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: Encore at Foulk Assisted Living

DATE SURVEY COMPLETED: September 16, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	
	An unannounced Annual and Complaint Survey was conducted at this facility from September 15, 2026, to September 16, 2026. The deficiencies contained in this report are based on observation, interviews, resident and employee record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-two (32). The survey sample totaled eight (8) residents plus one additional subsampled resident. Abbreviations/definitions used in this state report are as follows: DON – Director of Nursing; ED - Executive Director; EMR – Electronic Medical Record; LPN – Licensed Practical Nurse; RN – Registered Nurse.		
3225.0 **3225.1.0**	**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.**		

Provider's Signature: _____ Title: Executive Director/LNHA Date: 9/30/2026

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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 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, interview and review of other facility documentation, it was determined that one (R5) out of eight residents reviewed, the facility lacked evidence of a pneumococcal vaccine record. Findings include: 12/1/25 – R5 was admitted to the facility. The facility lacked evidence of R5's pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined. 9/16/26 1:50 PM – During an interview, E2 confirmed the pneumonia record was not in evidence. 9/16/26 – Findings were reviewed with E1 (ED), E2 and E5 (LPN) at the exit conference beginning at approximately 2:40 PM.	1. R5's medical record will be reviewed for pneumococcal vaccination history. If documentation cannot be obtained, vaccination status will be addressed with the resident/provider. Any refusal, education regarding health risks, or medical contraindication will be documented. 2. The Director of Assisted Living will audit 100% of current AL resident records for required pneumococcal vaccination documentation, contraindications, or documented refusal. Any deficiencies identified will be corrected. 3. The Executive Director will in-service the Director of Assisted Living using the Pneumococcal Vaccination Compliance In-Service. A standardized vaccination review/tracking process will be implemented for current residents and new admissions. 4. The Director of Assisted Living will audit applicable records weekly for 4 weeks, with a goal of 100% compliance, then monthly for 3 months, with a goal of 100% compliance. Any deficient findings will be corrected immediately and monitoring restarted.	9/30/2026

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3225.11.0 **3225.11.5** **S/S- D**	**Resident Assessment** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that one (R2) out of eight residents reviewed, the facility lacked evidence that an annual UAI was completed. Findings include: 4/26/24 - R2 was admitted to the facility. 4/24/25 – An annual UAI was completed. The facility lacked evidence that a 2026 UAI was completed. 9/16/26 1:50 PM – During an interview, E2 confirmed the 2026 UAI was not in evidence. 9/16/26 – Findings were reviewed with E1 (ED), E2 and E5 (LPN) at the exit conference beginning at approximately 2:40 PM.	1. R2 is no longer a resident of Encore at Foulk; therefore, the deficient practice cannot be corrected for that individual. No further resident-specific corrective action can be taken. 2. A 100% audit of AL resident records will be completed to verify required UAIs are current at 30 days after admission, annually, and with significant change in condition. Any missing or overdue UAI will be completed. 3. The Executive Director will in-service the Director of Assisted Living using the UAI Assessment Update Requirements In-Service. A UAI tracking system will be maintained for 30 days, annual, and significant-change assessments. 4. The UAI tracker will be reviewed weekly by the Director of Assisted Living for 4 weeks, with a goal of 100% compliance, then monthly for 3 months, with a goal of 100% compliance. Any deficient findings will be corrected immediately and monitoring restarted.	9/30/2026
3225.16.0 **3225.16.2** **S/S- E**	**Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.**		

Provider's Signature: _____ Title: Executive Director/LNHA Date: 9/30/2026

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	State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties 2024...Post Fall Assessment & Documentation- RN..." Updated 4/10/24. This requirement was not met as evidenced by: Based on record review, interviews and review of other facility documentation, it was determined that four (R3, R4, R5 and R6) out of eight residents reviewed for Accidents, the facility failed to ensure that nursing services met professional standards as evidenced by having LPNs complete the post fall assessment and documentation for residents' post fall which violates the Delaware State Board of Nursing Scope of Practice. Findings include: 1. 5/1/25 – R3 was admitted to the facility. 11/10/25 – Per EMR entry at 5:29 PM, E7 (LPN) noted R3 was observed laying on her right side on the floor. E7 documented R3 "was assessed," "had no apparent injuries, and was assisted off the floor by two person assist." The post fall assessment was completed by E7, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 7/17/26 – Per EMR entry at 1:06 PM, E5 (LPN) noted R3 rolled out of bed at about 6:45 AM. She was assisted off the floor, "assessed and no bruise/injury noted".	1. The Director of Assisted Living will review the status, fall risk, and fall-prevention interventions for R3, R4, R5, and R6. The historical initial RN assessments cannot be recreated retrospectively. 2. The Director of Assisted Living (RN) will review all current Assisted Living residents with a documented fall during the prior 30 days to verify that the initial post-fall assessment was completed by an RN. Any resident identified without the required RN assessment will have current fall-risk interventions and care needs reviewed and corrected as indicated. 3. The Director of Assisted Living and Director of Nursing will in-service applicable staff using the Post-Fall Assessment & Documentation In-Service. The revised process requires: •Initial post-fall assessment by an RN. •If no RN is immediately available in AL, staff will request RN support from the Encore at Foulk Healthcare Center. •For residents on hospice, the hospice provider will be notified and requested to send an RN. 4. The Director of Assisted Living will review 100% of AL falls weekly for 4 weeks, with a goal of 100% compliance, then monthly for 3 months, with a goal of 100% compliance with the RN initial-assessment requirement. Any deficient findings will be corrected immediately and monitoring restarted.	9/30/2026

Provider's Signature: Helen Yahn Title: Executive Director/LNHA Date: 9/30/2026

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	The post fall assessment was completed by E5, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 2. 6/9/23 – R4 was admitted to the facility. 11/26/25 – Per EMR entry at 11:10 PM, E7 noted R4 was "observed laying on the floor on her left side." "Resident assessed. Small S/T (skin tear) noted on left arm." The post fall assessment was completed by E7, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3. 12/1/25 – R5 was admitted to the facility. 8/29/26 - Per EMR entry by E6 (LPN) at 8:28 PM, E6 noted R5 was "observed sitting on the floor in the dining room." R5 "was checked for any injuries, and none were noted." The post fall assessment was completed by E6, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 4. 3/8/19 – R6 was admitted to the facility. 1/20/26 – Per EMR by E7 (LPN) at 8:40 PM, E7 noted R6 had a witnessed fall in the dining room "Resident assessed, no apparent injuries noted." The post fall assessment was completed by E7, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 9/16/26 2:30 PM – During an interview with E1 (ED) and E2 (DON), E1 stated an RN from		

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	the health center should be contacted when a resident falls "after hours" to assess. E2 stated she requires a hospice nurse to evaluate a resident post fall when hospice services are in place. E2 confirmed the EMR lacked evidence of a post-fall RN assessment for these residents. 9/16/26 – Findings were reviewed with E1, E2 and E5 (LPN) at the exit conference beginning at approximately 2:40 PM.		

Provider's Signature: Steven Ubry Title: Executive Director/LNHA Date: 9/30/2026