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
REVISED POST IDR REPORT

NAME OF FACILITY: The Lorelton

DATE SURVEY COMPLETED: February 11, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	REVISED POST IDR REPORT An unannounced Annual and Complaint survey was conducted at this facility from February 5, 2026, through February 11, 2026. The deficiencies contained in this report are based on observation, interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-five (85). The survey sample totaled ten (10) residents. Abbreviations/definitions used in this state report are as follows: ABT – antibiotic; Acetaminophen – Tylenol/medication use for pain; ADL – activities of daily living/tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; AL – assisted living; Atherosclerotic heart disease – disease caused by plaque buildup in arterial walls; Atorvastatin – also known as Lipitor/medication to treat high cholesterol; Atrial fibrillation – aFib/irregular heart rhythm; Avulsion – injury in which a body structure (skin) was torn off by either trauma or surgery; Bilateral cataracts – condition when the lenses of both eyes become cloudy, causing blurriness; Bipolar disorder – mood disorder; BOD – Business Office Director; Bupropion – medication to treat depressive disorder;		

Provider's Signature _____ Title Executive Director Date 5/28/26

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	Chronic kidney disease stage 3 – mild to moderate loss of kidney function; Copious – large amount; Dementia – severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation; Diabetes mellitus – DM/chronic disease where sugar levels are too high; Dialysis – cleansing of the blood by artificial means when the kidneys have failed; Dialyvite – supplement medication for dialysis patient; DON – Director of Nursing; ED – Executive Director; Eliquis – medication use to treat and prevent blood clots in individuals with aFib; EMR – electronic medical record/systematized collection of patient and population electronically stored health information in a digital format; Epidermal – top layer of skin that is a barrier to infection; ESRD – end stage renal disease/when the kidneys lose nearly all their filtering ability and require artificial means to cleanse the blood of waste products; Executed – legally binding agreement that has been signed by all necessary parties, making it enforceable and complete; Glaucoma – condition of the eye that can cause vision loss and blindness by damaging the optic nerve located in the back of the eye; Hematoma – collection of blood as a result of trauma or injury to blood vessels; Hyperlipidemia – common condition characterized by high levels of fats in the blood;		

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	Hypertensive retinopathy – damage to the retina caused by chronic high blood pressure, which can lead to vision loss; IL – independent living; Influenza – contagious respiratory infection; Laceration – cut/tear in skin; Lamictal – also known as Lamotrigine/medication used to treat seizures or bipolar disorder; LPN – Licensed Practical Nurse; Macular Degeneration – eye disease that affects central vision; MD – Medical Director; Midodrine – medication used to treat low blood pressure; Miralax – medication use to stimulate bowel movements; MRSA – Methicillin-Resistant Staphylococcus Aureus/bacterium resistant to many antibiotics, causing serious skin, bloodstream, or pneumonia infections. Primarily spread through direct contact with infected skin or contaminated items; Occ – Occasional; Osteomyelitis – infection in a bone; Osteopenia – loss of bone density; Pain Intensity Scale: 0 – no pain, 1 – mild, 2 – moderate, 3 – severe, 4 – very severe, 5 – worst possible; Palmar – having to do with the palm of the hand; Parkinsonism – clinical syndrome characterized by a combination of motor symptoms primarily slowness of movement, along with resting tremor, muscle rigidity and impaired walking/balance; Parkinson's Disease – progressive disorder of the nervous system that affects your		

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	movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination; Peripheral neuropathy – disease affecting nerves often causing weakness, numbness and pain, usually in your hands and feet; PCP – primary care physician; POA – power of attorney/legal document appointing someone to make decisions on behalf of a resident if he/she is unable to do so; POS – physician order sheet/monthly report of resident's active physician orders; Pressure ulcers – PUs/sore area of skin that develops when the blood supply to it is cut off due to pressure; Psychotic disorder – severe mental disorder that cause abnormal thinking and perceptions; RA – Resident Aide; Renvela – medication used to control phosphorous levels in dialysis patients; RN – Registered Nurse; Sensipar – medication used to support bone health and manage calcium levels for dialysis patients; Service Agreement – written document developed with each resident which describes what services will be provided, who will provide the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome; SNF – skilled nursing facility; Stage III (3) pressure ulcer – skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin;		

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	Total Contact Cast – TCC/specialized, non–removable, below–knee fiberglass or plaster cast designed to heal diabetic foot ulcers (DFUs) by offloading pressure from the wound; UAI – Uniform Assessment Instrument/written document to collect information regarding an assisted living applicant/resident's physical condition, medical status and psychosocial needs. The information is to be used to: (1) determine if an applicant meets eligibility for entrance or retention in an assisted living facility; (2) if admitted, determine the appropriate level of care for the resident and develop a service agreement; and (3) update service needs and the service agreement; UM – Unit Manager; Unna boot – compression dressing, typically made of zinc oxide – impregnated gauze, used to treat venous leg ulcers, lymphedema, and sprains by enhancing venous return and promote healing; Velphoro – medication used to reduce absorption of phosphorous levels for dialysis patients; Warfarin – medication to treat and prevent blood clots in residents with irregular heartbeats.		
3225.0	**Assisted Living Facilities**		
3225.5.0	**General Requirements**		
3225.5.9	**An assisted living facility shall not admit, provide services to, or permit the provision of services to individuals who, as established by the resident assessment:**		
3225.5.9.5	**Have developed stage three or four skin ulcers.**		

