DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
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STATE SURVEY REPORT

NAME OF FACILITY: Rockland Place

DATE SURVEY COMPLETED: January 13, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from January 7, 2026, through January 13, 2026. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-seven (87). The survey sample totaled fourteen (14) residents and a subsample survey of an additional twelve (12) residents. Abbreviations/definitions used in this state report are as follows: DD – Dining Director; Embolism - A blockage-causing piece of material, inside a blood vessel such as a blood clot; ED - Executive Director; Eliquis – An anticoagulant used to reduce the risk of stroke and blood clots in people at risk; EMAR – Electronic medical administration record; HRD – Human Resources Director; HS – Housekeeping Services; LPN – Licensed Practice Nurse; MA/Tech – Medication Assistant/Technician; MC – Memory Care; MCPD – Memory Care Program Director; MD – Maintenance Director; NA/CG – Nurse Aide/Caregiver; NAYA – A caregiver who has received the designated Dementia 12-hour training and "titled" as a NAYA by the facility; RCD - Resident Care Director;		

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3225.0 **3225.1** **3225.8.0** **3225.8.3** **3225.8.3.5** **S/S - E**	ROM – Range of Motion; RN – Registered Nurse; Thrombosis - The formation of a blood clot inside a blood vessel, obstructing the flow of blood. **Assisted Living Facilities** **Purpose** **The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facilities. These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The regulations establish the minimal acceptable level of services for residents of assisted living facilities.** **Medication Management** **Medication stored by the assisted living facility shall be stored and controlled as follows:** **All expired or discontinued medication, including those of deceased residents, shall be disposed of according to the assisted living facility's medication policies and procedures.**	A) All medication carts and refrigerators have been reviewed for expired medications for residents reviewed during survey. All expired have been removed with appropriate refills ordered as necessary. (DON and ADON) B) All medication carts and refrigerators reviewed for all existing residents for expired medications. All expired medications removed and refills ordered as necessary. (DON and ADON) C) Expired medications were present due to observation of Pharmacy date and not the manufactured date. All Llams and Nurses educated on the need to check manufactured expiration dates and removed all expired medications as dates indicate. (DON and ADON) D) 1 Cart and 1 refrigerator check completed daily until 100% compliance is met on 3 consecutive days. THEN: 1 Cart and 1 refrigerator weekly until 100% compliance 3 consecutive weeks THEN: 1 Cart and 1 Refrigerator checked 1 month later to ensure 100% compliance. (DON and ADON)	2/27/26

Provider's Signature _Paul Taylor_____ Title _Executive Director_____ Date _2/17/26_____

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	This requirement was not met as evidenced by: Based on observation and interview, the facility failed to provide proper disposal of expired medications located in one of the medication carts. Findings include: 1/9/26 - During Medication Storage observation at approximately 1:00 PM, the Surveyor found: • 2 boxes of Humalog Insulin 100u/ml Kwik Pens, located in the medication refrigerator, had manufacturer printed expiration dates of 2025-Jun-11. • Insulin Lispro Junior Kwik Pen, located in the medication refrigerator, had a manufacturer printed expiration date of 2025-Dec-18. • a tube of Gentamycin Sulfate ointment .1%, located in the medication drawer, had a manufacturer printed expiration date of 2025 Sep. • a bottle of Mucinex located in the medication drawer, had a manufacturer printed expiration date of 2025 Sep. 1/9/26 - Per interview with E2 (RCD) at approximately 2:00 PM, E2 confirmed the medications listed were expired. E2 removed the expired medications from the medication cart at this time. 1/13/26 - Findings were reviewed with E1 (ED), E2, E3 (MCPD) and E5(HRD) at		

