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: AL - Paramount Senior Living at Newark **DATE SURVEY COMPLETED:** June 11, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint Survey was conducted at this facility beginning June 3, 2026, through June 11, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census on the first day of survey was eighty – two (82) residents. The survey sample size totaled nineteen (19) residents. Abbreviations/definitions used in this report are as follows: AD – Activities Director; DON – Director of Nursing; ED - Executive Director; HK – Housekeeper; MT – Medication Technician; PT – Physical Therapist; RCA – Resident Care Assistant; Service Agreement – Allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include lodging, board, housekeeping, personal care and supervision services; UAI – A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical and psychosocial needs and sta-		

Provider's Signature Janine Hackett Title Executive Director Date 6/29/26

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	tus. The assisted living facility shall be required to use the UAI to evaluate each resident on the ongoing basis.		
3225.0	**Assisted Living Facilities**	1) Resident R21 was impacted and continues to reside in the facility. Action taken immediately. The residents significant change UAI was updated to reflect resident's assaultive behavior event and potential danger to others. All UAI assessments were audited by the Director of Nurses (DON) for resident assessment compliance. Resident assessments were reviewed with the resident or POA and documented in the form of a signature on the assessment document or documentation of telephone review of the assessment in the resident's electronic progress notes.	
3225.11.0	**Resident Assessment**		
3225.11.5	**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.**		
S/S – D	**These requirements were not met as evidenced by:**		
	Based on record review and interview, it was determined that for two (R21 & R9) out of nineteen residents reviewed the facility failed to update the UAI assessment when there was a significant change in the resident. Findings include:		
	1. Review of R21's clinical record revealed:		
	9/25/25 – A significant change UAI assessment completed for R21 documented that the resident was not a danger to self or others with no history of assaultive behavior.		
	5/19/26 - An incident report submitted to the State Agency documented that R21 was the aggressor in a resident-to-resident incident.		
	5/26/26 – An incident report submitted to the State Agency documented that R21 was the aggressor in a resident-to-resident incident.	2) All residents have the potential to be impacted by this practice. DON audited all resident records for assessment compliance, verifying signatures or documentation of telephone reviews. Non-compliant records were corrected through in-person or phone reviews. 3) Root Cause: The facility experienced multiple DON turnovers. The current DON is actively working to update UAIs following past resident events and changes. To resolve, all resident significant events will be updated in real time to reflect the resident's current condition and state.	7/30/26

Provider's Signature Jamme Hackett Title Executive Director Date 6/29/26

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	6/7/26 – Review of R21's clinical record lacked evidence of a revision to R21's UAI assessment to address the resident's assaultive behavior and potential danger to others. 6/8/26 11:42 AM – During an interview, E2(DON) confirmed that R21's UAI assessment was not updated following allegations of aggression. 6/8/26 3:00 PM – Findings were reviewed with E1 (NHA). 2. Review of R9's clinical record revealed: 8/30/17 – R9 was admitted to the facility. 7/31/25 – An annual UAI assessment documented R9 was dependent for transfers. 6/5/26 12:00 PM – An observation revealed a Hoyer lift in R9's bathroom. 6/5/26 12:10 PM – During an interview E7 (RCA) reported "[R9] uses the Hoyer lift with two people to help. E7 stated, "[R9] has used the Hoyer lift since I started working here in December last year." Further review of R9's UAI lacked evidence that a Hoyer lift was required for transfers." 6/5/26 12:49 PM – An interview with E2 (DON) confirmed R9's UAI had not been reviewed. E2 stated, "I haven't reviewed [R9's] UAI assessment yet this is the one that hasn't gotten done yet, so I will need to do a significant change for the Hoyer lift for transfers and the two person assist."	4) The Plan of Correction was discussed and evaluated. Resident significant changes will result in the completion of a Change of Condition UAI. Date of completion: Immediate. The Director of Nursing (DON) or designee will randomly audit 50% of the assessments weekly x 4 weeks and monthly x3 months to ensure 100% compliance is achieved. Date of Completion: 7/30/26. Any records found out of compliance will be corrected at time of audit with documentation of correction.	7/30/26

