



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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

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

STATE SURVEY REPORT

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NAME OF FACILITY: The Pointe Lodge Senior Living

DATE SURVEY COMPLETED: August 26, 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, complaint, and emergency preparedness survey was conducted at this facility from August 24, 2026, through August 26, 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 thirty-four (34). The survey sample totaled eighteen (18) residents. Abbreviations/definitions used in this state report are as follows: Adrenal insufficiency - a disorder that occurs when the adrenal glands don't make enough of certain hormones; Alzheimer's disease - progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain; Anemia - low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues, or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues, which may make you feel very tired and weak; Antipsychotic- a class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Anti-anxiety medication - medication used to treat anxiety disorders and related conditions;		

Provider's Signature [Signature] Title Executive Director Date 9/18/26



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	Aranesp – a synthetic form of erythropoietin, a hormone that stimulates the production of red blood cells in the bone marrow. It is primarily used to treat anemia associated with chronic kidney disease; BOD – Business Office Director; Dementia – a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation, or loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; ED – Executive Director; EHR – Electronic Health Record; LPN – Licensed Practical Nurse; MA – Medication Assistant; Mg = milligrams; RA – Resident Assistant; RDRC – Regional Director of Resident Care; RN – Registered Nurse; SA – (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. SLUMS – Saint Louis University Mental Status exam/brief cognitive screening tool designed to detect early signs of mild cognitive impairment and dementia.		

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3225.0	Assisted Living Facilities		
3225.1.0	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.		
3225.12.0	Services	3225.12.1.3	
3225.12.1	The assisted living facility shall ensure that:	3-304.14	
3225.12.1.3	Food service complies with the Delaware Food Code	1. Upon identifying the deficient practice, culinary staff were immediately reminded that wiping cloths must be stored between uses in an approved chemical sanitizer solution maintained at the required concentration.	
S/S -F	This requirement was not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 4458 State of Delaware Food Code Regulations 2.0 Adoption of United States Public Health Service 2022 Food Code	2. All residents have the potential to be affected by this deficient practice. 3. An in-service for all culinary staff was started on 9/1/26, educating on proper wiping-cloth use and storage, sanitizer preparation, required sanitizer concentrations, proper use of test strips, and when to change sanitizer solutions. CSD/designee will clearly identify sanitizer buckets and maintain them in appropriate food preparation and service areas.	9/30/26

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	2.1 The State of Delaware Food Code adopts, as if fully set forth in this regulation, the United States Public Health Service 2022 Food Code: 2022 Food Code U.S Food and Drug Administration Chapter 3 Food 3-3 Protection From Contamination After Receiving 3-304 Preventing Contamination from Equipment, Utensils, and Linens 3-304.14 Wiping Cloths, Use Limitation. (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 3-305 Preventing contamination from the premises 3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. 8/24/26 – During the survey of the facility at approximately 11:00 AM, an observation of the refrigerator in the kitchenette of the Green Unit revealed items that were not part of the food service, including a Gatorade drink, an opened Ice drink, an open package of Oreos, and a container with a	4. The CSD/designee will conduct a daily audit for x4 weeks until 100% compliance is verified then weekly x2 until 100% verified. Results will be presented in the Quality Assurance meeting for review and recommendation. 3-304.15 1. Upon identifying the deficient practice, staff involved in food handling were reminded that single-use gloves are for one task only and must be discarded when changing tasks, when they become soiled or damaged, or when food-handling activities are interrupted. 2. All residents have the potential to be affected by this deficient practice. 3. An in-service was started on 9/14/26 for culinary staff and care staff on infection control and proper glove use to include but not limited to proper handwashing, appropriate use of single-use gloves, changing gloves between tasks, avoiding contact with non-food-contact surfaces while handling food, and removing and replacing gloves whenever contamination occurs or the task is interrupted. 4. The CSD/HSD/designee will conduct a daily audit for x4 weeks until 100% compliance is verified then weekly x2 until 100% verified. Results will be presented in the Quality Assurance meeting for review and recommendation.	9/30/26