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3225.9.0 **3225.9.6** **S/S – D**	the exit conference, beginning at approximately 3:30 PM. **Infection Control** **The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, 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 influenza 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, interview and review of facility provided documentation, it was determined that one (R13) out of fourteen residents sampled for vaccinations, the facility failed to provide evidence of the administration of the annual influenza vaccine, or that the vaccine was offered to the resident and declined. Findings include: 10/3/25 – R13 was admitted to the facility. The facility lacked evidence that the 2025 annual influenza vaccine was administered, or that the vaccine was offered to the resident and declined. 1/13/26 - Findings were reviewed with E1 (ED), E2 (RCD), E3 (MCPD) and E5	A) R13 Annual Influenza declination form obtained B) Review of all existing residents to assure Annual Influenza vaccine obtained or declination form present. C) Delvax checked for all new residents for vaccine dates, Influenza administration documented or declination form present. All residents to obtain influenza vaccination annually or have a declination form present. D) New admit residents to be reviewed for proper vaccination record or declination on file until 100% compliance is met with 2 consecutive residents. THEN: Skip next admission and check following admission for 100% compliance. THEN: Check 2 new residents the following month to assure 100% compliance is met. (DON and ADON)	2/27//26

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	(HRD) at the exit conference, beginning at approximately 3:30 PM.		
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S – F**	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** Based on observations and interviews, it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **3-3 PROTECTION FROM CONTAMINATION AFTER RECEIVING 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.** 1/7/26 11 :00 AM –An observation of the memory care food service area revealed a refrigerator containing food items of fried chicken and wonton soup that were not labeled or dated when opened and were not part of the food services operation. The observation also revealed a freezer containing ice packs labeled with a resident's name that is used for treatment. During an interview with E9 (HS) at the time of the observations, E9 confirmed the above findings.	A) All products indicated as not dated, labeled or were for resident sue were removed from the refrigerators and freezer. B) A complete review of all food, open containers, labels, dates were reviewed to assure all appropriate information was provided. C) Products not labeled or dated were utilized that day and required dates and labels. Staff educated to ensure all products are labeled, dated and secured in the appropriate locations. D) Daily check of food storage areas for appropriate dates, labels and location until 100% compliance has been met on 2 consecutive occasions. THEN: Weekly check of food storage areas for appropriate dates, labels and location until 100% compliance has been met on 2 consecutive occasions. THEN: Check food storage areas 1 month later for appropriate dates, labels and location for 100% compliance. (DSD and/or DRM)	2/27/26

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	1/7/26 – Findings were reviewed with E3 (MCPD) and E8 (DD) at approximately 4:00 PM. **3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in ¶¶ (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The		

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	day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. 1/7/26 10:00 AM An observation of the reach in refrigerator revealed milk, tomato juice, and whip cream that was not dated when opened. In addition, ketchup and prepared tartar sauce placed in disposable containers were not dated. During an interview with E8 (DD) at the time of the observations, E8 confirmed the above findings. 1/7/26 – Findings were reviewed with E3 (MCPD) and E8 at approximately 4:00 PM. **4-302 Utensils, Temperature Measuring Devices, and Testing Devices.** **4-302.13 Temperature Measuring Devices, Manual and Mechanical Ware washing. (B) In hot water mechanical WAREWASHING operations, an irreversible registering temperature indicator shall be provided and readily accessible for measuring the UTENSIL surface temperature.** 1/7/26 10:00 AM - A request was made to test the water temperature in the dishwasher. During an interview with E8 (Dining Director) at the time of the survey, E8 stated that they did not have a device to test the temperature. E8		

