DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: State Street Assisted Living

DATE SURVEY COMPLETED: October 28, 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 October 23, 2025, through October 28, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documents as indicated. The facility census on the first day of survey was seventy-six. The survey sample totaled seventeen residents. Abbreviations/definitions used in this report are as follows: CM – Care Manager; CC – Celebration Coordinator; DHW – Director of Health and Wellness ED – Executive Director; MT – Medication Technician; MCD – Memory Care Director; UAI – Uniform Assessment Instrument – assessment completed by the facility;	**3225.8.3.1** **1.)** **DHW took immediate action once informed of this observation on 10/24/25 by surveyor. MT (medication technician) (E8) received performance review concerning policy violation and 1:1 counseling on importance of ensuring all medications carts are locked when away from cart.** **2.) All residents in the community have the potential to be affected by this practice.** **3.) Root Cause Analysis (RCA) Indicated a knowledge deficit of the importance of safe storage of medications. The DHW immediately conducted a documented Inservice with all MTs in the community reviewing the policy for storage of Medications on 10/24/25.** **4.) The DHW or licensed designee with audit a random cart every shift to ensure staff has cart locked while away from cart. Any cart found unlock while unattended will immediately be reported to the DHW/ED.** **Goal: No carts found unlocked while unattended.** **3x/week x 4 weeks; then monthly x 2 months. Audits will continue until substantial compliance is achieved. Findings will be reviewed by the QAPI committee.** **Date of Compliance: 12-12-2025**	12-12-2025
3225 **3225.8.0** **3225.8.3** **3225.8.3.1** **S/S – D**	**Assisted Living Facilities** **Medication Management** **Medication stored by the assisted living facility shall be stored and controlled as follows:** **Medication shall be stored in a locked container, cabinet, or area that is only accessible to authorized personnel;**		

Provider's Signature Cheryl A. Hills Title Executive Director Date 11/18/25

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	This requirement was not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that medications were stored in a locked cabinet only accessible to authorized personnel. Findings include: The facility policy on medication storage last updated 11/12/24 indicated, All medications including over the counter medications are kept in locked storage at all times. 10/23/25 8:40 AM – 8:44 AM- During initial tour of the third-floor medication cart three was observed unlocked and unattended by authorized personnel. 10/23/24 8:45 AM – E8 (MT) opened the door and exited room 329 and confirmed that Med cart 3 was left unattended and unlocked. 10/28/25 2:50 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).	**3225.8.6** **1.) Resident R8 had an on-site assessment and medication review of their medication regimen on 10/29/25. R8 was found to continue independent in self-medication administration. Attachment #3.** **2.) All residents who self-medicate in this community have the potential to be affected by this practice. When a resident is initially assessed for admission and the UAI reflects self-medication administration the resident will then be assessed by the DHW or RN prior to admission or on the day of admission. Attachment #4.** **3.) RCA indicated a systemic breakdown /failure to audit all residents who self-medicate have completed self-medication evaluations. All residents that self-administered their medications were reviewed to ensure they all had the required onsite review for their ability to self-medicate. Completed by DHW on 10/30/25.** **4.) DHW will set up a monthly calendar that includes all residents initial self-medication assessments, when re-assessment is due, and if there are any changes in condition results in an assessment completed prior to the resident's annual assessment. The move-in**	
3225.8.6 **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.**		

Provider's Signature Cheryl A Ellis Title Executive Director Date 11/18/25

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	Based on record review and interview it was determined that for one (R8) out of two residents review for self-medication administration the facility failed to complete an onsite review by a registered nurse of the resident's medication regimen for a resident who self-administers medications. Findings include: The facility policy titled "Resident Self-Management and Storage of Medications last updated 11/12/24, indicated "Any resident (current or prospective) who desires to self-manage their medication must be assessed by the DHW using the Evaluation for Medication and Self-Management form. Review of R8's clinical record revealed: 2/7/25 – A UAI assessment documented that R8 was independent for medication administration. 2/12/25 – A service agreement documented that R8 was "completely independent with self-medication administration." 2/16/25 – R8 was admitted to the facility. 10/24/25 – Review of R8's clinical record lacked evidence an onsite review was completed by a registered nurse to assess R8's ability to self-administer medications. 10/27/25 11:55 AM – During an interview E2 (DHW) confirmed the finding.	**check list will include self-medication assessment if applicable to the residents. Self-Medication Calendar will be audited by ED weekly x 4 weeks, Bi-weekly x 2 Months, then Monthly x 2 Months until 100% compliance is achieved for all residents that self-medicate in the community. Attachment #4.** **5.) Date of Compliance: 12/12/25** **3225.9.0/3225.9.7** **1.) Resident R9 pneumococcal vaccine was reviewed with daughter and resident, daughter stated resident has had pneumonia vaccine prior to her admission to State Street in February. Pneumonia vaccine declination completed and in residents record for 2025. Completed 11/7/25. Attachment #5** **2.) All residents residing in the community have the potential to be affected by this practice. The DHW or licensed designee will review all resident vaccine records in the community that they have a consent/declination form in chart.**	10/30/25 ongoing
3225.9.0 **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**	**3.) RCA indicated a systemic breakdown/failure to execute the process for all new admissions having a vaccine consent/declination on file**	