Provider's Signature Jeanne Hackett Title Executive Director Date 6/29/26

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3225.11.4 **S/S – D**	**The resident assessment shall be completed in conjunction with the resident.** **These requirements were not met as evidenced by:** Based on interview, record review and review of other facility records it was determined for one (R9) out of nineteen residents reviewed the facility failed to ensure the UAI (User Assessment Instrument) was signed and dated by the resident and/or responsible person upon completion. Findings include: 1. R9's clinical record revealed: 8/30/17 – R9 was admitted to the facility. 7/31/25 – A review of R9's annual UAI assessment lacked evidence of being signed by the resident or the responsible person for R9. 6/5/26 12:49 PM – An interview with E2 (DON) confirmed that R9's UAI had not been signed after it was completed. E2 stated, "I haven't looked at the assessment, yet it was done but it wasn't signed by the responsible person."	1) Resident R9 was not impacted and continues to reside safely in the facility. Action taken immediately. The residents UAI was updated to reflect resident's Hoyer Lift All UAI assessments were audited by the Director of Nurses (DON) for resident assessment compliance. Resident's signature obtained. Resident assessments were reviewed with the resident or POA and documented in the form of a signature on the assessment document or documentation of telephone review of the assessment in the resident's electronic progress notes. 2) All residents have the potential to be impacted by this practice. DON audited all resident records for assessment compliance, verifying signatures or documentation of telephone reviews. Non-compliant records were corrected through in-person or phone reviews. 3) Root Cause: The facility experienced multiple DON turnovers. The current DON is actively working to update UAIs following past resident events and changes. To resolve, all resident significant events will be updated in real time to reflect the residents' current condition and state. Confirmation of signatures also completed. 4) The Plan of Correction was discussed and evaluated. Resident significant changes will result in the completion of a Change of Condition UAI. Date of	7/30/26
3225.13.0 **3225.13.1**	**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**		

Provider's Signature Amma Hackett Title Executive Director Date 6/29/26

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	perform their obligations under the agreement. **These requirements were not met as evidenced by:** Based on interview, record review and review of other facility records it was determined for two (R1 and R2) out of nineteen residents reviewed for service agreements the facility failed to ensure the service agreement was signed and dated by the resident and/or responsible person once completed. Findings include: 1. R1's clinical record revealed: 3/29/24 – R1 was admitted to the facility. 2/27/26 – A service agreement was completed for R1. The service agreement lacked evidence of R1's signature. 6/8/26 10:10 AM – During an interview E2 (DON) reported "the form for the service agreement does not have a place for the resident and/or responsible person to sign." E2 stated, "I will have R1 sign the service agreement." 2. R2's clinical record revealed: 5/25/22 - R2 was admitted to the facility. Undated – A service agreement was completed by E2 (DON). The service agreement lacked evidence of R2's signature. E2 confirmed the service agreement was not dated and that R2 had not signed it. E2 stated, "I will take care of this."	completion: Immediate. The Director of Nursing (DON) or designee will randomly audit 50% of the assessments weekly x 4 weeks and monthly x3 months to ensure 100% compliance is achieved. Date of Completion: 7/30/26. Any records found out of compliance will be corrected at time of audit with documentation of correction. 1) Residents R1 and R2 were not impacted and continue to reside safely impacted in the facility. Action taken immediately. All admission charts were audited by the HCD for resident service agreement compliance. Resident service agreements were reviewed with resident or POA and documented in form of a signature on the service agreement document or documentation of telephone review of the assessment in the resident's electronic progress notes. A copy of the service agreement was provided to the resident or POA either as a paper or electronic document. 2) All resident records were audited by the DON for service agreement compliance. Service agreements were audited for resident and POA signature or documentation of a telephone review. A signature line (POA participant's signature) page to be	

