

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	was determined that for one (R2) out of eight sampled residents, the facility failed to provide safety measures to a resident to prevent a delay in care. Findings include: 5/28/24 – R2 was admitted to the Memory Care unit at the facility with a diagnosis of severe dementia and under Hospice care. 8/23/24 – Per investigative reports, E8 (PCA) worked in the Memory Care the night of 8/22/24. On 8/23/24 when questioned by facility management team, E8 stated R2 did fall in the "common area about 9:00 PM when she stood up from a chair and lost her balance." R2 fell to the floor landing on her left side. E8 stated she assisted R2 off the floor and assisted back to her room and into bed. E8 stated R2 slept through the night without complaints. E8 failed to report or notify any staff member, on or off duty, that the fall occurred. 8/23/24 – Per statement from E2 (DON) provided to the facility, E2 stated that F1 (daughter of R2) knocked on her office door during morning meeting at approximately 11:15 AM and asked to have R2 evaluated. On entering the room, E2 was assessed and found to have slightly swollen left knee with obvious bone spurs and R2's left hip with a small, bruised area. R2's left elbow had a skin tear. R2 was lying in a fetal position, denied pain but yelled on repositioning. E2 advised F1 that R2 needed to be sent to ER for evaluation. 8/23/24 - Per E5 (LPN) EMR entry at 4:44 PM, E5 stated at approximately 11:30 AM, E5 entered the room with E2 and found F1 sitting at the end of R2's bed and stated "this doesn't look right" while pointing to R2's left knee and stating R2 was in pain. F1 stated she found R2 in bed lying on her side complaining		

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	of excruciating pain in her hip and multiple cuts and bruises on her body. F1 noted R2's left knee was tender to touch and "didn't look right". R2 was unable to explain what happened but denied a fall. Per E5's entry. 911 was called and R2 was transported to the hospital. 8/23/24 – Per the ER admission assessment visit record at 1:51 PM, the assessment showed "patient presenting with suspected fall and altered mental status". X-ray indicated a left femoral fracture and R2 was admitted to the hospital. 8/26/24 – Per E6 (MT) statement provided to the facility, E6 indicated that she arrived at the facility at approximately 6:00 AM. E6 stated there was no report given about any fall incidents. Per E6 statement. R2 was checked around 7:15 AM and that R2 took her morning medications without incident. About 10:00 AM, E6 stated the Hospice caregiver asked for her assist in getting R2 up for the day but R2 was refusing due to "being tired" and when asked regarding pain, R2 stated her knee hurt but denied PRN medication. E6 stated the R2 denied any falls. 8/26/24 – Per E1 (ED) investigative report, R2 did sustain a fall on 8/22/24 at approximately 9:15 PM in which E8 failed to report the fall to anyone. 11/1/24 – Per interview with E6 at approximately 9:30 AM, E6 confirmed the findings of her statement on 8/26/24. 11/1/24 – Per interview with E1 (ED) at approximately 10:30 AM, E1 confirmed the findings. E1 stated E8 was suspended and then employment was terminated for E8		

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	once the incident investigation was completed. E1 stated he reached out to the family several times but got no response. The family moved R2's belongings out of the facility on 8/26/24. E1 stated R2 was admitted to inpatient Hospice services. 11/1/24 - Per interview at approximately 2:00 PM with E2 (DON) confirmed the findings. E2 provided evidence of the staff training completed by E2 on 8/28/24. E2 confirmed that all of the Wellness staff were re-educated in fall procedures including the necessity to report any resident fall within the facility immediately to a supervisor. The training attendance sheet was reviewed and verified by the Surveyor. The facility responded timely once the fall was confirmed, E8 was suspended and employment was terminated on 8/28/24, and nursing staff were re-educated in fall procedures. However, the lack of reporting by E8 resulted in R2 not being assessed for injury after a fall with a subsequent delay in care for over 12 hours. After review of the facility records, it was determined that the facility identified their deficient practice and corrected it. This correction was verified through record review and interview with both E1 and E2, the alleged compliance was met and confirmed by the Surveyor on 8/28/24. 11/1/24 - Findings were reviewed with E1 and E2 at the exit conference, beginning at approximately 3:05 PM.		

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