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	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 (R9) out of 13 residents reviewed for immunizations the facility failed to provide evidence of vaccination or declination of pneumococcal pneumonia. Findings include: The facility policy on immunization of residents last updated 11/12/24, indicated "Residents will be asked to provide immunization records to the community. Documentation of vaccine availability and resident refusal on a yearly basis are retained in the resident's record." Review of R9's clinical record revealed: 2/19/25 – R9 was admitted the facility at the age of seventy-seven years old. 10/24/25 – Review of R9's immunization records lacked evidence of immunization or declination for administration of the pneumococcal pneumonia vaccine.	**by day of admission. DHW, ED and MSD reviewed admission checklist revised to ensure immunization records included for all new admissions. In addition, DHW is developing an immunization spreadsheet to be able to track and ensure documents are kept up to date upon admission and annually. Attachment #4** **4.) The administrative team and DHW or licensed designee to meet within the week of all new admissions and review the admission checklist to ensure compliance with the facility policy on immunizations are always kept in compliance. DHW will conduct audits for 5 random residents charts weekly x 4 weeks, then monthly x 2 months until substantial compliance is achieved of 100%. Ongoing** **5.) Date of Compliance: 12-12-25**	

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	10/27/25 10:48 AM – During an interview E2 (DHW) confirmed and stated, "R9 did not arrive at the facility with historic immunization records." 10/28/25 2:50 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).		
3225.11.0 **3225.11.1** **3225.11.5** **S/S – D**	**Resident Assessment** **Each assisted living facility shall use a Uniform Assessment Instrument (UAI) developed by the Division. The UAI shall be used in conducting all resident assessments.** **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 interview, record review and review of other facility provided documents, it was determined for three (R2, R7 and R11) out of thirteen residents sampled for resident assessment the facility failed to complete UAI assessments as required. Findings include: Review of R2's clinical record revealed: 1. 4/8/25 – R2 was admitted to the facility. 4/8/25 – R2's UAI documented an initial assessment 4/3/25. Further review of the UAI revealed the 30-day assessment had not been completed.	**3225.11.0/3225.11.1/3225.11.5** **1.) Resident R2 UAI completed by DHW on 6/3/35 and E2 told surveyor that it was completed but not signed off on the UAI. E2 will complete the next assessment (6 months) on 11/30/25. R2 assessment was available in our VITALS program on 6/3/25. Attachment #6** **R7: UAI completed by DHW on 11/6/25. Attachment #7** **R11: UAI completed by DHW on 11/7/25. Attachment #8** **2.) All residents have the potential to be affected by this practice. All Resident records will be reviewed by DHW or licensed designee to ensure at a minimum the UAI developed by the Division is up to date and completed prior to admission, 30 days post physical move-in, during any significant change in condition, and annually.**	

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	10/27/25 12:06 PM – An interview with E2 (DHW) revealed R2's 30-day UAI assessment had not been completed. E2 stated, "No it wasn't done." 2. Review of R7's clinical record revealed: 6/26/24 – An initial UAI assessment was completed for R7. 6/29/24 – R7 was admitted to the facility. 10/24/24 - Review of R7's clinical record lacked evidence that an annual UAI assessment was completed. 10/28/25 11:17 AM – During an interview E2 (DHW) confirmed the finding. 3. Review of R11's clinical record revealed: 5/31/23 – R11 was admitted to the facility. 7/25/24 – An annual UAI assessment was completed for R11. 10/23/25 – Review of R11's clinical record lacked evidence that an annual UAI assessment was completed. 10/27/25 12:45 PM – During an interview E2 (DHW) confirmed the findings. 10/28/25 2:50 PM – Findings were reviewed during the exit conference with E1 (ED) and E2(DHW).	**3.) RCA indicated is a systemic failure to ensure all assessments were current in the residents record. DHW to develop monthly assessment binder for all required assessments to ensure they are completed within the required time frame.** **Goal: All required assessments are current in all residents charts in this community.** **4.) The admission check list will include a 30-day assessment which will include the 30-day assessment date. This task will be added to the DHW outlook calendar. To ensure assessment calendar is successful; DHW and ED will meet weekly x 4 weeks, then Monthly x 2 months to address all upcoming assessments and the completion of most recent assessments until substantial compliance is achieved.** **Attachment #4** **5.) Date of compliance: 12-12-25**	
3225.11.7 **S/S – E**	**The assisted living facility shall provide an instrument to assess interests, strengths, talents, skills and preferences of each resident within 30 days of admission to be used in activity planning.**		