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3225.13.0	slice of cake, all obtained from outside of the facility food service operation. In addition, there were three pitchers of juice located in the refrigerator which were part of the food service operation. This places the food service items at risk for contamination. A policy was requested from E23 (Culinary Services Director) for food brought in by visitors. This was unavailable at the time of the survey. 8/24/26 – During the survey of the facility at approximately 11:30 AM, an observation of the kitchen prep table revealed used wiping cloths located on the table and not stored in a chemical sanitizer solution between uses. 8/24/26 – Findings were confirmed with E23 (Culinary Services Director). 8/24/26 – During the survey of the facility at approximately 12:00 PM, an observation of the resident assistants in the Blue Unit and Green Unit dining areas revealed staff utilizing gloves in the dining area. While gloves were donned, resident assistants were observed touching multiple surfaces, including dishware, door handles, resident clothing, and resident tableware. 8/24/26 – An interview with E25 (Resident Assistant) revealed the resident assistants typically wear gloves during meal service. 8/26/26 3:20 PM – Findings were reviewed with E1 (ED), E2 (HSD), and E3 (RDRC) during the Exit Conference. Service Agreements	3-305.11 1. Upon identifying the deficient practice, all affected food items were immediately assessed and relocated as needed to ensure they were stored in a clean, dry location and protected from splash, dust, and other potential sources of contamination. Staff removed all personal items identified in refrigerators designated for resident food. 2. All residents have the potential to be affected by this deficient practice. 3. An in-service was started on 9/14/26 for culinary staff and care staff on proper food storage practices. Education will include maintaining food in clean, dry storage areas; protecting food from environmental contamination; ensuring food is properly covered or contained; and keeping storage areas sanitary. 4. The CSD/designee will conduct a daily audit for x4 weeks until 100% compliance is verified then weekly x2 until 100% verified. Results will be presented in the Quality Assurance meeting for review and recommendation.	9/30/26

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3225.13.2	The service agreement or contract shall address the physical, medical, and psychological services that the resident requires as follows:	3225.13.2.9	
3225.13.2.9	Notification procedures when an incident occurs or there is a change in the health status of the resident.	1. R5 continues to reside in the community. Family of R5 submitted a grievance on 7/6/26 regarding the lack of notification. Grievance, to include corrective action, was resolved on 7/7/26. Family satisfied with outcome.	
S/S - D	This requirement was not met as evidenced by: Based on interview and record review, it was determined that for one (R5) out of four residents reviewed for falls, the facility failed to have evidence of notification procedures in the service agreement to ensure the provider and/or resident's responsible representative would be notified when R5 was transferred to the ER after sustaining a fall. Findings include: A facility document entitled, "Residency Agreement", dated 10/2025 documented, "...C. Health Care Provider Notification and Arrangement of Services...you have authorized us...to contact specific individuals and health care providers (1) if we determine it is necessary to advise your concerned parties of your situation (2) to arrange for health care services and other assistance (3) if you have a life-threatening emergency...". Review of R5's clinical record revealed: 4/30/24 - R5 was admitted to the facility with diagnoses including Alzheimer's disease.	2. All residents have the potential to be affected by this deficient practice. All resident records were reviewed for accuracy in primary contact and primary medical provider and any updates were made to the Electronic Health Records in a prior correction by 6/1/26. 3. Nursing staff will be retrained on incident reporting including contacting the primary emergency contact and the primary medical contact with changes in resident condition. Training to include documentation within the incident report and progress notes of the name of the contact, with the date and time of the contact. 4. The HSD/designee will conduct a daily audit for x4 weeks until 100% compliance is verified of contact on Incident Reports and Progress notes. Ongoing with daily review (Monday-Friday) at clinical meeting and monthly review at Quality Assurance Meeting for review and recommendation.	9/30/26

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	3/13/26 -- A facility document entitled, "Semi-Annual Comprehensive Assessment" completed by E2 (HSD), documented that R5 was severely cognitively impaired. The document did not include notification procedures to R5's PCP (primary care provider) or responsible representative. 7/5/26 6:27 PM -- A facility document entitled "Incident Report" completed by E26 (CN, LPN), documented, "[R5] was found lying on the floor by a caregiver. [R5] was struck with an object. No bleeding or other injuries observed...[E2] recommended [R5] be sent to the ER [emergency room] for evaluation." 7/6/26 4:15 AM -- A "Progress Note" entered in the clinical record documented that R5 returned to the facility at 3:40 AM from the ER with no new orders and that E2 was notified. The note also documented that FM1 (R5's family member) was left a voicemail requesting a return call to the facility. 7/6/26 -- A facility document entitled, "Grievance/Complaint Report" completed by E2 documented that FM1 had filed a complaint that there was no notification given that R5 was sent to the ER on 7/5/26. The report also documented, "...[FM1] received notification on her phone from [hospital] portal that [R5]'s lab work had been done at [hospital]. [FM1] called the community [facility] and the phone was answered by [E26]...[FM1] inquired how long [R5] had been in the hospital and [E26] reported that she was with another patient and unable to speak, refused to give further		