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3225.12.5 **S/S – D**	stated the temperature was monitored using the machine's gages. 1/7/26 – Findings were reviewed with E3 (MCPD) and E8 at approximately 4:00 PM. **4-501.116 Ware washing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device.** 1/7/26 10:00 AM – A request was made to test the sanitation solutions that is used to disinfect surfaces and dishes. During an interview with E8 (Dining Director) it was reported that the testing kit was not available and needed to be reordered. 1/7/26 – Findings were reviewed with E3 MCPD) and E8 at approximately 4:00 PM. **The assisted living facility shall ensure that laundry and housekeeping services are offered and that all areas of the facility are maintained in a clean and orderly condition.** Based on observations and interview, it was determined that the facility failed to comply with the regulation. Findings include: 1/7/26 10:30 AM – An observation of the laundry room on the second floor revealed a black substance inside the utility sink. During an interview with	A) Dishwasher Temperature and Sanitization solution level tested and were found to be within range. B) Manual Thermometer and Sanitization solution testing strips provided in the kitchen. C) Dishwasher water temperature evaluated by gauge and sanitizing solution strips on back order. Manual thermometer in place to test water temp and testing strips in stock to test temp and level daily. D) Daily check of both temp and sanitization until 100% compliance is met for 3 consecutive days. THEN: Weekly check of both temp and sanitization until 100% compliance is met for 2 consecutive weeks. THEN: Check 1 month later to assure water temp and sanitization levels are met for 100% compliance. (DSD and/or DRM)	2/27/26

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3225.16.0 **3225.16.13** **S/S – D**	E10 (HS) at the time of the survey, E10 confirmed the substance. 1/7/26 11:00 AM – An observation of the laundry room in the memory care unit revealed a black substance inside the utility sink. During an interview with E9 (HS) at the time of the survey, E9 confirmed the substance. 1/7/26 11:45 AM –An observation of the facility's stairwell, near the kitchen, revealed a black substance stained on the carpet steps. During an interview with E6 (MD) at the time of the survey, E6 confirmed the substance. 1/7/26 – Findings were reviewed with E3 (MCPD) & E6 at approximately 4:00 PM. **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, interview and other facility and vendor document review, it was determined that for three (R24, R25 and R26) of three residents reviewed for quarterly medication reviews, the facility RCD failed to act upon the pharmacist's recommendations contained in the 4th quarter 2025 pharmacy review. RCD failed to bring the recommendations to the attention of	A) Landry room basins and stairwell opposite kitchen cleaned and extracted immediately. B) All other laundry room basins cleaned and all carpets are on a routine cleaning schedule. C) Laundry room basins and stair carpet are dated and worn. Basins to be cleaned on a daily basis as part of the Housekeeping Schedule. Carpets to be cleaned on a rotating basis. D) Daily check of laundry Room Basins and stair tower across from kitchen until 100% compliance is met 3 consecutive days. THEN: Weekly check of laundry Room Basins and stair tower across from kitchen until 100% compliance is met 2 consecutive weeks. THEN: Check laundry room basins and carpet 1 month later to assure 100% compliance. (MD)	2/27/26

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25.18.0	the Physician or the facility staff administering the medications. Findings include: 1. 11/13/25– R24's 2025 4th quarter Pharmacy Consultation Report identified the following recommendation made by the pharmacist. The RCD failed to review and follow up on the recommendation by bringing it to the attention of the Physician or staff administering the medications. "To reduce the risk of thrush, please update the order to include the directions: Rinse mouth with water after use. Do not swallow." 2. 11/13/25 – R25's 2025 4th quarter Pharmacy Consultation Report identified the following recommendation made by the pharmacist. The RCD failed to review and follow up on the recommendation by bringing it to the attention of the Physician or staff administering the medications. "Please ensure this medication is administered as follows: Administer intact tablet at least 30 minutes before the first food, beverage, or medication of the day with 6 to 8 ounces of plain water. Individuals should not lie down for at least 30 minutes and until after the first food of the day." 3. 11/13/25 - R26's 2025 4th quarter Pharmacy Consultation Report identified the following recommendation made by the pharmacist. The RCD failed to review and follow up on the	A) 4th quarter consultant report reviewed for R24, R25 and R26 with recommendations provided to the physician and LLAM's/Nurses. B) Remainder of 4th quarter consultant report reviewed with recommendations provided to the physician and LLAM's/Nurses. C) In review, full 4th quarter consultant review not completed by pharmacy. Upon receiving 1st quarter 2026 consultant report, report will be reviewed by DON with recommendations provided to the appropriate physicians and LLAM's/Nurses immediately. D) Each recommendation will be reconciled with response from physician with appropriate measures taken based on physician response. Review of 2 residents on report daily until 100% compliance is met. THEN: 1 Week later, review of 2 additional residents for 100% compliance. THEN: 1 month later review of full report for 100% compliance. (DON)	2/2726