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S/S – D	Based on interview and record review, it was determined that for one (R8) out of one resident reviewed for treatment, the facility failed to ensure that compliance with the general requirement was met when R8, with a right heel stage three pressure ulcer, was admitted to the assisted living facility. Findings include: Cross refer 11.5, 13.4 and 13.6 Review of R8's clinical record revealed: 4/14/25 – A facility Medical Information Report completed by P1 (SNF MD) documented, "Past Medical History... Parkinson's Disease... Patient also with (R) [right] heel pressure wound and has f/u (follow up) at wound care center." 4/17/25 – R8's initial UAI assessment revealed that R8 was oriented to person, place and time with mild dementia and independent with toileting, transfer and mobility with assist of a walker. R8 had an ongoing treatment for his right heel stage 3 pressure ulcer. 5/9/25 – R8 was admitted to the facility. 5/9/25 – A nurse observation note documented, "New ADMIT... Skin is clean, dry and intact but the resident has a pressure ulcer Stage 3 to his Right heel. The resident goes to the Wound Doctor once a week for his right heel treatment. He wears a support boot to his right foot for protection/ stability. The boot (sic) needs to be removed at	1. R8 is the only affected resident by the "deficient practice." Resident is now with Compassionate Care Hospice and a care plan remains in place with the podiatrist caring for the heel. 2. All residents new and existing have the potential of being affected. 3. This deficiency occurred because incomplete clinical information was received prior to admission. 4. New UAI's and supporting documentation will be brought to stand up and reviewed with IDT for disqualifying conditions. Inconsistent documentation will be identified by the IDT to ensure no individuals with disqualifying conditions are admitted. As admissions do not happen every day, we will do this for 45 days.	03/26/2026

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	bedtime and reapplied in the morning. He is independent with his ADL's but need assistance with his shower... d/t (due to) his right heel wound...". 5/17/25 – R8's 30-day UAI assessment revealed that R8 was oriented to person, place and time with mild dementia and independent with transfer and mobility with assist of a walker. R8 had an ongoing treatment for his right heel stage 3 pressure ulcer. 6/2/25 – A Wound Care Center Visit Summary documented, "Hydrofera Blue Transfer (an antimicrobial, non-cytotoxic foam dressing designed for heavily exuding, infected, or highly colonized acute or chronic wound) then Xtrasorb (a line of advanced, super absorbent wound dressings designed to manage moderate to heavily exuding wounds) was applied to the right heel wound prior to application of Total Contact Cast to the right lower leg. Tubigrip (size F) [multi–purpose, washable, and reusable elasticated tubular bandage dressing designed to provide lasting and effective support] was applied to the right lower leg prior to the application of the Total Contact Cast (fiber glass or plaster cast)...". 7/5/25 7:30 AM – An observation notes by E9 (LPN) documented that R8 was started on an antibiotic for "treatment of a heel infection." 1/20/26 – An encounter notes by P4 (Contracted NP) documented, "[R8] was admitted at the hospital from 11/11/25 to		

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	11/19/25 for right heel osteomyelitis with MRSA and leg wounds followed by a post-acute stay at a wound care/rehab setting until return to the assisted living community on 1/14/26... At today's visit [R8] reports the right heel wound remains present and is currently wrapped with a boot/Unna-type dressing...". 2/5/26 11:00 AM – When asked if the facility have residents with wounds and receiving treatment, E2 (DON/RN) replied that R8 had a wound on his right heel but it was already "healing" when he was admitted to the assisted living facility on 5/9/25. 2/10/26 10:00 AM – In a joint interview with E1 (ED) and E2, E2 stated that she did not know of R8's right heel pressure ulcer when he was admitted to the facility on 5/9/25. E2 further stated that R8 came and had an Unna boot on his right leg. E2 added, "That's the only way for me to accept him and that he will have to come with the Unna boot." 2/11/26 1:30 PM – Findings were discussed with E1, E2 and E3 (UM/LPN). 2/11/26 3:30 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.		
3225.6.0 3225.6.1	**Resident Waivers** **An assisted living facility may request a resident-specific waiver so that it may serve a current resident who temporarily**		

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	requires care otherwise excluded in section 5.9. A waiver request shall contain documentation by a physician stating that the resident's condition is expected to improve within 90 days.		
3225.6.3	**The assisted living shall submit in writing a request for a waiver, which shall include the following information:**		
3225.6.3.1	**An explanation of why the assisted living facility is seeking the waiver, to include physician documentation and a service agreement which details how staff will provide care;**		
3225.6.3.2	**An explanation of why denial of the waiver will impose a substantial hardship for the resident;**		
3225.6.3.3	**An explanation of why the waiver will not adversely affect the resident for whom the waiver is sought or other residents; and**		
3225.8.0	**Medication Management**		
3225.8.3	**Medication stored by the assisted living facility shall be stored and controlled as follows:**		
3225.8.3.1	**Medication shall be stored in a locked container, cabinet, or area that is only accessible to authorized personnel.**		
S/S – D	**This requirement was not met as evidenced by:**	1. No residents were adversely affected by the deficient practice. 2. Any resident could be affected by the deficient practice if someone were to remove their medication unlawfully. 3. Staff responsible for locking the carts did not follow protocol.	03/26/2026
	Based on observation and interview, it was determined that two medication carts were		

