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.
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STATE SURVEY REPORT

NAME OF FACILITY: Paramount Senior Living at Newark

DATE SURVEY COMPLETED: September 18, 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, Complaint and Emergency preparedness survey was conducted at this facility from September 16, 2025, through September 18, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was seventy-eight (78). The sample totaled sixteen (16) residents. Abbreviations/definitions used in this report as follows: DELVAX- a confidential online computer system used in Delaware by doctors, nurses, schools and practices to keep track of their patients/students immunizations; EMR- electronic medical record; PCV20 – one of several pneumococcal conjugate vaccines; PPD- known as the tuberculin skin test or Mantoux test, it is used to determine if a person has been infected with the bacteria that cause tuberculosis (TB); S/S- signs and symptoms. **Title 16 Health and Safety** **Chapter 11** **Subchapter IX Criminal background Checks; Drug Testing – PPECC** **1146 Mandatory Drug Screening** **(a) An employer may not employ an applicant without first obtaining**	A. Unable able to correct deficient practice at this time B. No residents were impacted by the deficient practice. C. There was no consistency on who completed the drug testing form and was responsible for assuring that the drug test was completed for each new employee. Education was provided on the critical process and Paramount policy for drug testing by the Corporate RN, regarding 1146 with the Executive Director, BOM/HR, Resident Care Manager and Assistant Resident Care Manager in order to identify who is responsible for completing the drug test form, assuring that employee completed drug test and to ensure compliance with 1146. The executive Director shall be responsible for the corrective action as identified above. The HR/BOM will conduct initial	10/15/2025

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S/S – D	**the results of that applicant's mandatory drug screening.** **(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** Based on record review and interview, it was determined that for one (E12) out of eight employees reviewed for staffing, the facility failed to have the results of E12's mandatory drug screening prior to her first day of work. Findings include: 2/20/25 – E12 (CNA) started working at the facility. 5/14/25 – E12's mandatory drug screening results were obtained by the facility. 9/18/25 2:00 PM – During an interview, E11 (BOM) confirmed that E12's first day of work at the facility was 2/20/25 and that the date on the mandatory drug screening test was 5/14/25, three months after E12's first day of work. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse).	audit of all current employees file to make sure all mandatory drug screens have been completed Prior to each new employee beginning work at Paramount, the Executive Director will sign off pre-employment checklist for each new hire which includes verification of drug screening results. This shall give authorization for employee to begin work. All future employees will be drug tested prior to starting orientation and results placed in employee file. The form needed to conduct the drug test was not stored in a consistent location to be found by the HR/BOM. D. To ensure on-going compliance with 1146 the Administrator/designee will conduct a 100% audit of all new hire files 3x a week for 3 consecutive successes. Then once a week for 3 consecutive successes, then once a week for 3 consecutive successes, then once a month and if 100% success is achieved, we can conclude we have successfully addressed the problem. Results shall be reported to QA for review of results. Continued compliance will be monitored monthly than quarterly thereafter.	
	Title 16 Health and Safety		
3225	**Assisted Living Facilities**		
3225.9.0	**Infection Control**		
3225.9.5	**Requirements for tuberculosis and immunizations:**		
3225.9.5.2	**Minimum requirements for pre-employment require all employees to have a**		

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	baseline two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA) or TB blood test such as Quantiferon.		
3225.9.5.2.4 **S/S – E**	**A report of all test results shall be kept on file at the facility of employment.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for five (E12, E15, E16, E17, and E18) out of eight employees reviewed for staffing, the facility failed to have the results of a PPD (TST) test prior to that employee's first day of work. Findings include: 1. A review of E12's employee file revealed: 3/21/25 – E12 (housekeeper) started working at the facility. 4/21/25 -E12's first step PPD test was read as negative for TB. 2. A review of E15's employee file revealed: 4/29/25 – E15 (LPN) started to work at the facility. 5/29/25 – E15's first step PPD test was read as negative for TB. 3. A review of E16's employee file revealed: 6/2/25 – E16 (dietary server) started working at the facility.	A. Facility is unable to correct this deficient practice d/t testing must be completed prior to the employee's orientation. B. No residents were impacted by the deficient practice. C. Root cause analysis showed that the new hire checklist was not reviewed for completion prior to the employee start date. Orientation checklist reviewed weekly with HR/BOM to ensure compliance. Executive Director will sign off on completed checklist. Corrective action will be taken for records not in compliance which will include documentation of administration by facility or outside entity. Resident Care Manager and Executive Director will review reports daily with HR/BOM of all future employees initial 2 step PPD. To ensure 2 step PPD is completed prior to orientation. D. An education was provided by the Corporate RN, regarding 3225.9.5.2.4 with the Executive Director, HR/BOM, Resident Care Manager, and Assist Resident Care Manger to ensure compliance with regulation 3225.9.5.2.4. The BOM/HR will conduct an initial audit of 100% current employees' files	10/17/2025