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3225.18.4 **S/S – D**	recommendation by bringing it to the attention of the Physician or staff administering the medications. "To reduce the risk of thrush, please update the order to include the directions: Rinse mouth with water after use. Do not swallow." 1/12/26 – Per interview with E2 (RCD) at approximately 2:00 PM, E2 confirmed she had not reviewed the pharmacist quarterly report or brought the recommendation to the attention of the Physician or staff administering the medications. 1/13/26 - Findings were reviewed with E1 (ED), E2, E3 (MCPD) and E5 at the exit conference, beginning at approximately 3:30 PM. **Emergency Preparedness** **The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.** Based on record review, interview and review of facility documentation, it was determined that two (E21 and E25) out of seven employees sampled for emergency preparedness training, the facility failed to provide evidence these employees completed the training. Findings include: 1. 11/15/24 - E21 was hired by the facility. The facility failed to have E21's	A) E21 and E25 assigned new training module on our new Relias platform. B) All new hired staff will be assigned the emergency Preparedness training during their orientation process. C) Site specific EPP training in previous program was not adequate. New Relais platform can provide greater coverage of emergency training and assigned to all staff in orientation and annually. D) Next 2 new hires reviewed for EPP training prior to release until 100% compliance met. THEN: New hires 4 and 5 reviewed to assure 100% compliance with EPP training. THEN: 2 new hires reviewed following month for 100% compliance with EPP training. (HRD)	2/27/26

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3225.19.0 **3225.19.6**	Emergency Preparedness training in evidence. 2. 7/1/24 - E25 was hired by the facility. The facility failed to have E25's Emergency Preparedness training in evidence. 1/8/26 – Per interview with E5 (HRD) at approximately 2:00 PM, E5 confirmed the emergency preparedness training was not in evidence for these employees. 1/13/26 - Findings were reviewed with E1 (ED), E2 (RCD), E3 (MCPD) and E5 at the exit conference, beginning at approximately 3:30 PM. **Records and Reports** **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.** **Reportable incidents include:** **Abuse as defined in 16 Del.C. §1131.** **Physical abuse.** **Staff to resident with or without injury.** **Sexual abuse.** **Staff to resident sexual acts.** **Significant injuries.**		
3225.19.7 **3225.19.7.1** **3225.7.1.1** **3225.7.1.1.1** **3225.19.7.1.2** **3225.19.7.1.2.1** **3225.19.7.7** **3225.19.7.7.2**			

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	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 for up to 48 hours. This requirement was not met as evidenced by: Based on record review, interview, review of hospital records and review of the State Agency Incident Reporting system, it was determined that for two (R1 and R20) out of fourteen sampled residents for reportable incidents, the facility failed to report an alleged staff to resident sexual assault and a resident fall that resulted in injury within the 8 hours of the occurrence to the Division. Findings include: 1. 12/1/25 - R1 was admitted to the facility. 1/6/26 - The State Agency received a report from a medical provider (not associated with the facility) at 3:09 PM regarding an alleged sexual assault that had occurred in early December 2025. 1/7/26 - The facility notified the State Agency of the incident at 2:09 PM, approximately fourteen hours after learning of the incident; not within the eight-hour reporting regulation. 1/7/26 - During an interview with E2 (RCD) at approximately 11:30 AM, E2 confirmed that the facility was made	A) R1 State Reportable submitted while surveyors were present within the community. R20's toe fracture healed as noted from the 8/25 fall. B) Community incident reports reviewed for any possible reportable incidents required. C) Further review of all incidents meeting the definition as State Reportable will trigger an immediate, initial State Reportable with final follow-up no greater than 5 days after incident. D) All incidents reviewed for the next week for a reportable trigger to meet 100% compliance. THEN: Review all incidents 2 weeks later for any reportable triggers for 100% compliance. THEN: Review 3 selected incidents the following month for 100% compliance. (DON and ADON)	2/27/26