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	left unlocked and unattended by nursing. Findings include: The following two surveyor observations of unlocked medication carts were made during the survey: - 2/5/26 9:56 AM – second floor east medication cart with no nurse present. Immediately confirmed when E20 (Med Tech) returned to the medication cart; and - 2/9/26 4:00 PM – medication cart in the 2nd floor nurse's station. Immediately confirmed when E12 (LPN) returned to the nurse's station. 2/11/26 2:05 PM – Finding was reviewed and discussed with E1 (ED), E2 (DON/RN) and E3 (UM/LPN). 2/11/25 3:30 PM – Finding was reviewed during the exit conference with E1, E2 and E3.	4. All med techs and nurses will be in serviced on importance of locking med carts. Audits will be conducted daily for our 6 med carts for 3 days until 100% compliance is reached. Moving forward audits will take place 3 times in a week until 100% compliance is reached. All med carts will be checked for 100% compliance the following week.	
3225.8.6 **3225.8.7** **S/S – D**	**Within 30 days after a resident's admission and concurrent with all UAI-based assessments, 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.** **The assisted living facility shall ensure that the review required by section 8.6 is documented in the resident's records, including**	1. R7 and R9 were the only residents affected by the deficient practice.	03/26/2026

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	any recommendations given by the reviewer. **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for two (R7 and R9) out of three residents reviewed for medication management, the facility failed to have evidence of on-site RN medication reviews of self-administration that were completed concurrently with the UAI assessments for each resident. Findings include: 1/4/26 last reviewed – The facility's policy and procedure for Self-Administration of Medications stated, "... Procedures: 1. Residents will be assessed upon admission... During the Uniform Assessment Evaluation, it will be determined if the resident is physically and cognitively able to safely self-administer medications according to their PCP's [primary care physician's] orders. 2. Following the initial self-administration assessment, an RN will annually, and as needed, reassess the physical and cognitive ability of the resident using the Self-Medication Assessment Form. 3. The RN may reassess the resident sooner if significant change in the resident occurs.	2. Any new resident or existing resident that self-administers medications could have been affected by this deficient practice. 3. Lack of documentation related to the onsite medication review. 4. The policy and medication review documentation sheet have been reviewed and updated so the practice can be documented in the resident's medical record. Along with the UAI schedule the first 3 individuals that are independent with medications will be audited by the IDT to ensure the RN assessment is completed and documented with 100% success. Then all residents that are independent with medication management that come in up until 03/26/2026 will also be reviewed by IDT.	

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	4. If the resident is found to be incapable of safely self-administering their own medications, their family/POA [power of attorney] will be notified by the Director of Nursing or designee. Thereafter, medications will be distributed by the nursing department, and the Personalized Service Agreement will be amended to reflect this change in level of care...". Attached to the facility's policy was a document entitled "The Lorelton Self-Administration of Medications Assessment & [and] Informed Consent Form... Part I Assessment... Part II Assessment Outcome... Part III Informed Consent... Resident Signature Date... Nurse Signature Date." 1. Review of R9's record revealed: 5/29/24 – The facility's Medical Information Report completed by R9's PCP documented, "... eyes poor... severe decrease in vision – followed by [name of eye physician practice]... mild memory issues... difficulty remembering appointments... May Self Administer Meds: Yes [checked] (may need assistance secondary to low vision)... Primary diagnosis: Atrial Fibrillation... ESRD on dialysis, type 2 DM [diabetes mellitus] with peripheral neuropathy, hypertensive retinopathy, bipolar disorder... See attached med [medication] record...". 5/31/25 – R9 was admitted to the facility. 6/1/25 – The annual UAI assessment completed by E2 (DON/RN) documented that R9 was independent for medication manage-		

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	ment and had diagnoses that included diabetes type II, end stage renal failure requiring dialysis three times a week, bipolar disorder, kidney cancer in remission. The UAI lacked evidence that R9 had any eye disorders, vision was adequate and had no memory issues. Under the Medications section, "Self-Medicates SEE POS [Physician Order Sheet]" was documented. There was no POS attached to the UAI. 2/9/26 10:12 AM – During an interview, R9 stated that he self-administers his medication. When asked if the RN reviewed his medication with him, he stated no. 2/9/26 12:50 PM – During an interview, surveyor asked E2 (DON/RN) for the on-site RN medication review for R9. The surveyor showed E2 a copy of the regulation. E2 asked surveyor for a copy of the regulation (page 7) and copy was immediately provided. E2 stated that she will get back to the surveyor about the medication review. A short while later in response, E1 (ED) and E2 referred the surveyor to R9's 6/1/25 UAI, under Activities of Daily Living, 10. Medication Management (checked) Independent as evidence of the on-site RN medication review. 2/11/26 2:05 PM – Finding was reviewed and discussed with E1, E2 and E3 (UM/LPN). Surveyor explained to E1 and E2 that after discussion with a Supervisor from the State Agency, completion of the UAI does not meet the regulation. 2. Review of R7's record revealed:		