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	6/18/25 - E16's first step PPD test was read as negative for TB. 4. A review of E17's employee record revealed: 5/21/25 – E17 (resident care aide) started to work at the facility. 5/29/25 - E17's first step PPD test was read as negative for TB. 5. A review of E18's employee record revealed: 7/3/25 – E18 (LPN) started to work at the facility. The facility lacked evidence that E18 had been tested for TB. 9/18/25 2:00 PM – During an interview, E11 (BOM) confirmed the start date and the PPD testing dates of each of these employees. For E18, E11 stated that there was no record of any PPD/TB testing in E18's employee file. The facility failed to have negative PPD test results in the employee's file prior to the employees' first shift of work. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse). **Title 16 Health and Safety** **Assisted Living Facilities** **Infection Control**	to make sure 2 step PPD are in place. Any current employees without a documented 2 step PPD will have the process initiated and completed in the appropriate timeframe. To ensure on-going compliance the administrator/designee will conduct 100% audit of all new hire files 3x a week for 3 consecutive successes than once a week for 3 consecutive successes, then once a month and if 100% success is achieved, we can conclude we have successfully addressed the problem. Audit results will be reported and reviewed by HR/BOM, Resident Care Manager, and Executive Director during facilities QAPI. Responsible Party: HR/BOM & Resident Care Manager	
3225. **3225.9.0**			

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3225.9.7 **S/S – D**	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for three (R3, R8 and R11) out of seven residents reviewed for vaccines, the facility failed to have evidence on file of these residents' vaccinations. Findings include: The facility's Immunization policy: Influenza/Pneumococcal-"...A. Pneumococcal vaccine: a. Ask all new residents upon admission for documentation of any previous pneumococcal vaccination. b. If no documentation of vaccination exists, encourage resident to receive vaccine, obtain written order from the resident's physician, and record in the Resident Medical Record...". Effective date 2/1/19. 1. A review of R3's clinical record revealed:	A. Unable able to correct deficient practice at this time	

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	5/1/24 – R3, aged 84 years, was admitted to the facility. 9/17/25 10:30 AM – The surveyor requested several residents' vaccination documentation or signed declination. The facility failed to provide evidence of R3's vaccines. 2. A review of R8's clinical record revealed: 4/13/25 – R8, aged 78 years, was admitted to the facility. 9/17/25 10:30 AM– The surveyor requested several residents' vaccination documentation or signed declination. The facility failed to provide evidence of R8's vaccines. 9/18/25 10:10 AM – A review of DELVAX records revealed R8 received a PCV20 (pneumococcal) vaccine at a rehabilitation facility on 8/20/25 prior to his admission to this facility. The facility failed to have documentation of R8's pneumococcal vaccine. 3. A review of R11's clinical record revealed: 9/15/25 – R11, aged 95 years, was admitted to the facility. 9/17/25 10:30 AM – The surveyor requested several residents' vaccination documentation or signed declination. 9/18/25 1:30 PM - The facility provided the Physician/Healthcare Provider Plan of Care form – Communicable Disease	B. No residents were impacted by the deficient practice. C. Root cause analysis showed that the facility did not keep a record of vaccine declinations. The DELVAX system was not used to track vaccine administration by the facility. A tracking system will be implemented for vaccine administration, documentation, and inclusion in Delvax and maintained by the Resident Care Manager and the Assistant Resident Care Manager. The records of all residents will be reviewed to check for records of administration or declination of pneumococcal vaccine. For those without documentation in the medical record the Delvax system will be checked. For those with no documentation in either location the Resident Care Manager/designee will contact their responsible party and physicians will be contacted to facilitate acceptance of the vaccine or obtain documentation as to why it has been refused. D. As part of the QAPI process acceptance or declination of the pneumococcal vaccine and accurate documentation will be tracked. This review will be weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained then quarterly. Responsible Party: Resident Care Manager and Executive Director.	10/15/2025

