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:** January 16, 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 on January 16, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The sample totaled fourteen (14) residents.	A. Unable to correct deficient practice at this time B. No resident was impacted by the deficient practice. Upon confirmation of a facility-wide COVID-19 outbreak on January 9, 2026, the facility immediately implemented its Infection Prevention and Control Outbreak Response Plan to mitigate further transmission and ensure resident and staff safety. All residents residing in the facility at the time of the identified outbreak were immediately assessed to determine potential exposure risk for signs and symptoms of COVID-19, including but not limited to fever, cough, shortness of breath, sore throat, fatigue, body aches, new loss of taste or smell, and changes in baseline condition. Any resident exhibiting signs or symptoms was immediately isolated, tested per physician order and current CDC/public health guidance, and appropriate transmission-based precautions were implemented. A 100% facility-wide surveillance process was initiated. Any staff member exhibiting symptoms or reporting exposure was excluded from work, referred for testing, and permitted to return only in accordance with CDC and public health return-to-work criteria. Enhanced environmental cleaning and disinfection of high-touch surfaces and common areas per CDC and manufacturer guidelines. Reinforcement of hand hygiene compliance monitoring. Review of PPE supply to ensure adequate availability. Ongoing communication with residents, responsible parties, staff, and the local health department as required. Through the immediate implementation of these corrective actions, 100% of residents and staff were assessed for signs and symptoms of COVID-19, and appropriate interventions were initiated without delay. Surveillance confirmed that no additional residents were impacted as a result of the deficient practice. C. Upon identification of the reporting delay on 1/16/26, the facility immediately verified that the COVID-19 outbreak report had been submitted to DPH on 1/14/26. The Executive Director (ED) and Director of Nursing (DON) reviewed confirmation of submission and ensured DPH receipt. All three residents (R3, R7, R14) were placed on appropriate transmission-based precautions per current infection control guidelines. Families and responsible	
3225.0	**Assisted Living Facilities**		
3225.9.0	**Infection Control**		
3225.9.8	**Specific Requirements for COVID-19:**		
3225.9.8.1	**Residents**		
3225.9.8.1.4 S/S – D	**Facilities must report all resident testing and test results to the Delaware Division of Public Health.**		
	Based on interview and document review, it was determined that the facility failed to comply with DPH (Delaware Division of Public Health) COVID-19 reporting requirements. Findings include: 1/16/26 – During the survey of the facility at approximately 10:30 AM, a request of Respiratory line list documentation was made. The documentation revealed three residents (R3, R7, & R14) out of 14 reviewed, had confirmed COVID-19 within a 3-day period. R3 had been diagnosed with COVID-19 on 1/7/26, R7 was diagnosed with COVID-19 on 1/8/26, and R14 was diagnosed with COVID-19 on 1/9/26. Current guidelines from Delaware Public Health (DPH) require three or more confirmed cases of COVID 19 among staff and residents within a seven-day period must be reported timely to DPH.		

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	1/16/26 – During an interview and review of documentation with E2 (Director of Nursing) at approximately 2:00 PM, nursing communication documentation revealed that the facility was notified from the hospital of the third (R7) COVID diagnosis on 1/9/26. 1/16/26 – During an interview with E1(Executive Director, ED) & E2 (Director of Nursing, DON) at approximately 2:00 PM, it was reported that the notification to DPH was sent on 1/14/26, five days later. 1/16/26 – Findings were reviewed with E1(ED), E2 (DON), E3 (DON II), and E4 (ADON) at approximately 2:30 PM.	parties had previously been notified of positive results. No additional adverse outcomes related to the reporting delay were identified. Education provided by corporate RN to Executive Director, Director of Nursing, ADON. Education included: DPH outbreak definitions, Timeliness requirements, Documentation expectations, Chain of responsibility, all education documented with signed attendance sheets. D. Audit was conducted of all reportable communicable diseases within the past 30 days to ensure no additional reporting delays occurred. The audit confirmed no other reportable outbreaks were submitted outside required timeframes. All current respiratory line lists were reviewed to ensure accuracy and completeness. Resident Care Manager will conduct monthly audit to ensure Monitor deficient practice for each resident to consistently meet 100% compliance. The DON/designee will conduct initiate 100% audits of: Respiratory line lists, confirmed communicable disease cases, reporting logs weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is maintained, regular checks will continue to maintain compliance. Audits will verify that any reportable condition is reported within required timeframes. Results will be reviewed monthly in QAPI for three months. Any identified delay will result in immediate corrective action and re-education. Completion Date: 1/20/26 Responsible Party: Director of Nursing/Executive Director	