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	information, and would call back. [E26] called [FM1] back 20 minutes later. In the meantime, [FM1] called [P1, DNP] who confirmed she had not been notified of the incident...". 7/7/26 -- A facility document entitled, "HR-Corrective Discipline Form" completed by E2 documented that E26 did not notify the PCP or responsible representative when R5 was sent to the ER on 7/5/26. 8/25/26 12:45 PM -- During an interview, FM1 stated, "I got notification from [hospital] that [R5] had new labs results. I called [facility] to ask if [R5] was okay and how long [R5] had been at the ER. [E2] said she would have to look at her notes and call me back. I called [P1], and she called the ER. [R5] had been alone at [hospital] for an hour and a half. If I didn't get that message from [hospital] I don't know if I ever would have been told that [R5] had to be sent to the ER or if [R5] was okay." 8/26/26 10:52 AM -- During an interview, E26 stated, "I was about to call [FM1], but I had a resident who had just fallen and another resident with low blood sugar. I did call [FM1] back. I don't know if I called the provider." 8/26/26 12:00 PM -- During an interview, E2 confirmed that R5's PCP and responsible representative were not notified when R5 was sent to the ER. E2 stated, "When I responded to [E26], I told [E26] who [R5]'s provider was. [E26] should have known who to contact."		

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3225.16.0 3225.16.14 3225.16.14.2 3225.16.14.2.1 3225.16.14.2.2 S/S – D	8/26/26 12:15 PM – Findings were confirmed with E1 and E2. 8/26/26 3:20 PM – Findings were reviewed with E1 (ED), E2 and E3 (RDRC) during the Exit Conference. Staffing Assisted living facility resident assistants shall at a minimum: Participate in a facility-specific orientation program that covers the following topics: Fire and life safety, and emergency preparedness plans; Infection Control, including Standard Precautions; This requirement was not met as evidenced by: Based on interview and review of employee records, it was determined that for one (E5) out of five newly hired resident assistants, the facility failed to ensure that facility-specific orientation trainings on fire and life safety, emergency preparedness plans, and infection control including standard precautions were completed. Findings include: E5's (RA) first day in the facility was 1/19/26. 8/26/26 11:00 AM – A review of E5's employee training records lacked evidence that she completed the fire and life safety,	3225.16.0 1. E5 remains employed at the community. Community was not able to locate documentation that Fire and Life Safety, Emergency Preparedness and Infection Control education was completed. 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis revealed the required education trainings for Fire and Life Safety, Emergency Preparedness and Infection Control were not being properly monitored for compliance due to Community Ownership turnover. An education audit for all current staff was completed on 9/15/26 and all staff will complete Fire and Life Safety, Emergency Preparedness and Infection Control training by 9/30/2026. Training module with all training has been established and will be assigned upon hire and annually by BOD/ED/designee. 4. The BOD/designee will conduct a weekly audit for all staff, including new hires, for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented in the Quality Assurance meeting for review and recommendation.	9/30/26

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3225.16.14.2.3 S/S- E	emergency preparedness plans, and infection control, including standard precautions trainings. 8/26/26 12:00 PM – Finding was discussed and confirmed by E16 (BOD). 8/26/26 3:20 PM – Finding was reviewed with E1 (ED), E2 (HSD), and E3 (RDRC) during the Exit Conference. Basic Food Safety; This requirement was not met as evidenced by: Based on interviews and review of employee records, it was determined that for five (E5, E9, E10, E11, and E12) out of five newly hired resident assistants, the facility failed to ensure that training on basic food safety was completed. Findings include: - E5's (RA) first day in the facility was on 1/19/26. - E9's (RA) first day in the facility was on 2/12/26. - E10's (RA) first day in the facility was on 2/12/26. - E11's (RA) first day in the facility was on 2/12/26. - E12's (RA) first day in the facility was on 6/16/26. 8/26/26 11:15 AM – A review of E5, E9, E10, E11, and E12's employee training records lacked evidence that they completed the training on basic food safety.	3225.16.14.2.3 1. E5, E9, E10, E11, E12 remain employed at the community. Community was not able to locate documentation that Basic Food Safety education was completed. 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis revealed the required education training for "Basic Food Safety" was not being properly monitored for compliance due to Community Ownership turnover. An education audit for all current staff was completed on 9/15/26 and all staff will complete Basic Food Safety training by 9/30/2026. Training module with the required training has been established and will be assigned upon hire and annually by BOD/ED/designee. 4. The BOD/designee will conduct a weekly audit for all staff, including new hires, for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented in the Quality Assurance meeting for review and recommendation.	9/30/26