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	Screening. The "Current immunization status:" was blank. The facility failed to provide evidence of R11's vaccines. 9/18/25 10:10 AM – A review of DELVAX records revealed R11 received a PCV23 (pneumococcal) vaccine on 10/17/01. Per current CDC guidelines, R11 should have been offered to be vaccinated with PCV20 (pneumococcal) vaccine. 9/18/25 2:45 PM – During an interview, E2 (DON) stated that the facility did not have documentation of some of the residents' vaccinations. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse).		
	Title 16 Health and Safety		
3225	**Assisted Living Facilities**		
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**		
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**		

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	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.** 9/18/25 – During the survey of the facility, a review of the dining staff schedule revealed there was not a Certified Food Protection Manager scheduled to work on the evening shifts after 4:30 PM between 8/31/25 and 9/13/25. It was also revealed that a Certified Food Protection Manager was not present on 9/6/25 and 9/7/25. 9/18/25 – During an interview with E6 (Director of Food Services) at approximately 1:45 PM, the lack of a CFPM on duty during all hours of operation was confirmed.	A. Unable to correct deficient practice at this time B. No residents were impacted by the deficient practice. C. All cooks will be trained for certified food protection manager by 11/06/2025, Dietary Director and HR/BOM. The Dietary Director will verify once all staff are certified is active and on file for each designated shift. The dining schedule will not be finalized until certified food protection manager has been confirmed. D. The Administrator/designee will review the dietary staff schedule weekly for three months then once a week for 3 consecutive successes then once a month until 100% success is achieved to ensure certified food protection manager coverage is maintained during all operating hours. Audit results will be reported and reviewed by Dietary Director and Executive Director during the facilities QAPI meeting. Responsible Party: Director of Food Service & Executive Director.	10/09/2025
	2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (E) After handling soiled EQUIPMENT or UTENSILS; (I) After engaging in other activities that contaminate the hands.	A. Unable to correct the deficient practice at this time. B. No residents were impacted by the deficient practice. C. Education provided by Dietary Director for all kitchen employees on the proper washing procedures in the dish room. one person loads the soiled dishes and another person puts the sanitized dished away. If there is only one person then they load soiled then washes their hands and then is able to put sanitized dishes away. Have all employees sign off after the in-service. The facilities infection control policy 5.0 gloves, 4.8 Food Service, 4.10 Food Service Sanitation	10/09/2025

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	9/16/25 – During the survey of the facility, an observation of the dishwashing procedure revealed E10 (dietary server) wearing gloves and loading dirty dishes then removing the clean dishes while wearing the same gloves. 9/16/25 – During an interview with E6 at approximately 1:00PM, the dishwashing procedure was confirmed.	requirements. A All employees were educated by Dietary Director on 10/09/2025. Root cause showed change in Dietary management resulted in lack of proper handwashing techniques. No system changes are needed at this time as correction can be made through education. D. Dietary Director will conduct visual checks of handwashing and glove changing practices daily three times a week until you consistently reach 100% success at 3 consecutive evaluations then once a week until you consistently reach 100% success over 3 consecutive evaluations. Once a success rate of 100% is achieved over 4 weeks, audits will be concluded but regular checks will continue to maintain compliance. Audits will be reported and reviewed by Dietary Director and Executive Director at facilities QAPI meeting. Responsible Party: Dietary Direct & Executive Director.	
	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 57oC (135oF) 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 54oC (130oF) or above; P or (2) At 5ºC (41ºF) or less. P**	A. Unable to correct the deficient practice at this B. No residents were impacted by the deficient practice. C. Root cause showed change in Dietary management resulted in lack of temperature being recorded. No system changes are needed at this time as correction can be made through education. The facility failed to maintain consistent food temperature logs. This deficient practice was immediately addressed as all Dietary Staff was educated on Policy 22.0 Monitoring Food Temperature and 28.0 Refrigerator and Freezer Temperature logs by the Dietary Director. D. Dietary Director will conduct regular checks of all temperature logs. Audits will be conducted 3 times a week. Once a success	10/09/2025