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	aware of the allegation on 1/6/25 at approximately 5:00 PM when the resident returned to the facility from a medical appointment. E2 confirmed the late reporting of the incident. 1/13/26 – The reported sexual assault Investigative finding was unable to be substantiated during the State survey. 2. 3. 4/7/25 – R20 was admitted to the facility. 8/16/25 – Per EMR incident note by E11 at 6:42 AM, E11 noted "This writer notified by caregiver that resident is on the floor". Upon assessment, E11 noted R20's right foot 5th digit toe discolored pink and purple, edematous, tender to touch. R20 was sent to ER for evaluation. 8/16/25 – The ER documentation confirmed a fracture of the toe of "left" foot. 1/13/26 – Per the State Reporting system, the facility failed to report R20's fall with injury to the State. 1/13/26 – Per E2 (RCD) at approximately 12 Noon, E2 confirmed the incident of R20's fall with injury was not reported to the State. 1/13/26 - Findings were reviewed with E1 (ED), E2, E3 (MCPD) and E5 (HRD) at the exit conference, beginning at approximately 3:30 PM.		

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	Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.) **12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.** **c. Failure to carry out a prescribed treatment plan for a patient or resident.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R21) out of seven sampled residents for medication administration, the medication container differed from the medication order in the EMAR, which resulted in R21 receiving the incorrect dosage of a high-risk medication. This medication dosing error placed R21 at risk for the potential of developing thrombus and embolism. 8/30/25 - R21 was admitted to the facility with diagnoses including dementia		

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16 Delaware Code, Chapter 11, Subchapter 3 **S/S – D**	and a history of venous thrombosis and embolism. 1/8/2026 - During a Medication Pass observation for R21 at approximately at 10:12 AM, the Surveyor found: • R21's medication container was from an outside pharmacy and brought by family at R21's admission. Instructions on the label included dosing of "Eliquis 2.5 mg tablet twice daily." • The Physician's order in the EMAR was for "Eliquis 5mg tablet, take 1 tab (5mg) by mouth twice daily." • E26 (MA/Tech) dispensed one 2.5 mg tablet. 1/8/25 – Per interview with E26 at the time of dispensing, E26 confirmed that the container was labeled as 2.5 mg with directions to take twice daily. E26 confirmed the EMAR order was for 5 mg, take 1 tablet twice a day. E26 confirmed that she had been administering one 2.5 mg tablet. 1/8/26 – The medication error was reviewed with E2 (RCD) at approximately 11:00 AM. E2 stated the medication is expensive and they were using up the previously prescribed medication but should have been following the EMAR dosing instructions. E2 stated the Physician, and pharmacy would be notified of the error. 1/8/26 – R21's diagnosis was one of potential clotting. In not receiving the cor-		

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	rect dosing of the Eliquis (anticoagulant), R21 was at greater risk for blood clotting potential. 1/13/26 - Findings were reviewed with E1 (ED), E2, E3 (MCPD) and E5 at the exit conference, beginning at approximately 3:30 PM. **Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act. (81 Del. Laws, c. 206, § 40.)** **§ 1141. Criminal background checks.** **(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(c) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.** **(3) Opiates.** **(4) Phencyclidine ("PCP").** **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department under regulations promulgated under this section.** **(d) An agency, including temporary agencies, must provide the drug screening results it receives regarding an applicant referred to work in a facility to that particular facility so that the**	A) Proper dosage and order information provided for E26. No adverse effects observed. B) All medications not in Blister Pack form from our pharmacy were reviewed for appropriate dosage aligned with physician order. C) All medications provided to the community from an external pharmacy will be reviewed to match the physician order. Any medication not labeled in alignment with physician order will be returned to the family with replacement provided by outside pharmacy or our pharmacy based on timing and availability. D) 2 resident medications not in blister pack form to be reviewed weekly until 100% compliance has been met. THEN: 2 residents reviewed the following week until 100% compliance is met. THEN: 2 residents reviewed the following month to assure 100% compliance. (DON and ADON)	2/27/26