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3225.16.14.2.5 S/S - D	8/26/26 12:10 PM – Findings were discussed and confirmed by E16 (BOD). 8/26/26 3:20 PM – Findings were reviewed with E1 (ED), E2 (HSD), and E3 (RDRC) during the Exit Conference. Job responsibilities; This requirement was not met as evidenced by: Based on interview and review of employee records, it was determined that for one (E5) out of five newly hired resident assistants, the facility failed to ensure that training on job responsibilities was completed. Findings include: E5's (RA) first day in the facility was 1/19/26. 8/26/26 11:20 AM – A review of E5's employee training records lacked evidence that she completed the training on job responsibilities. 8/26/26 12:15 PM – Finding was discussed and confirmed by E16 (BOD). 8/26/26 3:20 PM – Finding was reviewed with E1 (ED), E2 (HSD), and E3 (RDRC) during the Exit Conference. Hospice Services. This requirement was not met as evidenced by: Based on interview and review of employee records, it was determined that for five (E5, E9, E10, E11, and E12) out of five newly hired resident assistants, the facility failed	3225.16.14.2.5 1. E5 remains employed at the community. Community was not able to locate documentation that Job Responsibility education and training was completed. 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis revealed the required New Hire Orientation Checklist was not being properly monitored for compliance due to leadership turnover. A review of the New Hire Orientation Checklist form was completed on 8/26/26 to ensure content accuracy. BOD/designee will self-audit all new hire files after orientation to ensure all required documents are acknowledged and present in the file. 4. The BOD/designee will conduct a weekly audit for all new hires, for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented in the Quality Assurance meeting for review and recommendation.	8/26/26
3225.16.14.2.10 S/S - E	This requirement was not met as evidenced by: Based on interview and review of employee records, it was determined that for five (E5, E9, E10, E11, and E12) out of five newly hired resident assistants, the facility failed	3225.16.14.2.10 1. E5, E9, E10, E11, E12 remain employed at the community. Community was not able to locate documentation that Hospice Services education was completed. 2. All residents have the potential to be affected by this deficient practice.	

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3225.16.19 S/S - D	to ensure that training on hospice services was completed. Findings include: - E5's (RA) first day in the facility was on 1/19/26. - E9's (RA) first day in the facility was on 2/12/26. - E10's (RA) first day in the facility was on 2/12/26. - E11's (RA) first day in the facility was on 2/12/26. - E12's (RA) first day in the facility was on 6/16/26. 8/26/26 11:25 AM – A review of E5, E9, E10, E11, and E12 's employee training records lacked evidence that they completed the training on hospice services safety. 8/26/26 12:20 PM – Findings were discussed and confirmed by E16 (BOD). 8/26/26 3:20 PM – Findings were reviewed with E1 (ED), E2 (HSD), and E3 (RDRC) during the Exit Conference. The assisted living facility shall provide orientation training to all new staff. This requirement was not met as evidenced by: Based on interview and review of employee records, it was determined that for one (E1, ED) out of four newly hired facility employees, the facility failed to ensure that the training on Abuse/Neglect/Exploitation	3. A root cause analysis revealed the required education training for "Hospice Services" was not being properly monitored for compliance due to leadership turnover. An education audit for all current staff was completed on 9/15/26 and all staff will complete Hospice Services training by 9/30/2026. Training module with the required training has been established and will be assigned upon hire and annually by BOD/ED/designee. 4. The BOD/designee will conduct a weekly audit for all staff, including new hires, for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation. 3225.16.19 1. E1 remains employed at the community. Community was not able to locate documentation that Abuse/Neglect/Exploitation education was completed upon hire. The education was completed on 8/25/26. 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis revealed the required education training for "Abuse/Neglect/Exploitation" was not being properly monitored for compliance or	9/30/26