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	9/16/25 – During the survey of the facility, an observation of the thermometer in the kitchen refrigerator at approximately 11:45 AM, revealed a temperature of 50° F on the thermometer. 9/16/25 – During an interview with E6 (Director of Food Services) and E9 (Dietary Server) at approximately 11:45 AM, the temperature was confirmed. 9/16/25 – During the survey of the facility, review of temperature log documentation between May 2025 and August 2025 revealed 93/93 meal temperatures in the month of May were unavailable and 14/93 meal temperatures in the month of July were unavailable. 9/16/35 – During an interview with E6 at approximately 2:30 PM, the missing meal temperature documentation was confirmed. **4-302 Utensils, Temperature Measuring Devices, and Testing Devices.** **4-302.13 Temperature Measuring Devices, Manual and Mechanical Warewashing. (B) In hot water mechanical WAREWASHING operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the UTENSIL surface temperature.** 9/16/25 – During the survey of the facility, an observation of the high temperature dishwasher revealed the rinse cycle gauge reading 160°F at approximately 1:00 PM. The dishwasher ran an additional three times before the temperature increased to	rate of 100% is achieved over 4 weeks, audits will be concluded but regular checks will continue to maintain compliance. Audit results will be reported and reviewed by Dietary Director and Executive Director at facilities QAPI meeting. Responsible Party: Dietary Director & Executive Director A. Unable to correct the deficient practice at this time B. No residents were impacted by the deficient practice. C. Change in management resulted in deficient practice. The dishwasher was immediately scheduled for service and recalibrated to reach the required 180F rinse temperature. All dietary staff were educated in the required temperature parameters for mechanical dishwashing and proper use of temperature indicators by Dietary Director on 10/09/2025 D. Dietary Director/designee will review the dishwasher temperature log daily for four weeks, then weekly for three months, then once a week for 3 consecutive successes, then once a month and if 100% success is	10/9/2025

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	180°F. The data plate identifies a required temperature of 180°F for sanitation during the rinse cycle. The facility did not have a way of measuring the utensil surface temperature. At approximately 1:30 PM the temperature inside the dishwasher was tested utilizing a waterproof max temp thermometer revealing a temperature of 159.3°F with two confirming trials. 9/16/25 – During an interview with E6 at approximately 1:30 PM, the dishwasher temperature findings were confirmed. **4-501 Equipment** **4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.** 9/16/25 – During the survey of the facility, an observation of the kitchen revealed the kitchen sink was leaking creating a puddle alongside the wall, beneath the prep table. 9/16/25 – During an interview with E6 at approximately 11:30 AM, the leak was confirmed. 9/16/25 – During the survey of the facility, an observation of the walk-in unit revealed water leaking along the outside of the freezer. Water was located outside the walk-in freezer unit along the floor in the kitchen and along the floor to the right and left of the unit's door. 9/16/25 – During an interview with E6 and E8 at approximately 11:40 AM, the leaks were confirmed.	achieved, we can conclude we have successfully addressed the problem. Audit results will be reported and reviewed by Dietary Director and Executive Director during facilities QAPI meeting. Responsible Party: Dietary Director & Executive Director A. Unable to correct the deficient practice at this time B. No residents were impacted by the deficient practice. C. Change in management resulted in deficient practice. The leaking kitchen sink, walk in freezer and ice machine were repaired by Director of Maintenance and Innoserv. All affected areas were cleaned, sanitized, and dried to prevent slipping hazards or bacterial growth by Director of Maintenance immediately. The Director of Maintenance and Dietary Director will perform joint monthly walk-through the kitchen to identify and address any signs of leakage repair immediately repaired on site and contractors called for immediately service repair. All staff educated by Dietary Director on procedures for immediate leaks or equipment malfunctions. Maintenance logs will include verification of repairs and follow up checks to ensure equipment remains in proper working	10/15/2025