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	facility is better able to make an informed decision whether to accept the referral. **(e) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **(f) Any employer who fails to comply with the requirements of this section is subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation.** **(71 Del. Laws, c. 466, § 2; 72 Del. Laws, c. 2, § 1; 72 Del. Laws, c. 366, § 1; 78 Del. Laws, c. 303, § 2; 81 Del. Laws, c. 206, §42.)** Based on record review, interview and review of other facility documentation, it was determined that for ten (E5, E11, E12, E13, E14, E15, E16, E17, E18 and E19) out of ten sampled employees, the facility failed to provide evidence that the pre-hire drug screening contained testing for marijuana/cannabis per the DE Code regulations, or that the testing was not completed prior to hire. Findings include: 1. 10/14/25 – E5 (HRD) was hired at the facility. The pre-hire drug testing done on 10/14/25 did not contain testing for marijuana/cannabis. The drug testing was completed on the day of hire, not prior to hire. 2. 6/27/25 – E11 (RN) was hired at the facility. The pre-hire drug testing done		

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	on 5/8/25 did not contain testing for marijuana/cannabis. 3. 5/29/25 - E12 (NA/CG) was hired at the facility. The pre-hire drug testing done on 5/7/25 did not contain testing for marijuana/cannabis. 4. 11/25/25 – E13 (MA/Tech) was hired at the facility. The pre-hire drug testing done on 11/25/25 did not contain testing for marijuana/cannabis. The drug testing was completed on the day of hire, not prior to hire. 5. 12/8/25 – E14 (NA/CG) was hired at the facility. The pre-hire drug testing done on 12/8/25 did not contain testing for marijuana/cannabis. The drug testing was completed on the day of hire, not prior to hire. 6. 7/31/25 – E15 (LPN) was hired at the facility. The pre-hire drug testing done on 7/23/25 did not contain testing for marijuana/cannabis. 7. 7/2/25 - E16 (Cook) was hired at the facility. The pre-hire drug testing done on 6/12/25 did not contain testing for marijuana/cannabis. 8. 9/25/25 – E17 (NAYA) was hired at the facility. The pre-hire drug testing done on 9/17/25 did not contain testing for marijuana/cannabis. 9. 9/23/25 – E18 (LPN) was hired at the facility. The pre-hire drug testing done	A) E5, E11-19 to undergo testing as soon as the new tests arrive covering THC. B) All staff will undergo testing for THC. C) All new hire staff will undergo pre-hire drug screening to include testing for THC until the Chapter is updated to be in alignment with Delaware law. D) Each new staff member drug screen reviewed for inclusion of THC testing until 100% compliance is met with 3 consecutive new staff. THEN: 2 new staff from the next orientation class drug screen reviewed for THC for 100% compliance. THEN: 2 new staff drug screen reviewed the following month for 100% compliance. (HRD and ED)	2/27/26

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Title 16 Delaware Code Chapter 11, Subchapter IV **S/S – E**	on 10/2/25 did not contain testing for marijuana/cannabis. The drug testing was completed after E18 was hired, not prior to hire. 10. 10/30/25 – E19 (Receptionist) was hired at the facility. The pre-hire drug testing done on 11/2/25 did not contain testing for marijuana/cannabis. The drug testing was completed after E19 was hired, not prior to hire. 1/8/25 – Per interview with E5 at approximately 2:00 PM, E5 confirmed the drug testing was done on site and did not test for the marijuana/cannabis. 1/13/25 – Per interview with E1 (ED) at approximately 3:25 PM, E1 stated the facility no longer tests for marijuana/cannabis since the State approved recreational use of the drug. 1/13/26 - Findings were reviewed with E1, E2 (RCD), E3 (MCPD) and E5 at the exit conference, beginning at approximately 3:30 PM.		

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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Provider's Signature _Paul Taylor_____ Title _Executive Director_____ Date _2/17/26_____