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3225.9.0	5/22/25 – The facility's Medical Information Report completed by R7's PCP documented under Primary Diagnosis "Macular degeneration, Glaucoma, Arthritis, osteopenia, CKD [chronic kidney disease]." Under the section titled "Further details of positive responses:", R7's PCP documented "Dx'd [diagnosed] AMD [age-related macular degeneration] 2011, decreasing vision. Now low vision right eye, no vision L eye...Fatigue - due to low vision..." May Self Administer Meds: Yes [checked]. 5/17/25 – The initial UAI assessment completed by E2 (DON/RN) documented that R7 was independent for medication management and had diagnoses that included stroke, bilateral cataracts that had been removed, glaucoma, macular degeneration and CKD stage 3. Under Vision, "Sees adequately with or without corrective lenses" was checked. Under the Medications section, "Self-Medicates SEE POS [Physician Order Sheet]" was documented. There was no POS attached to the UAI. 6/18/25 – R7 was admitted to the facility. 1/8/26 – The significant change UAI completed by E2 documented that R7 was independent for medication management. Review of R7's electronic and paper records lacked evidence of an on-site RN medication review of self-administration that was completed concurrent with the 1/8/26 significant change UAI. 2/11/25 3:30 PM – Findings were reviewed during the exit conference with E1 (ED), E2 and E3 (UM/LPN).		

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3225.9.7 **S/S – D**	**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 and interview, it was determined that for one (R7) out of three residents reviewed for vaccines, the facility failed to have evidence that R7 had received, or declined, the pneumococcal vaccination. Findings include: Review of R7's record revealed: 5/22/25 – Form titled The Lorelton Medical Information Report was completed. The section "Date of Pneumococcal vaccine" was blank. 6/18/25 – R7 was admitted to the facility.	1. "Affected resident", R7 has been identified in the deficiency. Has subsequently been found to have a declination signed in the vaccination book that was provided. 2. All residents had the potential to be affected by the deficient practice. 3. Our current system will remain as this was an oversight by the surveyors. 4. A random sample of 3 charts will be pulled to identify pneumovax compliance to ensure the current system is effective. Then all new incoming resident's vaccination status until 03/26/2026 is compliant at 100%.	03/26/2026

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	6/18/25 – The Resident Information Form was completed in the resident's electronic health record. The subsection "Pneumonia" listed under "Vaccination and Screenings" was blank. 2/10/26 1:25 PM - R7's printed Resident Vaccination Sheet located in the facility's Immunization Binder was reviewed. There was no documentation that R7 received or declined the pneumococcal vaccination. 2/10/26 1:30 PM - During an interview, E4 (LPN) confirmed that there was no documentation that R7 received or declined the pneumococcal vaccination. 2/11/26 3:30 PM - Finding was reviewed with E1 (ED), E2 (DON/RN), and E3 (UM/LPN) during the exit conference.		
3225.10.0 3225.10.10 S/S – D	**Contracts** **No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed.** Based on record review and interview, it was determined that for one (R3) out of one resident reviewed for contract, the facility failed to have an executed service agreement before R3's contract was signed. Findings include: Cross refer 3225.11.2 example 1 Review of R3's record revealed:	1. R3 was the affected resident. 2. Any resident whose POA was unavailable to sign the service agreement in person could've been affected. 3. POA's inability to meet personally with the DON to sign assessment and service agreement. Facility needs to attach all emails attempting to share and get a signature to original documentation. 4. To ensure current practice continues to be successful, the first 3 service agreements of both new residents and upcoming scheduled service agreements for existing residents have signatures or timely emails requesting a signature. All scheduled	03/26/2026

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	6/23/25 – The initial UAI assessment and service agreement were completed and signed by E2 (DON/RN). Both the UAI and Service Agreement were not signed by R3's POA and remained unsigned as of 2/10/26. 7/7/25 12:15 PM – A nursing note documented that R3 was admitted to the facility and accompanied by R3's POA. 7/7/25 – The Lorelton Agreement [contract] was signed by R3's POA. The Agreement stated "... 63.405 No contract shall be signed before a full assessment of the Resident has been completed and a service agreement, with costs, has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment...". 11/12/25 2:16 PM – An email from E2 was sent to R3's POA stating, "Attached are... initial and 30-day [UAI] assessment and service agreements that need signed. If you could stop in the nurse's station the next time you are in and sign them that would be great!" 2/11/26 2:05 PM – Finding was reviewed and discussed with E1 (ED), E2 and E3 (UM/LPN). E1 responded, "There was one attempt from November. That's plenty. You expect us to go out to someone's house. We attempted, that's all we need." Surveyor acknowledged that there was one documented attempt from November 2025; however, the regulation was not met.	and new admit service agreements until 3/26/2026 will have a signature or documentation indicating it has been shared requesting a signature.	