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3325.13.5 **S/S - D**	6/11/26 12:00 PM - Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference. **The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **These requirements were not met as evidenced by:** Based on observation, record review and interview it was determined that for one (R21) out of nineteen residents reviewed the facility failed to ensure that service agreement was followed regarding R21's need for supervision. Findings include: Review of R21's clinical record revealed: R21's service agreement documented that the resident required extensive supervision. 6/8/26 – E5 (RA) was assigned to care for R21. 6/8/26 8:55 AM – R21's room was observed as empty. 6/8/26 8:59 AM- E4 (MT) found R21 across the hall in another resident's room resting in bed. 6/8/26 9:12 AM - E5 (RA) "I'm not sure who has him today but we both get him up when there's two we do everyone together. E5 was not aware that R21 was in another resident's bed.	maintained with the service agreement and UAI was added to the service agreement. Those found out of compliance were brought into compliance with either in-person review or telephone review. A copy of the service agreement will be provided to the resident or POA as a paper or electronic document. 3) Root Cause: In the instances where the resident service agreement was not signed, the facility experienced multiple DON turnovers. The current DON is actively working to update UAIs following past resident events and changes. To resolve, all annual UAIs to be reviewed for signature compliance. In addition, the facility's previous service agreement document did not have a specified signature line for POA's and residents. 4) The Plan of Correction was assessed and evaluated. Resident or POA will meet with Director of Nursing or designee will randomly audit 50% of service agreements weekly x4 weeks and monthly x3 months or until 100% compliance is achieved. Date of completion 7/30/26. Any records found out of compliance will be corrected at the time of the audited with documentation of a phone conversation to review the service agreement will be provided or POA as a paper or electronic copy with signatures obtained.	7/30/26

Provider's Signature Jeanne Hackett Title Executive Director Date 6/29/26

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3225.13.6 S/S- D	6/8/26 3:00 PM – Findings were reviewed with E1 (NHA). 6/11/26 12:00 PM - Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference. **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.** **These requirements were not met as evidenced by:** Based on record review and interview it was determined that for three (R21, R7 and R9) out of nineteen residents reviewed the facility failed to ensure that the service agreement was reviewed when the needs of the residents had changed. 1. Review of R21's clinical record revealed: 9/25/25 – A service agreement completed for R21 documented that the resident had no aggression. 5/19/26 - An incident report submitted to the State Agency documented that R21 was the aggressor in a resident-to-resident incident. 5/26/26 – An incident report submitted to the State Agency documented that R21 was the aggressor in a resident-to-resident incident.	1) Residents R21 were not impacted and continue to reside safely impacted in the facility. Action taken immediately. At the time of survey, resident was redirected out of resident room and accounted for. Defined resident assignments completed to clearly designated an assigned care aide. 2) All resident assignments were reviewed and staff interviewed. It was determined that staffed assignments were not clearly specified when 2 aides are on duty on the dementia unit. 3) Root Cause: Staff assignments were not clearly divided when the unit was staffed with two care aides. Further, staff were not following resident R21's service plan of care, specifically related to rounds. With undefined assignments, care aides worked "all residents together" without clear task allocation. As a result, the resident was able to wander into another resident's room undetected during the lunch meal service. 4) The Plan of Correction was assessed and evaluated. The ADON created an assignment sheet for shifts staffed with 2 care aides as well as 3. The ADON will train staff on various staffing assignments with clearly defined duties, including rounding frequency. The date of completion: 7/30/26. Any assignments found to	7/30/26