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	Prevention and Dementia was completed. Findings include: 8/25/26 10:39 AM – A list of facility employees sampled for staff training review was provided to the facility. 8/26/26 10:32 AM – A spreadsheet of facility employees' training records was presented to the surveyor. E1's first day in the facility was on 6/1/26. 8/26/26 11:35 AM – A review of E1's employee training records revealed that E1 completed her training on Abuse/Neglect/Exploitation Prevention and Dementia the day before, 8/25/26, after the surveyor's request. 8/26/26 12:40 PM – During an interview, E16 (BOD) confirmed that E1 did not have her trainings on Abuse/Neglect/Exploitation Prevention and Dementia until yesterday when requested by the surveyor. 8/26/26 2:50 PM – In an interview, E1 stated that the trainings on Abuse/Neglect/Exploitation Prevention and Dementia were not assigned to her to do. 8/26/26 3:20 PM – Findings were reviewed with E1 (ED), E2 (HSD), and E3 (RDRC) during the Exit Conference.	assignment due to Community Ownership turnover. An education audit for all current staff was completed on 9/15/26 and all staff will complete "Abuse/Neglect/Exploitation" training by 9/30/2026. Training module with the required training has been established and will be assigned upon hire and annually by BOD/ED/designee 4. The BOD/ED/designee will conduct a weekly audit for all staff, including new hires, for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	9/30/26
3225.18.0	Emergency Preparedness	3225.18.0	
3225.18.1	Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction	1. The community was unable to provide requested documentation of past inspections, to include testing and maintenance. 2. All residents have the potential to be affected by this deficient practice.	
S/S- F			

Provider's Signature

[Signature]

Title

Executive Director

Date

9/18/26



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	This requirement was not met as evidenced by: Based on interview and document review, it was determined that the facility failed to comply with Delaware State Fire Prevention Regulations. Findings include: 700 Delaware State Fire Prevention Regulations 4.0 Periodic Inspections, Testing, And Maintenance Service. 4.1 General. 4.1.4 Annual Inspection, Testing, and Maintenance Service. Annual inspection, testing, and maintenance is required for all fire alarm signaling, fire suppression, and any other fire protection systems, devices, and equipment installed within the State of Delaware. This annual inspection, testing, and maintenance service shall be completed by a company licensed in accordance with Regulation 703, Chapters 2, 4, 5, 6, and/or 7. Upon completion of this annual inspection, testing, and maintenance service, the licensed company shall submit an Annual Certificate of Inspection along with the appropriate fees as listed in these Regulations, in accordance with §4.1.5 of this Chapter. 8/24/26 – During the survey of the facility at approximately 2:00 PM, a review of the Fire Marshal documentation revealed a past-due fire alarm system inspection, an unapproved new panel installation, and an outdated electrical inspection on 8/14/25. The surveyor requested additional documentation from E1 (ED) and E24 (Environmental Services Director) to support a reinspection or certification of approval from the Office of the Fire Marshal. Documentation was unavailable at the time of the survey.	3. A root cause analysis revealed the required documentation and record keeping were not being properly monitored for compliance due to Community Ownership and leadership turnover. Multiple requests for previous community reports were made with no response. Community is due for Annual Fire Marshal Inspection. After annual inspection is completed, findings, to include testing and/or maintenance documentation, will be uploaded to TELS program for digital filing. 4. The MD/designee will conduct a weekly audit on all Maintenance TELS Regulatory Task Documentation for x4 weeks, until 100% compliance is verified then monthly x2 until 100% verified. Results will be presented in the Quality Assurance meeting for review and recommendation.	8/25/26, Ongoing