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3225.11.0 **3225.11.5** **S/S – D**	2/11/25 3:30 PM – Finding was reviewed during the exit conference with E1, E2 and E3. **Resident Assessment** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for one (R8) out of ten residents reviewed for UAI assessment, the facility failed to ensure that R8's UAI assessment was updated with a change in condition to accurately reflect R8's stage 3 right heel pressure ulcer and the special wound care services that were required for treatment. Findings include: Cross refer 5.9.5, 13.4 and 13.6 Review of R8's clinical record revealed: 4/17/25 - R8's initial UAI assessment revealed that R8 had a stage 3 right heel pressure ulcer. 5/9/25 4:15 PM – An observation note by E4 (LPN) documented that R8 was admitted to the facility with a right heel stage three pressure ulcer. E4 further documented, "[R8] goes to the Wound Doctor once a	1. R8 is the affected resident. 2. All residents could be affected if a change in condition is not identified. 3. Facility did not identify a change in condition. 4. IDT to review any changes in condition to determine if the change constitutes a significant change triggering a change in condition assessment. Success will be determined when assessments are performed on returning residents from acute and subacute care a UAI will be automatically completed and compared to previous UAI to determine if there is a change in condition as determined by the IDT and if a change in condition is identified the IDT will audit returning charts to ensure that a new service agreement is initiated at 100% compliance until 03/26/2026.	03/26/2026

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	week for his right heel treatment. [R8] wears a support boot to his right foot for protection/ stability. The boot need (sic) to be removed at bedtime and reapplied in the morning...". 5/17/25 - R8's 30-day UAI revealed that R8 had a stage 3 right heel pressure ulcer with treatment in progress. 7/5/25 7:30 AM - A nurse observation notes by E9 (LPN) documented, "... [R8] was started on ABT Therapy for treatment of a heel infection." 7/8/25 – A review of R8's status log in the EHR (electronic health record) revealed that R8 was sent out to the hospital. 8/7/25 – A review of R8's status log in the EHR revealed that R8 was readmitted to the facility. 11/10/25 – R8's November 2025 MAR revealed a wound care order to "Cleanse with Normal Saline, Apply Foam Dressing and change Every 1 to 3 Days. Strict Off Loading of Right Heel." 11/11/25 - A review of R8's status log in the EHR revealed that R8 was sent out to the hospital. 1/20/26 – A facility encounter note by P4 (Contracted NP) documented, "... Osteomyelitis... (right heel osteomyelitis noted)... continue offloading and wound care plan... Follow up with podiatry and infectious disease as directed... MRSA infection control		

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	and wound care measures... monitor for... worsening wound appearance, or new drainage... Monitor for increased redness, swelling, drainage, odor, fever or escalating pain...". 2/10/26 10:00 AM – In a joint interview with E1 (ED) and E2 (DON), E2 stated that she did not know of R8's stage 3 pressure ulcer as resident came to the facility on 5/9/25 in an Unna boot. She further stated, "That's the only way for me to accept him and that he will have the Unna boot. The boot gets changed by the wound care center. I did not see his wound because it was in a cast." When asked if the facility had records of R8's wound care center visit notes with treatment recommendation, E1 replied and stated that R8's son and POA, (FM1) takes R8 to the wound care center every week. E1 stated, "[FM1] has all the wound care notes and other papers. I thought I could get those papers from him, but I wasn't able to. We don't deal with [R8's] wound treatment." 2/11/26 1:30 PM – Findings were discussed with E1, E2 and E3 (UM/LPN). The facility failed to update R8's UAI skin assessment when R8 was readmitted on 1/6/26 with osteomyelitis and MRSA on his right heel stage 3 pressure ulcer that required monitoring and wound care services. 2/11/26 3:30 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.		

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3225.12.0 **3225.12.3** **S/S – D**	**Services** **The assisted living facility shall ensure that the resident's service agreement is being properly implemented.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for one (R8) out of three residents reviewed for medication management, the facility failed to ensure that R8's service agreement was properly implemented when facility staff left R8's medication for him to self-administer. Findings include: Review of R8's clinical record revealed: 4/14/25 – A facility Medical Information Report completed by P1 (SNF MD) documented, "Past Medical History... Hypertension... Prostate Enlargement... Parkinson's Disease... Others (Specify) Atherosclerotic heart disease, dementia, hyperlipidemia... Patient with recent hospital stay for slurred speech and no evidence of CVA (stroke) on imaging...". 4/17/25 – R8's initial UAI and service agreement revealed that R8 was alert and oriented to person, place and time and was dependent with medication administration. 5/9/25 – R8 was admitted to the facility. 5/17/25 – R8's 30-day UAI and service agreement revealed that R8 was alert and	1. R8 was determined by the surveyors to be the affected resident from this deficiency. 2. Without proper medication administration being followed any resident could be affected by this deficient practice. 3. Claims were made that meds were left unsupervised in a resident's possession and were not properly administered to said resident. 4. DON or DON representative will audit the med pass of R8 and 2 randomly selected residents. Success will be determined by 100% compliance with the med passer watching ingestion of all medications, then 3 more med passes will be randomly selected and audited by DON or DON rep with 100% compliance.	03/26/2026