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3225.9.9 3225.9.9.1 3225.9.9.2 S/S – F	**Infection Prevention and Control Program** **The assisted living facility shall establish an infection prevention and control program which shall be based upon Centers for Disease Control and Prevention and other nationally recognized infection prevention and control guidelines.** **The individual designated to lead the assisted living facility's infection prevention and control program must develop and implement a comprehensive plan that includes actions to prevent, identify, and manage infections and communicable diseases. The plan must include mechanisms that result in immediate action to take preventive or corrective measures that improve the assisted living facility's infection control outcomes.** Based on interview and document review, it was determined that the facility failed to comply with DPH and CDC COVID-19 guidance regarding testing procedures, implementing transmission-based precautions, and the provision of personal protective equipment for staff, vendors, and visitors. Findings include: 1/16/26 - During an interview with E2 (DON) and E4 (ADON) at approximately 1:00 PM, it was stated that E4 (ADON) was overseeing the infection prevention and control (IPC) practices when R3's case was identified on 1/7/26. Current guidance from CDC (2026) states: "Prevent spread - Test residents and healthcare personnel (HCP) with new respiratory illness signs or symptoms. Selection of	A. Unable to correct deficient practice at this time B. No resident was impacted by the deficient practice. Upon confirmation of a facility-wide COVID-19 outbreak on January 9, 2026, the facility immediately implemented its Infection Prevention and Control Outbreak Response Plan to mitigate further transmission and ensure resident and staff safety. All residents residing in the facility at the time of the identified outbreak were immediately assessed to determine potential exposure risk for signs and symptoms of COVID-19, including but not limited to fever, cough, shortness of breath, sore throat, fatigue, body aches, new loss of taste or smell, and changes in baseline condition. Any resident exhibiting signs or symptoms was immediately isolated, tested per physician order and current CDC/public health guidance, and appropriate transmission-based precautions were implemented. A 100% facility-wide surveillance process was initiated. Any staff member exhibiting symptoms or reporting exposure was excluded from work, referred for testing, and permitted to return only in accordance with CDC and public health return-to-work criteria. Enhanced environmental cleaning and disinfection of high-touch surfaces and common areas per CDC and manufacturer guidelines. Reinforcement of hand hygiene compliance monitoring. Review of PPE supply to en-	

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	diagnostic tests will depend on the suspected cause of the infection (e.g., which respiratory viruses are circulating in the community or the facility, recent contact with someone confirmed to have a specific respiratory infection) and if the results will inform clinical management (e.g., treatment, duration of isolation). At a minimum, testing should include SARS-CoV-2 and influenza viruses with consideration for other causes (e.g., RSV)." 1/16/26 – During an interview with E2 (DON) and E4 (ADON) at approximately 1:00 PM, the surveyor asked about additional testing and precautions that were put in place upon identification of the COVID-19 virus on 1/7/26. It was reported by E4 that three residents were tested at the facility on 1/7/26. The testing included R3, R14 and one additional resident with symptoms which resulted in two positive cases (R3 and R14). It was also reported that no staff were tested in house. 1/16/26 – Review of respiratory surveillance line list revealed an initial COVID 19 virus was identified in R1 on 12/30/25. It also revealed that ten residents (R2, R4, R5, R6, R8, R9, R10, R11, R12, & R13) out of ten reviewed, had identified symptoms of cough, cold symptoms or congestion between 1/6/26 and 1/13/26. These residents were not tested according to the line list documentation. Current guidance from CDC (2026) states: "Ensure everyone, including HCP, residents, and visitors are aware of recommended in-	sure adequate availability. Ongoing communication with residents, responsible parties, staff, and the local health department as required. Through the immediate implementation of these corrective actions, 100% of residents and staff were assessed for signs and symptoms of COVID-19, and appropriate interventions were initiated without delay. Surveillance confirmed that no additional residents were impacted as a result of the deficient practice. C. Change in nursing leadership resulted in the deficient practice. The deficient practice was determined to be the result of a systems failure associated with a recent change in nursing leadership, rather than the actions of any single individual. During the transition in nursing leadership, there was an interruption in the continuity of clinical oversight and infection prevention monitoring processes. The facility did not have a formalized transition plan to ensure uninterrupted infection prevention oversight during leadership changes. Additionally, there was no structured handoff process to clearly assign accountability for outbreak monitoring and compliance verification while the new nursing leader was being oriented. This systems gap contributed to the deficient practice, as monitoring processes were not consistently audited for completeness during the leadership transition. Upon identification of the root cause, the facility implemented measures to ensure sustained oversight of infection prevention activities regardless of leadership changes, including clearly defined accountability structures, cross-training of leadership staff. No residents were harmed as a result of this deficient practice. On 1/16/26, all residents identified with respiratory symptoms (R2, R4, R5, R6, R8, R9, R10, R11, R12, and R13) were immediately assessed by nursing staff. Transmission-based precautions	