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	9/18/25 – During the survey of the facility, an observation of the ice machine revealed water collecting under the machine and running along the front of the counter. 9/18/25 – During an interview with E6 and E7 (Director of Maintenance), the water beneath the ice machine was confirmed.	order. Dietary Manager should report to direct of maintenance any leaks or malfunctioning equipment immediately. D. Director of Maintenance will inspect all kitchen plumbing, refrigeration, and ice equipment weekly for 3x a week for 3 months, then once a week for 3 consecutive successes, then once a month and if 100% success is achieved, we can conclude we have successfully addressed the problem. Audit results will be reported and reviewed by Dietary Director, Director of Maintenance and Executive Director during facilities QAPI meeting. Responsible Party: Dietary Director, Director of Maintenance & Executive Director	
3225 **3225.14.0** **3225.14.2** **S/S – D**	**4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device.** 9/16/25 – During the survey of the facility, an interview with E6 revealed they were unable to test the solution due to a recent change in solution and they were awaiting the delivery of the new testing strips compatible with the solution. 9/16/25 – During an interview with E6, the finding of the unavailable testing strips was confirmed. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse).	A. Unable to correct the deficient practice at this time B. No residents were impacted by the deficient practice. C. New compatible sanitizer test strips were obtained and placed in the kitchen immediately upon delivery. All staff was educated on the requirements to rest and document sanitizer concentrations daily before use by Dietary Director. The facility will review supply inventory to ensure test kits and related sanitation supplies are maintained in stock at all times. The Dietary Director will verify that appropriate sanitizer testing supplies are available and not expired during weekly inspections. D. The Dietary Director will verify and document sanitizer testing weekly	10/16/2025

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	Title 16 Health and Safety **Assisted Living Facilities** **Resident Rights** **Each resident has the right of privacy in his/her room, including a door that locks, consistent with the safety needs of the resident.** **§ 1121. Resident's rights. (b) It is the public policy of this State that the interests of the resident must be protected by a declaration of a resident's rights, and by requiring that all facilities treat their residents in accordance with such rights, which must include the following: (23) Each resident shall have the right to retain and use the resident's own personal clothing and possessions where reasonable, and shall have the right to security in the storage and use of such clothing and possessions.** Based on document review and interview it was determined that one resident (R5) out of four residents reviewed for resident rights, the facility failed to maintain R5's right to retain and use their own personal possessions when a credit card was removed from R5's room. 5/29/25 – A facility reported incident was received when a family member (F1) reported a bank card was missing from a resident's locked drawer. The police were notified, and a fraud alert was placed on the credit card.	for 3x a week for 3 months, then once a week for 3 consecutive successes, then once a month and if 100% success is achieved, we can conclude we have successfully addressed the problem A. Unable to correct the deficient practice at this time. B. No residents were impacted by the deficient practice. The facility promptly notified law enforcement and resident representative. Resident R5 at the time of admissions 04.03.2020 was provided a facility issued lock and key. Family member F1 provided	10/15/2025
3225 **3225.16.0**			