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	oriented to person, place and time and dependent with medication administration. 5/19/25 – R8 had a physician's order for Depakote (also known as Divalproex Sod Er) 500 Mg (milligram) one tablet by mouth at bedtime for mood disorder. 6/25/26 10:55 PM – An observation notes by E6 (Med Tech) documented, "Divalproex Sod Er 500 Mg Tab No Pass: Refused by Resident... resident refuses to take this medication, he states it makes him fall and it's way too much mg." 6/26/25 10:56 PM – An observation notes by E7 (Med Tech) documented, "Divalproex Sod Er 500 Mg Tab No Pass: Refused by Resident... nurse aware." 7/2/25 8:49 PM – An observation notes by E7 documented, "Divalproex Sod Er 500 Mg Tab No Pass: Refused by Resident... would only take half dose." 7/6/25 9:34 PM - An observation notes by E8 (Med Tech) documented, "Divalproex Sod Er 500 Mg Tab No Pass: Refused by Resident... He stated that he will not take it because he does not like how it makes him feel, nurse made aware." 8/7/25 - R8 had a new physician's order for Divalproex Sod Er 250 Mg take 2 tablets by mouth at bedtime for bipolar disorder. 8/10/25 - R8 had a physician's order increase Divalproex Sod Er to 500 Mg take 2		

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	tablets by mouth at bedtime for bipolar disorder. 10/8/25 – A facility psych consultation form by P3 (Psych MD) documented, "... [R8] meds are administered by nursing staff when his nighttime meds are left in a cup for him to take at his convenience, sometimes he throws out Depakote or breaks it in half. He attributes Depakote to occ (sic) feeling unsteady on his feet after taking nighttime meds although he is on multiple meds and doesn't know this for certain...". 10/14/25 – A forwarded fax transmittal sheet regarding P3's psych consultation notes from the facility addressed to P4 (Contracted NP) documented, "Reviewed by [P4] and no (no new orders), No (sic) changes made to meds." 2/6/26 2:25 PM – During an interview, R8 stated that he used to live in IL (independent living facility) and was self–administering his own medications. R8 stated, "I messed up big time because I made dose adjustments on my own... I got hospitalized... I cannot take medications on my own, someone must give it to me... but some nursing staff here left my nighttime meds for me to take when I want it." R8 further stated that there were times when they (nursing staff) left his night medicine Depakote for him to take at night at his convenience whenever he wants to take it. R8 stated, "Yeah, back then, I took one pill instead of two pills of Depakote because they were too much for me. It made me unsteady. I threw away the other pill and split		

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	the dose in half... That Depakote medicine caused me to go out of balance... You found me on the floor today... good thing you came "! 2/6/26 12:45 PM – In an interview and when asked if R8 had behaviors of refusing his Depakote medication or reports of side effects from taking Depakote, E5 (LPN Supervisor) stated that he is not aware that R8 was not taking the correct dose of his Depakote medication at night. E5 further stated, "In AL, the residents have the right to refuse their medications... it's not a behavior when they refuse their medications – it's their right." 2/6/26 2:40 PM – In a follow up interview, E5 told this surveyor that he found a psych consultation note by P3 documenting that R8 reported splitting his Depakote medication. E5 stated, "I do not know about that!" 2/9/26 9:20 AM – In an interview, P4 (Contracted NP) stated that she read P3's note regarding nursing staff leaving R8's nighttime Depakote medication for R8 to take at his own convenience. P4 further stated that R8 was not taking the correct dose as prescribed. When asked if this was discussed with nursing, P4 replied, "No. It's [P3] looking into that." 2/10/26 10:00 AM – In a joint interview with E1 (ED) and E2 (DON/RN), when asked what the facility do to address R8's issue of not taking his Depakote as prescribed by the physician and what oversight was done to ensure R8's medication was administered		

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	as ordered, E1 stated that the resident was psychotic. E1 further commented, "Would you believe that? [R8] is psychotic, he has bipolar." E2 also added that she was not aware of the past instances when Med Tech and R8 reported that nursing staff were leaving his nighttime Depakote medicine for him to take at his own convenience and that resident was not taking the correct dose as prescribed. E2 further stated that she did not know about R8 not taking the right dose of Depakote as written in P3's consultation notes on 10/8/25. 2/11/26 1:30 PM – Finding was discussed with E1, E2 and E3 (UM/LPN). 2/11/26 3:30 PM - Finding was reviewed with E1, E2 and E3 during the exit conference.		
3225.13.0 **3225.13.1** **S/S – D**	**Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.** Based on record review and interview, it was determined that for one (R3) out of one resident reviewed for contract, the facility	1. R3 was the affected resident. 2. Any resident whose POA was unavailable to sign the UAI in person could've been affected. 3. POA's inability to meet personally with the DON to sign UAI. Facility needs to attach all emails attempting to share and get a signature to original documentation. 4. To ensure current practice continues to be successful, the first 3 service agreements of both new residents and upcoming scheduled service agreements for existing residents	03/26/2026