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3225.19.7.5.2 Title 16 Health and Safety Chapter 11 Long Term Care Facilities and Services Subchapter III. Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. 1131. Definitions S/S-D	8/26/26 3:20 PM – Findings were reviewed with E1 (ED), E2 (HSD), and E3 (RDRC) during the Exit Conference. Resident Elopement (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. This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R6) out of two residents reviewed for elopement, the facility failed to ensure that doors to a staff service hall and a rear exit door of the facility were maintained and secured to prevent R6 from eloping outside of the building unsupervised. Findings include: Review of R6's clinical record revealed: 7/21/25 – R6 was admitted to the facility with diagnoses including Alzheimer's disease. 1/21/26 – A facility document entitled, "Initial Comprehensive Assessment", completed for R6 documented, "...1. Cognitive Skills for Daily Decision Making...Severely Impaired...". The assessment also documented that R6 had a SLUMS Evaluation score of 0-13, indicating severe cognitive	3225.19.7.5.2 1. R6 continues to reside in the community. Event did not result in physical or psychological injury. 2. All residents have the potential to be affected by this deficient practice. All residents were reassessed for Elopement risk using the Sinceri Elopement Risk tool by 6/29/26. 3. All community staff were retrained in Elopement Prevention and Dementia Unit Safety with a post-test to confirm competency. Nursing completed Elopement Prevention Monitoring Audits every shift (3x daily) to audit: Door security; Resident Supervision; and Staff Knowledge of Elopement Prevention, for 30 days until compliance was achieved. Environmental repairs were made to rear exit door in service hall, alarm bar was re-keyed with limited staff access to prevent accidental disengagement, and door hinge was replaced to ensure proper closure. Doors to serving pantries were enhanced and repaired with self-closing hinges to avoid doors from remaining open after use, keypads were repaired to automatically lock after use. Repairs were completed by 6/30/26. Maintenance performed exit door safety checks to ensure all locking mechanisms were functioning daily. 4. The MD/Designee will continue to conduct a daily audit (Monday-Friday) on all exit doors. Ongoing Elopement trainings are being conducted as needed. Elopement	9/30/26

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[Signature]

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	impairment, was able to independently ambulate, and was at low risk for elopement. 6/6/26 – A facility training document entitled, "Elopement Prevention and Dementia Unit Safety" documented, "...Door Security...no exit or secured door may be left unlocked. No exit or secured door may be propped open. Staff must verify close and latch completely after use...". 6/8/26 10:23 AM – A facility training document entitled, "Work Order", entered by E1 (ED) documented, "...Please repair or replace the coded door locks for the two secondary doors in the serving areas leading to the dining room in Memory Care. Those doors must be always locked...". It was also documented that E18 (ESM) completed the repairs on 6/8/26 at 5:20 PM. 6/18/26 2:00 PM – A facility document entitled, "Incident Report", documented "[R6] observed standing outside the building under a tree near the service entrance...the service door from the service hall to the outside was not properly latched and had the lock turned off so [sic] the door did not alarm...". The document also indicated that R6 had no injuries. 8/22/26 11:04 – A facility email correspondence authored by E2 (HSD) documented, "...[R6] may have walked out of a service hallway and out the door from the service hallway out of the building...[E1] and [E2] immediately went to check the door and found that when the door was opened it was not closing and latching properly. It could still be pushed open...[E1] and [E2] looked at the door locks from the	policy and response expectations are included in New Hire Orientation. Results will be presented in the Quality Assurance meeting for review and recommendation.	

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	serving room to the service hallway. Doors were again found unlocked...". 8/24/26 – Facility documents entitled, "Training Sign-in Sheet- Elopement Safety Plan", signed by facility staff, were given to the Surveyor indicating that all staff had received the elopement prevention training between 6/6/26 and 6/16/26. 8/25/26 1:18 PM- During an interview, E2 stated, "There was an issue with the rear door. It looked closed, but it was not secured. The alarm did not go off because the door was not closed when [R6] got out...There was an issue with the doors being propped open." 8/25/26 1:34 PM- During an interview, E1 stated, "The door from the dining room was not locked...[contractor] repaired the keypad that is used to unlock the door to the service hall. Both self-closing arms on the rear exterior door and service hall door were repaired..." 8/26/26 8:34 AM – During an interview, E21 (HSK) stated, "I was taking out the trash, and I saw [R6]. I had [R6] come in, and I called the nurse. I don't know how [R6] got out. Maybe someone left the door open...". The Surveyor asked if elopement training was provided. E21 stated, "Yes, we had training before and after this happened." 8/26/26 12:15 PM – Findings were reviewed with E1 and E2. 8/26/26 3:20 PM – Findings were reviewed with E1, E2 and E3 (RDRC) during the Exit Conference.		