Provider's Signature Anne Hackett Title Executive Director Date 6/29/26

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	6/7/26 – Review of R21's clinical record lacked evidence of a revision to R21's service agreement to address the resident's aggression and a plan to meet the service need. 6/8/26 11:42 AM – During an interview, E2 (DON) confirmed that R21's service agreement was not updated following allegations of aggression. 6/8/26 3:00 PM – Findings were reviewed with E1 (NHA). 2. R7's clinical record revealed: 12/5/22 – R7 was admitted to the facility. 11/20/25 – A review of R7's annual service agreement documented "mobility devices used to assist R7 from one place to another in a wheelchair and/or a walker. 6/8/26 1:08 PM – A review of R7's annual service agreement dated 11/20/25 lacked evidence that R7 required footrests for all transports. 6/9/26 9:37 AM – An interview with E2 (DON) revealed R7's service agreement had not been revised to reflect [R7] requires footrests on the wheelchair for all transport. E2 stated, "I have not had the chance to review [R7's] service agreement I will update the service agreement with the footrests." 3. R9's clinical record revealed: 8/30/17 – R9 was admitted to the facility.	be out of compliance will be corrected at the time of the audit. 1) Resident R16, R17 and R21 were not impacted and continues to reside safely in the facility. Resident R16, R17 and R21 service agreements were updated to reflect resident's current care needs and safety round frequency. All service assessments were audited by the Director of Nurses (DON) for resident assessment compliance. 2) All residents have the potential to be impacted by this practice. DON audited all resident records for service agreement and accuracy compliance based on resident need. Care Aides re-trained on round and safety check completion and proper sign out and documentation by DON. Nurse/Med Tech on duty to review round frequency completion at shift end to ensure compliance. 3) Root Cause: The facility experienced multiple DON turnovers. The current DON is actively working to update service agreements to reflect past resident events and changes. To resolve this, all resident service agreements will be updated in real time to reflect each resident's current condition and safety needs. In addition,	

Provider's Signature Johnnie Hackett Title Executive Director Date 6/29/26

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	7/31/25 – A review of R9's annual service agreement had not been reviewed and updated to reflect R9 required a Hoyer lift and two persons for transfers. 6/5/26 12:49 PM – An interview with E2 (DON) confirmed R9's service agreement lacked evidence of a revision that R9 required two-persons and a Hoyer lift for transfers. E2 stated, "Yes, I am aware, that is being taken care of." 6/11/26 12:00 PM – Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference.	rounding frequency checks and documentation were not consistently monitored during each shift for compliance, and staff lacked training on the importance of conducting safety rounds as care planned and documenting them on the safety log accordingly. 4) The Plan of Correction was discussed and evaluated. Resident service agreements reviewed and updated to reflect updated and accurate resident information. Daily Safety and documentation reviewed. Care Aides observed to ensure completion of safety rounds are care planned. Current Round reviewed for accurate completion: Immediate. The Director of Nursing (DON) or designee will randomly audit 50% of the service agreements weekly x 4 weeks and monthly x3 months to ensure 100% compliance is achieved. Date of Completion: 7/30/26. Any records found out of compliance will be corrected at time of audit with documentation of correction. Care Aide retrain by DON or designee: Date of Completion: 7/30/26.	7/30/26
3225.19.0 **3225.19.1** **S/S – D**	**Records and Reports** **The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service agreement for each resident.** **These requirements were not met as evidenced by:** Based on record reviews and interviews, it was determined that for three (R16, R17, and R21) out of three residents reviewed for resident-to-resident incidents the facility failed to document the implementation of supervision indicated in the residents' service agreement. Findings include: 1.Review of R16's clinical record revealed: 5/7/25 – R16's service agreement documented that the resident required moderate supervision.	1) Resident R16, R17 and R21 were not impacted and continues to reside safely in the facility. Resident R16, R17 and R21 service agreements were updated to reflect resident's	