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	failed to have an executed service agreement no later than the day of admission. Findings include: Cross refer 3225.10.10 Review of R3's record revealed: 6/23/25 – The initial service agreement was completed and signed by E2 (DON/RN). The service agreement was not signed by R3's POA and remained unsigned as of 2/10/26. 7/7/25 12:15 PM – A nursing note documented that R3 was admitted to the facility and accompanied by R3's POA. 11/12/25 2:16 PM – An email from E2 was sent to R3's POA stating, "Attached are... initial and 30-day assessment and service agreements that need signed. If you could stop in the nurse's station the next time you are in and sign them that would be great!" 2/11/26 2:05 PM – Finding was reviewed and discussed with E1 (ED), E2 and E3 (UM/LPN). E1 responded, "There was one attempt in November. That's plenty. You expect us to go out to someone's house. We attempted, that's all we need." Surveyor acknowledged that there was one documented attempt from November 2025; however, the regulation was not met. 2/11/25 3:30 PM – Finding was reviewed during the exit conference with E1, E2 and E3.	have signatures or timely emails requesting a signature. All scheduled and new admit service agreements until 3/26/2026 will have a signature or documentation indicating it has been shared requesting a signature.	

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3225.13.4 **S/S – D**	**The facility shall be responsible for appropriate documentation in the service agreement for services provided or arranged by the facility.** Based on observation, interview and record review, it was determined that for one (R8) out of ten residents reviewed for service agreement, the facility failed to appropriately document in the service agreement, the service provided by the facility to offload R8's right heel. Findings include: Cross refer 5.9.5 and 11.5 Review of R8's record revealed: 4/17/25 - R8's initial service agreement did not indicate that R8 was needing assistance with offloading his right heel. 5/9/25 4:15 PM – R8 was admitted to the facility with a right heel stage 3 pressure ulcer. R8 wore a "support boot "to his right foot which needed to be removed at bedtime and reapplied in the morning. 5/17/25 - R8's 30-day service agreement did not indicate that R8 was needing assistance with offloading his right heel. 11/7/25 – A review of R8's November 2025 TAR revealed that a care task was added to assist offloading boot to R8's right heel. 11/10/25 – R8's November 2025 MAR revealed a wound care order to "Cleanse With Normal Saline, Apply Foam Dressing and	1. R8 was identified as the affected resident in this deficient practice. An immediate change in care plan or service agreement would not be applicable. 2. Any resident who had a change in care plan but not in the associated service agreement could be affected by this deficient practice. 3. Failure to identify new orders that could change the care plan and would trigger a new service agreement. 4. Physician orders will be taken to stand up after the physicians visit for the week. The orders for week one will be reviewed by the IDT to determine if changes in the care plan should occur significant enough to warrant a new service agreement. Success will be determined by 100% compliance with care plan updates and when appropriate from all orders received until 3/26/2026.	03/26/2026

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	change Every 1 to 3 Days. Strict Off Loading of Right Heel." 1/20/26 – A facility encounter note by P4 (Contracted NP) documented "... Continue offloading and wound care plan...". 2/10/25 – Review of R8's 1/7/26 through 2/7/26 TAR revealed an active care task to "offload boot and assist with placing and offloading boot to right heel." 2/10/26 10:00 AM – In a joint interview with E1 (ED) and E2 (DON), E1 presented to the surveyor a copy of P4's (Contracted NP) encounter notes dated 1/20/26 and stated, "[P4] did not mention in her notes about offloading heels...". E2 stated that she was not aware of P4's order for staff to check with offloading R8's heel which was on an Unna boot. E2 also stated that she was not aware of an old and discontinued physician's order or care task to assist R8 with removing the black walking boot at bedtime and putting the boot back on in the morning. E1 also stated, "The walking boot is just like a shoe. We don't let our staff put on and take off our residents' shoes! No, we don't do that!" 2/11/26 1:30 PM – Findings were discussed with E1, E2 and E3 (UM/LPN).		
3225.13.6 **S/S – D**	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.**	1. R8 was identified as the affected resident in this deficient practice. An immediate change in care plan or service agreement would not be applicable.	03/26/2026

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	This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R8) out of ten residents reviewed for service agreement, the facility failed to ensure that R8's service agreement was updated with a change in condition to accurately reflect R8's stage 3 right heel pressure ulcer and the special wound care services and treatment that was required. Findings include: Cross refer 5.9.5 and 11.5 Review of R8's record revealed: 1/20/26 – A facility encounter note by P4 (Contracted NP) documented, "Monitor for fever, worsening wound drainage/redness... Osteomyelitis... (right heel osteomyelitis noted)... Continue offloading and wound care plan... Follow up with podiatry and infectious disease as directed... MRSA infection control and wound care measures... monitor for fever, worsening wound appearance, or new drainage... Heel Ulcer... ongoing right heel ulcer with boot/Unna dressing;... continue offloading and wound care... Monitor for increased redness, swelling, drainage, odor, fever or escalating pain...". The facility failed to update R8's service agreement for a change in skin condition when R8 was readmitted on 1/6/26 with osteomyelitis and MRSA on his right heel stage 3 pressure ulcer that required monitoring and wound care services.	2. Any resident who had a change in care plan but not in the associated service agreement could be affected by this deficient practice. 3. Failure to identify new orders that could change the care plan and would trigger a new service agreement. 4. Physician orders will be taken to stand up after the physicians visit for the week. The orders for week one will be reviewed by the IDT to determine if changes in the care plan should occur significant enough to warrant a new service agreement. Success will be determined by 100% compliance with care plan updates and when appropriate from all orders received until 3/26/2026.	