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	fection prevention and control (IPC) practices in the facility. This includes when specific IPC actions are being implemented in response to new infections in the facility or increases in respiratory virus levels in the community by sharing and posting communication materials such as posters, mask graphics and signs." 1/16/26 – During an interview with E4 (ADON) at approximately 1:00 PM, the surveyor asked what was implemented after identification of the virus. It was reported that facility staff were notified of the current cases. The surveyor asked for the processes for use of PPE for infection control and the use of signage to identify transmission-based precautions. It was reported by E4 (ADON) that it was a dignity concern to post signage. In addition, it was reported that PPE was available, although it was not made readily available outside of the resident rooms for any staff, visitor, or vendor to be able to access. 1/16/26 – Findings were reviewed with E1(ED), E2 (DON), E3 (DON II), and E4 (ADON) at approximately 2:30 PM.	were implemented immediately for confirmed and suspected cases in accordance with current guidance from the Centers for Disease Control and Prevention (CDC). Appropriate PPE (gowns, gloves, surgical masks, N95 respirators, and eye protection) was placed on PPE carts and stationed outside affected resident rooms. Transmission-based precaution signage consistent with CDC guidance was posted outside affected rooms. Outbreak notification signage was placed at the main entrance of the facility and at all visitor entry points to inform visitors of the presence of COVID-19 in the building. The signage included instructions regarding required infection control measures, including symptom screening, hand hygiene, and required PPE use prior to entry. Visitors were instructed not to enter the facility if experiencing symptoms consistent with COVID-19 and were directed to notify the facility for further guidance. PPE stations are now maintained on each unit and monitored daily for adequate supply and accessibility. ADON will monitor monthly of the PPE supplies for continued compliance. All direct and in-direct staff which includes, Nursing, Dietary, Housekeeping, BOM/HR, Admissions, Maintenance were/will be re-educated on transmission-based precautions when caring for a resident with Covid 19. Corporate RN educated Executive Director, Resident Care Manager, and Assistant Resident Care Manager on policy 3.0 Universal Precautions, 5.0 gloves, 6.0 masks, 7.0 goggles, 8.0 gowns. D. A facility-wide audit of the respiratory surveillance line list was conducted to identify any resident with signs or symptoms of respiratory illness within the previous 30 days. All residents were assessed for current respiratory symptoms. An audit of PPE placement and transmission-based precaution signage throughout the facility was completed to ensure accessibility and visibility. PPE stations are now maintained on	

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		each unit and monitored daily for adequate supply and accessibility. Transmission-based precaution signage templates were implemented to balance infection control requirements and resident dignity. Resident Care Manager will education all nursing staff, CDC guidance, testing protocols, proper PPE use donning/doffing procedures, Transmission based precautions. Resident care manger, or designee will Audit 100% of new respiratory cases weekly for 4 weeks, then monthly for 3 months. Conduct weekly PPE availability audits for 4 weeks, then monthly for 3 months. Audit signage placement weekly for 4 weeks, then monthly for 3 months until 100% compliance is maintained. Ensure testing and transmission-based precautions are implemented promptly according to facility policy and CDC guidance. Results of audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting Any identified issues will result in immediate corrective action and staff re-education. Ongoing surveillance data will be trended and reported to leadership monthly. Completion Date: 02/4/2026 Responsible Party: Resident Care Manager & Executive Director	

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