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	Based on record review and interview it was determined that for four (R7, R9, R11 and R13) out of thirteen total residents reviewed the facility failed to provide an instrument to assess resident interest to be used in activity planning. Findings include: 1.Review of R7's clinical record revealed: 6/29/24 – R7 was admitted to the facility. 10/24/24 – Review of R7's clinical record lacked evidence than an activities assessment was completed. 2. Review of R9's clinical record revealed: 2/19/25 – R9 was admitted the facility 10/24/25 – Review of R9's clinical record lacked evidence that an activities assessment was completed. 3. Review of 11's clinical record revealed: 5/31/23 – R11 was admitted to the facility. 10/23/25 – Review of R11's clinical record lacked evidence that an activities assessment was completed. 4.Review of R13's clinical record revealed: 9/16/24 – R13 was admitted to the facility. 10/23/25 – Review of R13's clinical record lacked evidence that an activities assessment was completed. 10/27/25 9:07 AM – During an interview E4 (CC) confirmed the finding. E4 stated that the assessments were not completed due to a change of ownership.	**3225.11.7** **1.) Director of Celebrations (Director of Activities) collaborated with residents/families to complete our assessment "Lets Get to Know You" document on resident interests, strengths, talents, skills, and preferences.** **R7 completed 10/31/25 Attachment #9** **R9 completed on 10/31/25 Attachment #10** **R11 completed 10/31/25 Attachment #11** **R13 completed 10/31/25 Attachment #12** **2.) Residents residing in community have the potential to be affected by this practice. The Director of Celebrations will review all residents' records to ensure all residents have the interest document completed to ensure each resident has this tool to use with activity planning.** **3.) RCA indicated a systemic breakdown for the completion of the interest tool being available in resident's chart within 30 days of admission. The admission check list was revised to include completion of instrument to assess resident interest to be used in planning activities within 30 days of admission. (see attached) The Celebration Director and/or memory care director are responsible to ensure completion for each resident within 30 days post admission. Attachment #4**	

Provider's Signature Cheryl A Ellis Title Executive Director Date 11/8/25

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	10/28/25 2:50 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).	**4.) ED, DHW, BOD will complete audits on newly admitted residents no later than 25 days post admission to ensure all documents are completed within the 30-day time frame. Audits will be conducted for all new admits Weekly x 4 weeks, Monthly x 2 Months until substantial compliance is achieved. (ongoing)**	
3225.13.0	**Service Agreements**		
3225.13.1	**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.**	**5.) Date of Compliance: 12-12-25**	
S/S – E	**This requirement was not met as evidenced by:**		
	Based on interview, record review and review of other facility provided documents, it was determined for five (R2, R3, R8, R9 and R16) out of thirteen residents sampled for service agreements the facility failed to sign and date service plans. Findings include:	**3225.13.0/3225.13.1**	
	1. R2's clinical record revealed:	**1.) Service agreements based on the UAI have been completed on R2, last service agreement was completed 9/1/25 and reviewed with residents as she requested the assessment related to no level of care.**	
	4/8/25 – R2 was admitted to the facility.	**R2 signed 11/7/25 Attachment #13**	
	4/16/25 A review of R2's service plan lacked evidence of being signed and dated.	**R3 Service agreement completed on 9/4/25, reviewed with son, sent another copy for son to sign on 11/7/25. Unable to correct as resident no longer resides in our community.**	
	6/3/25 A review of R2's service plan lacked evidence of being signed and dated.	**Attachment #14**	
	10/27/25 12:06 PM An interview with E2 confirmed R2's service plan had not been signed and dated. E2 stated, "I was the one		