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	2/11/26 1:30 PM – Finding was discussed with E1 (ED), E2 (DON/RN) and E3 (UM/LPN). 2/11/26 3:30 PM - Finding was reviewed with E1, E2 and E3 during the exit conference.		
3225.16.0 **3225.16.13** **S/S – D**	**Staffing** **The Director of Nursing shall have overall responsibility for the coordination, supervision and provision of the nursing department/services.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for one (R9) out of three residents reviewed for medication management, the facility failed to ensure that R9's four quarterly pharmacy reviews that repeatedly requested for updated information and the resident's medication list were addressed. Findings include: The facility's undated job description of the Director of Nursing included, "... Essential duties and responsibilities... Clinical – Oversees general care and related services to residents. Oversees the monitoring system for medication administration and record keeping...". Review of R9's record revealed: 5/29/24 – The facility's Medical Information Report completed by R9's PCP prior to the	1. R9 was determined to be the only resident affected. Immediately pharmacy was called and updated med list was added to EMAR. 2. Any resident who self-administers meds had the potential to be affected. Audits of all residents that self-administer meds were completed immediately and all EMARs were updated. 3. A gap was identified between the pharmacy and our EMAR system. 4. 3 residents that are independent with med administration will be audited to ensure that they have an updated med list with 100% compliance, then all residents who self-administer meds will be audited with 100 % compliance to have an appropriate med list by 3/26/2026.	03/26/2026

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	resident's admission documented, "... See attached med [medication] record...". The attached Medication Reconciliation listed the following medications: Velphoro, Renvela, Lipitor, Bupropion, Acetaminophen, Warfarin, Sensipar, Miralax, Midodrine, Lamictal and Dialyvite. 5/31/24 – R9 was admitted to the facility. 2/9/26 - Review of R9's electronic medication record revealed that the resident's active medications were not profiled/listed; and R9's paper chart only had the 5/29/24 medication list. 2/9/25 2:14 PM – During an interview and observation of R9's medications in his room revealed that he had prescription bottles of Eliquis, Atorvastatin, Lamotrigine, Velphoro, Dialyvite, Bupropion, Midodrine and a couple of unidentified bottles that had faded labels. Immediately confirmed with E5 (LPN Supervisor). Review of the required quarterly Consultant Pharmacist Record of Medication Reviews facility form in R9's paper chart documented: - "4/21/25 need MAR [Medication Administration Record]"; - "7/21/25 no med [medication] list"; - "10/12/25 no recent PN [progress note] no med list"; - "1/21/26 no recent update on chart." As a result of the lack of updated resident information and medication list, the contracted Pharmacist was unable to complete		

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	the four quarterly medication reviews for R9 as required. 2/11/26 2:05 PM – Finding was reviewed and discussed with E1 (ED), E2 (DON/RN) and E3 (UM/LPN). 2/11/25 3:30 PM – Finding was reviewed during the exit conference with E1, E2 and E3.		
3225.16.14	**Assisted living facility resident assistants shall, at a minimum:**		
3225.16.14.2	**Participate in a facility-specific orientation program that covers the following topics:**		
3225.16.14.2.5	**Job responsibilities;**		
3225.16.14.2.7	**The resident assessment process; and**		
3225.16.14.2.8	**The use of service agreements.**		
S/S = D	**These requirements were not met as evidenced by:** Based on interview and review of employee records, it was determined that for four (E11, E15, E16 and E17) out of four nursing assistants reviewed for facility–specific orientation program topics: job responsibilities, resident assessment process and the use of service agreements, the facility failed to ensure trainings were completed. Findings include: E11's first day in the facility was on 7/16/25. E15's first day in the facility was on 8/25/25.	1. No residents were harmed or at risk of harm d/t this deficient practice. 2. All residents could be negatively impacted if staff are not properly oriented. 3. Job responsibilities, assessments, and service agreement topics are in the general orientation and specific Aide orientation. New sign off sheets have been developed to specifically identify these topics. 4. Compliance will be shown by review of our orientation sign off sheets from 2/26/2026 indicating specific sign offs for the above topics. Ongoing compliance will be determined at next orientation on 3/26/2026 having completed and been signed off all above topics.	03/26/2026

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	E16's first day in the facility was on 12/11/25. E17's first day in the facility was on 1/26/26. 2/11/26 9:00 AM – A review of E11, E15, E16 and E17's employee training records lacked evidence that they completed the following facility–specific orientation program topics on job responsibilities, the resident assessment process and the use of service agreements. 2/11/26 1:30 PM – Findings were discussed and confirmed by E2 (DON/RN) and E3 (UM/LPN). 2/11/26 3:30 PM - Findings were reviewed with E1 (ED), E2 and E3 during the exit conference.		

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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
REVISED POST IDR REPORT

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