Provider's Signature Jamie Hackett Title Executive Director Date 6/29/26

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	May 2026 – Review of documentation for completion of every fifteen-minute observations for R16 indicated a lack of supervision; blank entries on the following dates: 12:00 AM – 7:00 AM – 5/1 through 5/10, 5/12 through 5/14, 5/17, 5/18, and 5/21 through 5/25. 7:15 AM – 2:45 PM – 5/1 through 5/10 and 5/14 through 5/31. 3:15 PM – 11:30 PM – 5/2, 5/4, 5/7, 5/8, 5/11, 5/17, 5/18, 5/24 and 5/28. June 2026 – Review of documentation for completion of every fifteen-minute observations for R16 indicated a lack of supervision; blank entries on the following dates: 12:00 AM – 7:00 AM – 6/1, 6/5, 6/6, 6/7 and 6/8. 7:15 AM – 2:45 PM – 6/1, 6/2, 6/3. 6/6, and 6/7. 2. Review of R17's clinical record revealed: 5/7/26 – R17's service agreement documented that resident received every fifteen-minute supervision. May 2026 – Review of documentation for completion of every fifteen-minute observations for R16 indicated a lack of supervision; blank entries on the following dates: 12:00 AM – 7:00 AM – 5/7 through 5/14, 5/17, 5/18, 5/21 through 5/25, 5/27 through 5/29.	current care needs and safety round frequency. All service assessments were audited by the Director of Nurses (DON) for resident assessment compliance. 2) All residents have the potential to be impacted by this practice. DON audited all resident records for service agreement and accuracy compliance based on resident need. Care Aides re-trained on round and safety check completion and proper sign out and documentation by DON. Nurse/Med Tech on duty to review round frequency completion at shift end to ensure compliance. 3) Root Cause: The facility experienced multiple DON turnovers. The current DON is actively working to update service agreements to reflect past resident events and changes. To resolve this, all resident service agreements will be updated in real time to reflect each resident's current condition and safety needs. In addition, rounding frequency checks and documentation were not consistently monitored during each shift for compliance, and staff lacked training on the importance of conducting safety rounds as care planned and documenting them on the safety log accordingly. Safety Round training completed with care aides by DON or designee. Completion Date: 7/30/26.	

Provider's Signature Jasmine Hackett Title Executive Director Date 6/29/26

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	3:15 PM – 11:45 PM – 5/7 through 5/12, 5/17, 5/18, 5/24, and 5/25. June 2026 – Review of documentation for completion of every fifteen-minute observations for R16 indicated a lack of supervision; blank entries on the following dates: 12:00 AM – 7:00 AM – 6/1, 6/5, 6/6, 6/7 and 6/8. 7:15 AM – 3:00 PM – 6/1 through 6/3, 6/6, and 6/7. 3:15 PM – 11:45 PM – 6/1. 4:45 PM – 11:30 PM – 6/2. 3. Review of R21's clinical record: 9/25/25 - R21's service agreement documented that the resident required extensive supervision. May 2026 – Review of documentation for completion of every fifteen-minute observations for R16 indicated a lack of supervision; blank entries on the following dates: 12:00 AM – 7:00 AM – 5/1 through 5/5, 5/7 through 5/9, 5/12 through 5/14, 5/17, 5/18, 5/21 through 5/25, 5/28, and 5/29. 7:15 AM – 3:00 PM – 5/1 through 5/10, 5/12, 5/14 through 5/31. 3:15 PM – 11:45 PM 5/2, 5/4, 5/7, 5/8, 5/11, 5/17, 5/18, 5/24, 5/25, 5/28 and 5/31.	4) The Plan of Correction was discussed and evaluated. Resident service agreements reviewed and updated to reflect updated and accurate resident information. Daily Safety and documentation reviewed. Care Aides observed to ensure completion of safety rounds are care planned. Current Round reviewed for accurate completion: Immediate. The Director of Nursing (DON) or designee will randomly audit 50% of the service agreements weekly x 4 weeks and monthly x3 months to ensure 100%.	7/30/26