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3225.16.14 **3225.16.14.2.** **3225.16.14.2.1** **3225.16.14.2.2.** **3225.16.14.2.3.** **3225.16.14.2.4** **3225.16.14.2.5** **3225.16.14.2.6** **3225.16.14.2.7** **3225.16.14.2.8** **3225.16.14.2.9** **3225.16.14.2.10** **S/S – D**	5/30/25 – Employees were educated on the zero-tolerance policy for theft. 6/3/25 – An employee was identified by E1 as a suspect when camera footage from a store revealed an employee being present with another person during an attempt to utilize R5's credit card. At that time the employee was removed from the facility. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse). **Title 16 Health and Safety** **Assisted Living Facilities** **Staffing** **Assisted living facilities resident assistants shall, at a minimum:** **Participate in a facility-specific orientation program that covers the following topics:** **Fire and Life safety, and emergency disaster plans;** **Infection control, including Standard Precautions;** **Basic food safety;** **Basic first aid and the Heimlich Maneuver;** **Job responsibilities;** **The health and psychosocial needs of the population being served;**	resident with self-brought desk lock and drawer. Family member F1 refused to use facility provided lock and drawer. Paramount risk policy #9 included in admission packet states Paramount will not be responsible for the loss of such items. C. Change in management resulted in deficient practice. The involved employee was arrested on the facility premise upon confirmation of policy violation. Employees were educated by Executive Director on the facilities zero-tolerance policy for the theft on resident rights regarding personal property. All employees were educated on resident right. D. Executive Director/designee and Director of Maintenance will continue to monitor all current residents and new residents to ensure Paramount issued locks continue to be provided and utilized. Audits will be conducted 3 times a week. Once a success rate of 100% is achieved over 4 weeks, audits will be concluded but regular checks will continue to maintain compliance. Incident reports involving residents' property will be reported and reviewed by Director of Maintenance and Executive during facilities QAPI meeting to monitor trends and ensure preventative actions are effective. Responsible Party: Maintenance Director & Executive Director.	

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225 **3225.18.0** **3225.18.4** **S/S – D**	**The resident assessment process; and** **The use of service agreements;** **16 Del C Ch.11, pertaining to residents' rights; reporting abuse, neglect, mistreatment, and financial exploitation; and the Ombudsman Program;** **Hospice services.** This requirement was not met as evidence by: Based on record review and interview, it was determined that for two (E13 and E15) out of ten employees reviewed for staffing, the facility did not have evidence of facility-specific, orientation training documentation for direct care provider in their employee file. Findings include: 1. A review of E13's employee file revealed: 7/9/25 – E13 (CNA) started working at the facility. 9/18/25 2:00 PM – During an interview, E11 (BOM) confirmed E13's start date. E11 stated that there was no documentation of any facility-specific training in E13's employee file. 2. A review of E15's employee file revealed: 4/29/25 – E15 (LPN/ADON) started working at the facility. 9/18/25 2:00 PM – During an interview, E11 (BOM) confirmed E15's start date. E11 stated that there was no documentation	A. Unable to correct deficient at this time B. No residents were impacted by the deficient practice. C. Pre-hire checklist includes the required topics related to facility specific orientation, proof of competency in providing fire and life safety, emergency disaster, infection control, basic food safety, basic first aid, job responsibilities, health and psychosocial needs, resident assessment, service agreements, resident rights, reporting abuse, neglect, mistreatment, and financial exploitation, Ombudsman program. D. Root cause analysis showed that only partial education records were maintained in employees' files due to change in management. The facility will provide quarterly fire drill reports. The facility will maintain complete education files for all employees and they will be reviewed by HR/BOM and Resident Care Manager prior to scheduling. HR/BOM completes all new hire education on the day of orientation except hands on training which is completed during 1st seven days of employment. HR/BOM will verify that all orientation documentation is	10/17/2025

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	of any facility-specific training in E15's employee file. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse).	completed and files before all new employees begin independent work. Department managers were educated by HR/BOM on training documentation procedures and the regulatory requirements. E. As part of the QAPI process, the pre-hire checklist for all employees will be reviewed weekly for 4 weeks until 100% compliance is maintained and then quarterly. The Maintenance Director will conduct weekly audits to ensure all fire drill reports are accurate and up to date (this includes on all shifts). The Maintenance Director or Administrator will review outcome audits at QAPI Committee x 3 months. The Maintenance Director or Administrator will review outcome audits at QAPI meeting x 3 months. Responsible Party: Resident Care Manger and HR/BOM	
	Title 16 Health and Safety **Assisted Living Facilities** **Emergency Preparedness**		
3225 **3225.19.0** **3225.19.5**	**The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.**		
S/S – D	Based on document review and interview, it was determined that three (E12, E13, and E19) out of nine employees reviewed, did not receive emergency training during orientation.		