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16 Del. C. Chapter 11, Subchapter III, ss 1131 Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents S/S- E	12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes...: c. "Failure to carry out a prescribed treatment plan for a patient or resident." This requirement was not met as evidenced by: Based on interview and record review, it was determined that for five (R3, R4, R6, R7 and R14) of the five residents reviewed for medications, the facility failed to ensure each resident received all their prescribed medications according to the physician's orders and plan of care. Findings include: 1. Review of R3's record revealed: 9/8/22 – R3 was admitted to the facility with diagnoses that included, but were not limited to, Alzheimer's disease and essential primary hypertension. 3/13/25 – The July 2026 eMAR documented a physician order start date of 3/13/25 for lisinopril 40 mg tablet by mouth daily at 9:00 AM. 8/24/26 – Review of the July 2026 eMAR for R3 revealed two separate occurrences on 7/9/26 and 7/10/26 of "Medication not available" for lisinopril 40 mg tablet scheduled at 9:00 AM. 2. Review of R4's record revealed: 9/1/22 - R4 was admitted to the facility on 9/1/22 with diagnoses that included, but were not limited to, Alzheimer's disease,	16 Del. C.11.section 1131 1. R3, R6, R7, R14 continues to reside at the Community. R4 no longer resides in the community. 2. All residents have the potential to be affected by this deficient practice. All Resident Medication Administration Records (MARs) were audited to review any impact on residents. There were no additional findings of missed medications. 3. Retraining of LLAM staff and licensed nurses on process of missed medication reporting to include notification of the primary care provider, and resident's primary emergency contact. Training to include notification of the Charge Nurse prior to documentation of missed medication. Review of medication reordering process to include: LLAM reordering medication and faxing reorder sheet to pharmacy. Medication cart audits by Nursing x3 weekly to monitor medication reordering. Charge nurse to monitor medication passes in EMAR by running missed medication reports prior to the end of their shift to resolve any missed medications. The community has identified a new pharmacy vendor; transition is planned for 11/18/26. 4. HSD/Designee to monitor missed medication report daily. Follow up by Charge Nurse to resolve missed medication(s). Findings will be reviewed in the Daily Clinical Meeting (Monday-Friday) and monthly in the Quality Assurance meeting for review and recommendation.	8/25/26 10/8/26

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	adrenocortical insufficiency, restlessness, and agitation. 8/12/25 – The July 2026 eMAR documented a physician order start date of 8/12/25 for fludrocortisone acetate 0.1 mg tablet by mouth daily at 8:00 AM for adrenocortical Insufficiency. 2/19/26 – The July 2026 eMAR documented a physician order start date of 2/19/26 for quetiapine fumarate 25 mg tablet by mouth twice daily A.M. and noon. 3/18/26 – The July 2026 eMAR documented a physician order start date of 3/18/26 for lorazepam 0.5 mg tablet by mouth every morning. 8/24/26 – Review of the July eMAR for R4 revealed: - Four separate occurrences on 7/8/26, 7/25/26, 7/29/26, and 7/30/26 of "Medication not available" for fludrocortisone acetate 0.1 mg daily at 8:00 AM. - Two separate occurrences on 7/14/26 and 7/15/26 of "Medication not available" for lorazepam 0.5 mg scheduled every evening at 6:00 PM. - Three separate occurrences on 7/27/26, 7/28/26, and 7/29/26 of "ordered awaiting delivery" for quetiapine fumarate 25 mg scheduled at 8:00 AM. - Two separate occurrences on 7/27/26 and 7/28/26 of "Medication not available" for quetiapine fumarate 25 mg scheduled for 4 PM. - Three separate occurrences on 7/26/26, 7/27/26, and 7/28/26 of "Medication not available" for quetiapine fumarate 50 mg scheduled at 8:00 PM.		

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	8/25/26 1:30 PM - Findings of multiple medications not available or administered as prescribed were discussed with M1, who stated, "We go over pharmacy concerns in our morning meetings, and no one ever mentions this." 8/26/26 10:00 AM - Documentation was requested from E2 (DON) regarding medication discrepancies and corrective actions. No evidence was provided verbally or in writing at the time of survey exit. 8/26/26 3:15 PM - Regarding the multiple medication omissions, E3 (RDRC) stated, "We are switching pharmacies." 3. Review of R6's clinical record revealed: 7/21/25 - R6 was admitted to the facility with diagnoses including Alzheimer's disease. 2/21/26 - An order was entered for Memantine HCL 10 mg tablet (medication used to treat moderate to severe dementia) to be administered daily. 8/24/26 - Review of R6's July 2026 MAR (medication administration record) revealed that Memantine 10 mg was not administered on 7/29, 7/30, and 7/31. Review of R6's August 2026 MAR revealed that the medication was not administered for 21 days from 8/1 to 8/24. Each missed medication was documented as "medication not available." 8/25/26 11:45 AM - During an interview, E13 (RA/MA) stated, "I asked [E6, CN/LPN] about the missing medication yesterday		