Provider's Signature Amme Hackett Title Executive Director Date 6/29/26

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	June 2026 – Review of documentation for completion of every fifteen-minute observations for R16 indicated a lack of supervision; blank entries on the following dates: 12:00 AM – 7:00 AM – 6/1, 6/5 through 6/8. 7:15 AM – 3:00 PM - 6/1 through 6/3, 6/6 and 6/7. 6/8/26 9:07 AM – During an interview E5 (RA) confirmed that every 15 minutes checks are supposed to be documented. 6/8/26 9:09 AM – During an interview E6 (RA) confirmed that every 15 minutes checks are supposed to be documented "at least by the end of the shift". 6/8/26 9:30 AM – During an interview E2 (DON) confirmed the blank documentation on R16, R17 and R21's every fifteen-minutes checks for supervision. 6/8/26 3:00 PM – Findings were reviewed with E1 (NHA). 6/11/26 12:00 PM - Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference.		
Delaware Code – 16 Del. C. § 1121 – Definitions (Resident Rights)	**§ 1121(b)(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."** **These requirements were not met as evidenced by:**	1) Resident R15 was impacted and continues to reside safely in the facility. Resident R15 reported the incident to the Executive Di-	

Provider's Signature Jeanne Hackett Title Executive Director Date 6/29/26

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S/S - D	Based on interview and review of other facility reports it was determined for one (R15) out of two resident reviewed for resident rights the facility failed to ensure the security and safekeeping of R15's personnel items. Due to the facility's corrective measures following the incident this is being cited as past non-compliance with an abatement date of 4/23/26, which was verified by interviews and review of facility records. Findings include: R15's clinical record revealed: 10/31/25 – R15 was admitted to the facility. 4/18/26 11:39 AM – A review of the facility's investigation documented.... "Ring camera surveillance footage identified E9 entering R15's room without authorization and going through R15's personal belongings." 4/19/26 5:13 PM – A facility reportable incident to the division documented R15's FM1 (Son) emailed E1 (ED) "[R15's] room had been entered without authorization by [E9 (Housekeeping)]. [FM1] reported an engagement ring, wedding band and clear container of coins were missing from [R15's] room. Ring camera videos were provided as evidence to E9 walking around in R15's room. 6/9/26 1:30 PM – During an interview E1 reported "[FM1] reported R15's room looked disturbed with personal items disheveled. FM1 returned to the room on 4/15/26 and installed a ring camera. [FM1] reported a gold wedding ring set was missing and coins." E9 was interviewed on 4/19/26 and did not deny	rector initiating an immediate investigation with in an hour of the report. 2) All residents have the potential to be impacted by this practice. Following the close of the investigation, the employee responsible was terminated following immediate administrative leave and a police report was initiated. Mandatory Meeting/Trainings for staff were conducted by the Executive Director on all shifts regarding resident's rights, zero tolerance theft policy, and mandated reporting for suspicious behavior. Further, resident does will remain locked and unentered during extended leaves of absence. 3) Root Cause: Employee engaged in intentional misconduct resulting in theft. Further, the was not set "rules" prohibiting employees from entering rooms while residents are on leave. 4) The Plan of Correction was discussed and evaluated. All actions were completed at the close of incident investigation. Resident rights and the prohibition of theft, as outlined in the employee handbook, are reinforced during new employee orientation.	Completed.

Provider's Signature Jamie Hackett Title Executive Director Date 6/29/26

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	entering the residents room or removing the items that were reported missing. E9 was instructed to immediately return the stolen property. A gold ring was returned to the facility on 4/21/26 by E9 but was not the property of R15. The facility's immediate action following the interview with E9 included: 4/19/26 - E9 was placed on immediate administrative leave and escorted off the facility property. 4/19/26 - Local police were notified and a police report was filed. 4/20/26 - Termination of employment for E9 was completed and processed. 4/20/26 – 4/23/26 - E1 conducted mandatory meetings with all staff in all departments on all shifts. During these meetings the following actions were taken and expectations clearly reinforced: Review of facility handbook rules regarding theft which clearly states "theft or financial exploitation of residents is strictly prohibited and will result in immediate termination of employment, law enforcement involvement and required reporting to the state regulatory agencies. Employees are not permitted to enter resident rooms without proper cause, particularly for residents who are on leave of absence.		