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	9/18/25 – Review of employee training records revealed E12 (CNA) had not completed their orientation emergency training. 9/18/25 – Review of employee training records revealed E13 (CNA) had not completed their orientation emergency training. 9/18/25 – Review of employee training records revealed E19 (Housekeeper) had not completed their orientation emergency training. 9/18/25 – During an interview with E11 (BOM) at approximately 2:30 PM, the lack of orientation emergency training for E12, E13, and E19 was confirmed. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse). **Title 16 health and Safety** **Assisted Living Facilities** **Records and Reports** **Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:**	A. Unable to correct the deficient practice at this time B. No residents were impacted by the deficient practice. C. Change in management resulted in deficient practice. Documentation of completed training will be placed in employee files. All staff educated on the facilities emergency and evacuation procedures by Maintenance Director. Department managers and HR/BOM will ensure all staff complete emergency training before independent duties. Annual training on emergency preparedness will be provided to all employees and documented according. (Included annual training form) D. The HR/BOM will audit 100% of new hire files monthly for three months, then quarterly to verify emergency preparedness training has been completed. Audits will be reported and reviewing during facilities QAPI meeting. Responsible Party: HR/BOM & Executive Director.	10/17/2025
3225 **3225.19.0** **3225.19.6**	Based on document review and interview, it was determined that for one (R5) out of four residents reviewed for residents' rights, the facility did not conduct a complete investigation for a reported incident		

Provider's Signature _____ Title ED Date 11/5/25

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3225.19.7 **3225.19.7.7** **3225.19.7.7.1** **3225.19.7.7.2** **S/S – D**	when documentation was lacking statements from all direct staff, the reporter, and the alleged victim. 9/19/25 – at approximately 10:00 AM, a review of documentation for a facility reported incident on 5/29/25 lacked witness statements from direct care staff, the reporter, and the resident involved in the incident. 9/19/25 – The statements gathered were collected from the managers on duty E21 (Dietary Manager) and E22 (Activities Director) and dated 5/26/25. 9/19/25 – During an interview with E1 at approximately 10:45 AM, it was reported that there were no other statements or documentation. 9/19/25 – During an interview with F1 at approximately 11:45 AM, it was reported that when F1 spoke with E1 about the theft, E1 reported it to the police immediately. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse).	A. Unable to correct deficient at this time due to the lack of timely reporting. Reports to the division are now current. B. No residents were impacted by the deficient practice. C. Change in management resulted in deficient practice. Facilities Incident reporting and Investigation policy were reviewed and educated by the RN compliance nurse to ED to ensure comprehensive documentation requirements are clearly outlined. Executive Director and Resident Care Manager educated all nursing staff on the proper incident reporting, investigation procedures, and the importance of obtaining complete statements from all relevant individuals. Residents and staff members are communicating during shift change. Executive Director will educate all staff on the importance of obtaining complete and true accurate statements. Incident reports will be reviewed by Executive Director of completion to confirm all documents is present before closure. D. Executive Director and Resident care manager will ensure 100% of all witness statements will be collected at the time of the incident. Executive Director will audit 100% of witness statements weekly for 4 weeks until 100% compliance is achieved then monthly for 3 months until 100% compliance is maintained and then quarterly. Ensure all witness statements are dated to reflect true incidents dates and times are accurate. Audits reports will be reported and reviewed by Resident Care Manager and Executive Director during facilities QAPI meeting. Responsible Party: Resident Care Manager & Executive Director	10/17/2025

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	Title 16 Health and Safety **Assisted Living Facilities** **Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division.** **Reportable incidents include:** **Significant injuries.** **Injury from an incident of unknown source in which the initial investigation concludes that there is reasonable basis to suspect that the injury is suspicious. An injury is suspicious based on; the extent of the injury, ...** **Injury from a fall which results in transfer to an acute facility for treatment or evaluation...** This requirement was not met as evidence by: Based on record review and interview, it was determined that for two (R1 and R9) out of eight residents reviewed for grievances, the facility failed to report reportable incidents within in the required time frame. For R1, the facility failed to report an injury of unknown origin within the required time frame. For R9, the facility failed to report R9's fall with transfer to the hospital within the eight-hour time frame. Findings include: 1. A review of R1's clinical record revealed:	A. Unable to correct deficient at this time. Reports to the state are now current. Unable to correct the lack of timely reporting B. No residents were impacted by the deficient practice. Both incidents were immediately reported to the state agency once deficiencies we identified. C. Change in management resulted in deficient practice. Staff involved were educated on the requirements to report all reportable incidents within 8 hours of discovery by Resident care manager and Executive Director. The Executive Director and the Resident Care Manager reviewed the facilities incident reporting policy will all nursing and administrative staff. D. Executive Director will audit all incident reports weekly for three months to ensure timely reporting within the 8-hour require-	10/17/2025