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	that gave her son the plan to sign, but he didn't date it, and I didn't sign or date it." 2. R3's clinical record revealed: 7/10/25 – R3 was admitted to the facility. 9/10/25 - A review of R3's service plan lacked evidence of a signature and date. 10/27/25 11:00 AM – An interview with E2 confirmed R3's service agreement dated 9/10/25 was not signed by the resident or the responsible person. E2 stated, "I signed it but [R3's] son didn't sign it." 3. Review of R8's clinical record revealed: 2/12/25 – A service agreement was completed for R8. 4. Review of R9's clinical record revealed: 2/17/25 – A service agreement was completed for R9. 10/24/25 – Review of R9's service agreement lacked evidence of the resident's signature. 5. Review of R16's clinical record revealed: 2/27/25 – A service agreement was completed for R16. 10/27/25 – Review of R16's service agreement lacked evidence of the resident's signature. 10/27/25 12:45 PM – During an interview E2 (DHW) confirmed that R8, R9, and R16's service agreements lacked the resident's signatures.	**R9 Service agreement completed on 6/16/2025. She was verbally aware and resident signed 11/7/25, no changes.** **Attachment #15** **R16 Service agreement completed on 2/27/25 and 5/4/25 verbally reviewed and signed on 10/29/25** **Attachment #16** **R8 signed service agreement dated/signed 10/29/25** **Attachment # 17** **2.) All residents have the potential to be affected by this practice. Resident records to reviewed by DHW or licensed designee to ensure all service agreements are present and signed by the resident and DHW or licensed designee by date of compliance.** **3.) RCA indicated a systemic failure to audit all new and past admissions service plans to ensure all service plans are signed by residents/resident's representative and the facility. The admission checklist revision will include ensuring the Service agreement for all residents are signed prior to or on the day of admission by facility and resident/resident's representative.** **4.) DHW, ED, and BOD will audit all admission checklists completed weekly x 4 weeks and Monthly x 2 months until substantial compliance is achieved and ensure all documents are in place and signed, ongoing.** **Goal: All residents have a signed service agreement in records before or on day of admission.** **5. Date of compliance: 12-12-25**	

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	10/28/25 2:50 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).		
3225.19.0	**Records and Reports**		
3225.19.6 **S/S – D**	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.**		
3225.19.7	**Reportable incidents include:**		
3225.19.7.7.2	**Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff up to 48 hours.**		
	This requirement was not met as evidenced by:		
	Based on interview, record review and other facility provided documents, it was determined for one (R2) out four residents reviewed for falls the facility failed to report R2's fall with injury within eight (8) hours of the fall. Findings include:	**3225.19.0/3225.19.6/3225.7.7.2**	
	R2's clinical record revealed:	**1.) Resident R2 was sent to hospital after fall on 9/11/25, hospital notified community on 9/12/25 that a fracture occurred, and the state report was completed post this notification of a fracture on 9/12/25.**	
	4/8/25 – R2 was admitted to the facility.	**2.) No Residents that reside in this community have the potential to be affected by this practice. If a resident falls and states they have pain, hit their head or appear to have a change in condition they are sent to the hospital and once a serious injury has been identified then the facility completes the state report related to serious injury. Should we suspect injury in the future we**	
	9/11/25 3:30 PM – Review of a facility incident report documented "[R2] was found on the floor in the bathroom, moaning and complained of right ankle pain." R2 was transferred to the hospital. The facility reported the fall to the division on 9/12/25 at		

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	12:00 PM, more than twenty (20) hours after the incident. 9/12/25 10:58 AM – The facility was notified by the hospital [R2] had a right ankle fracture. 10/27/25 1:20 PM – An interview with E2 (WHD) confirmed R2's fall and transport to the hospital was reported late. E2 stated, "I don't have anyone else here to do the reporting, that's why it was reported late, I'm the one that has to do the reports." 10/28/25 2:50 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DHW).	**will complete a state report upon sending them to the hospital and verify information in 5-day follow-up.** **3.) RCA indicated knowledge deficit with the state reporting policy and procedure. The DHW will review the state reportable policy/procedure with all nurses and ensure we are following the policy and procedure and all serious injuries are being reported within the 8-hour time frame.** **4.) DHW and ED will be notified immediately of all state reportable incidents and will review timelines to ensure compliance with timely reporting. Weekly x 4 weeks; then Monthly x 2 until substantial compliance is achieved. (Ongoing)** **5.) Date of Compliance: 12-12-25**	

Provider's Signature Cheryl A Hollis Title Executive Director Date 11/18/25

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