Provider's Signature Annmarie Haslett Title Executive Director Date 6/29/26

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	Emphasized the organizations zero -tolerance policy for violations involving resident safety, property and trust. Notified staff that compliance with these Handbook rules will be continuously monitored and enforced. All staff were instructed to immediately report a suspicious activity, policy violations or concerns involving resident property to management without delay. 6/11/26 – The facility's response to the theft of R15's personal property included education of resident rights, review of the facility handbook on theft and the financial exploitation of residents is strictly prohibited. Staff interviews conducted with E10 (AD), E11(HK), E12 (MT) and E13 (RCA) confirmed the education was completed, received and understood. 6/11/26 12:00 PM - Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference.		
Delaware Code – 16 Del. C. § 1131 – Definitions (Neglect) **S/S – D**	**§1131 (a) (12) "Neglect means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."** **These requirements were not met as evidenced by:** **Cross Refer 3225.13.6** Based on interview, record review and review of other facility records it was determined that for one (R7) out of nine residents		

Provider's Signature Jamie Hackett Title Executive Director Date 6/29/26

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	reviewed for falls the facility failed to ensure R7's footrests were on the wheelchair while being assisted back to the room. R7 fell forward out of the wheelchair onto the floor resulting in a head injury. R7 was sent to the hospital for further evaluation and treatment. Findings include: R7's clinical record revealed: 12/5/22 – R7 was admitted to the facility. 11/20/25 – A review of an annual UAI assessment documented R7 was cognitively intact no short- or long-term memory problems. 1/15/26 2:36 PM – A facility reported incident to the division documented "R7 was being pushed in the wheelchair to the room. R7 dropped a foot down to the carpet while being pushed and fell forward out of the wheelchair onto floor. R7 was sent to the hospital for treatment and evaluation for a large hematoma and abrasion above the left eye." 1/15/26 12:12 PM – R7 was sent to the hospital for evaluation and treatment. 1/15/26 - R7 returned to the facility. 6/8/26 1:30 PM – During a phone interview E14 (MT) reported "I brought [R7] from downstairs after lunch stopped at the med cart gave medication to R7 and started to push R7 back to the room. R7 dropped his feet down and fell forward there was no way I could stop him from falling forward. I called a nurse right away on the radio. I did not know he needed footrests on the wheelchair. Like I said I'm an MT, and I was just pushing	1) Resident R7 was impacted and continues to reside safely in the facility. Following the incident immediate response to resident's fall with injury, and facility fall investigation was conducted by the Executive Director 2) All residents have the potential to be impacted by this practice. Following fall investigation, ED conducted care aide training on the importance of footrests for the wheelchair and how they are stored on the back of wheelchair. 3) Root Cause: Care Aide failed to put footrest on resident R7's wheelchair due to a lack of understand and oversight in ensuring placement. To resolve, care aide training were conducted. 4) The Plan of Correction was discussed and evaluated. The Director of Nursing (DON) or designee will randomly observe 50% of the wheelchair use weekly x 4 weeks and monthly x3 months to ensure 100% compliance is achieved. Date of Completion: 7/30/26. Footrest training added to care aide orientation: 7/30/26.	7/30/26

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	R7 back from the dining room I didn't know that footrests needed to be on the wheel-chair." 6/9/26 10:00 AM – An additional review of the facility's reported incident to the division documented "Therapy re-educated at the time of the fall the importance of footrests for the wheelchairs and how they are stored on the back of each wheelchair. 6/9/26 10:40 AM – During an interview E8 (PT) reported "I was told [R7] had fallen out of the wheelchair, apparently [R7's] footrests were not on the wheelchair there are bags on the chairs for storage of the footrests when they aren't being used." 6/9/26 11:00 AM – During an interview R7 stated, "I'm clumsy for one thing I trip on my own feet, it was after a meal I was in the wheelchair we were going a little too fast down the hallway there, I was trying to tell [E14] your going too fast towards my room." E7 then stated, "I put my foot down lightly my right foot and then I put the left one down all the way I fell forward and landed on my face they sent me to the hospital I had a lump over my right eye, and it was bleeding." 6/11/26 12:00 PM – Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference.		

Provider's Signature Jeanne Hackett Title Executive Director Date 6/29/26

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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