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3225.7.0 **3225.7.1.14.1** **S/S – D**	2/23/23 – R1 was admitted to the facility. 8/28/25 2:52 PM – E19 (LPN) documented in R1's progress notes, "Resident stated to med tech med tech this am that he "fell in his rm (room) the other day". Large purple bruise noted to right rib cages...". 8/29/25 – R1's chest Xray revealed nondisplaced fractures involving 6th, 7th and 8th ribs on the right side. 8/29/25 10:53 AM – E1 (ED) reported R1's incident as injury/fall or unexpected medical issue-injury of unknown origin/source to the State Agency. The report of this incident to the State Agency occurred twenty hours after the facility was aware of the injury. The facility failed to report R1's injury from an incident of unknown source within the required eight-hour time frame. 2. A review of R9's clinical record revealed: 12/3/22 – R9 was admitted to the facility. 8/12/25 7:14 AM – R9's EMR progress note documented, "...[R9] fell out of Geri chair at 5:45, reopened forehead laceration... transferred to [hospital]." 8/15/25 9:58 AM - E1 (ED) reported R9's incident as injury/fall or unexpected medical issue-fall with injury to the State Agency. The report of this incident to the State Agency occurred three days (seventy-two hours) after the facility was aware of the injury. The facility failed to report R9's injury from a fall that required transfer to	ments, then 6 months until 100% compliance is met. Any late reporting will trigger immediate retaining and corrective action. Audit reports will be reported and reviewed by Resident care manager and Executive Director during facilities QAPI meeting. Responsible Party: Resident Care Manager & Executive Director.	

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	the hospital within the required eight-hour time frame. 9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse). **Title 16 Health and Safety** **4202 Control of Communicable and Other Disease Conditions** **Control of Specific Contagious Diseases** **Physician and other health care providers who give immunizations shall report about the immunization and the person to whom it was given for addition to the immunization registry in a manner prescribed by the Division director or designee.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of seven residents reviewed for vaccines, the facility failed to document the vaccine given in the facility in DELVAX, Delaware's online immunization registry. Findings include: 2/23/23 - R1 was admitted to the facility. 11/8/24 – R1 received the influenza vaccine at the facility. The facility failed to document R1's influenza vaccine in the Delaware immunization registry.	A. Unable to correct the deficient practice at this time B. No residents were impacted by the deficient practice. All resident charts shall be reviewed for the administration for the vaccines. All residents not vaccinated shall be vaccinated or declination received immediately. C. Change in management resulted in deficient practice. Resident Care Manager administering vaccines will document the immunization in both the resident chart and the Delvax system within 24hours of administration. Resident Care Manger conducted an 100% audit for all residents who received vaccines into the facility from November 2024-October 2025 to ensure all immunizations were entered into the Delvax system. D. Resident Care Manger will conduct monthly 100% audit of all residents who received immunizations to ensure information is entered in both resident chart and Delvax system. Then 6 months until 100% compliance is met. Audit reports will be reported and reviewed by Resident Care Manager and Executive Director during facilities QAPI meeting. Responsible Party: Resident Care Manager & Executive Director.	10/17/2025

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	9/18/25 3:40 PM – The findings were reviewed at the exit conference with E1 (ED), E2 (DON) and E23 (Corporate Compliance Nurse).		

Provider's Signature _____ Title ED Date 11/5/25

DELAWARE HEALTH AND SOCIAL SERVICES

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

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STATE SURVEY REPORT

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