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	and today. I think there is an issue with the pharmacy." 8/25/26 3:30 PM – During an interview, M1 (M) confirmed that R6 was not administered the medication from 8/1/26 to 8/24/26. M1 also stated that [pharmacy] was contacted to reorder the medication. R6 was not administered Memantine HCl 10 mg as ordered for 28 consecutive days. 8/25/26 3:45 PM – During an interview, E6 stated, "I called the pharmacy about [R6]'s medication. I was told her insurance would not cover the medication until September 1st." The Surveyor asked E6 if the HSD or provider was notified. E6 stated, "I work the 11-7 [11:00 PM to 7:00 AM] shift. I told the oncoming nurse to tell [E2, HSD]. I don't know if the provider knows [R6] has not been getting the medication." 8/26/26 12:00 PM – During an interview, E2 stated, "I tried to order [R6]'s medication myself. There is an issue with this pharmacy. I contacted the provider and the medication has been discontinued as of yesterday [8/25/26]." 8/26/26 12:15 PM – Findings were confirmed with E1 and E2. 4. Review of R7's clinical record revealed: 5/28/25 – R7 was admitted to the facility with diagnoses including, but not limited to, dementia, heart failure, and anemia related to chronic kidney disease. R7's clinical record documented a SLUMS score of 0, indicating severe cognitive impairment and required assistance from staff for all activities		

Provider's Signature [Signature]

Title Executive Director

Date 9/18/26



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	of daily living, including medication administration. 3/26/26 – R7's physician's orders included, "Aranesp injection solution [to treat low hemoglobin] prefilled syringe 60 mcg/0.3ml, Instill 0.3ml subcutaneously every other week as needed, hold for hemoglobin greater than 10." 4/1/26 - R7's lab record documented a hemoglobin level of 8.4 (low). 4/11/26 – R7's clinical record lacked evidence of documentation that the Aranesp was administered. 4/14/26 – R7's lab record documented a hemoglobin level of 8.9 (low). 4/17/26 – R7's clinical record documented that he received the Aranesp injection. 4/21/26 – R7's lab record documented a hemoglobin level of 8.8 (low). 4/23/26 – R7's clinical record lacked evidence of documentation that the Aranesp was administered. 6/2/26 - R7's lab record documented a hemoglobin level of 8.8 (low). 6/4/26 - R7's clinical record lacked evidence of documentation that the Aranesp was administered. 6/10/26 - R7's lab record documented a hemoglobin level of 9.5 (low). 6/18/26 - R7's clinical record lacked evidence of documentation that the Aranesp was administered.		

Provider's Signature

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Date

9/19/26



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	6/19/26 - R7's lab record documented a he- moglobin level of 9.7 (low). 6/24/26 - R7's lab record documented a he- moglobin level of 8.7(low). 7/22/26 - R7's lab record documented a he- moglobin level of 7.4 (low). 8/12/26 - R7's lab record documented a he- moglobin level of 8.1 (low). 8/13/26 - R7's clinical record lacked evi- dence of documentation that the Aranesp was administered and evidence that the physician was informed of the missed med- ication. 8/20/26 - R7's lab record documented a he- moglobin level of 9.5 (low). R7 did not re- ceive the Aranesp despite the missed dose on 8/13/26 and the new lab result. 8/26/26 10:00 AM – During an interview, E2 HSD (Health Services Director) stated, "We were aware of the missed medication on 4/11/26 and the nurse was written up." The facility failed to administer R7's Aranesp for five out of 10 opportunities. 8/26/26 11:30 AM – Findings were re- viewed and confirmed with E2 HSD. 5. Review of R14's clinical record revealed: 7/22/19 – R14 was admitted to the facility with diagnoses including but not limited to dementia and anxiety. R14's SLUMS assess- ment documented severe cognitive impair- ment and a total dependence on staff for all activities of daily living, including medica- tion administration. The medication care		

Provider's Signature [Signature] Title Executive Director Date 9/18/26



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	plan documented, "Resident to take medications correctly, timely, and per physician's orders, staff to assist with resident's medication administration needs routinely and as needed." 9/2/24 – R14's medication record included, "Aspercreme Lidocaine 4 % cream [pain medication], apply a small amount topically two times a day for pain." 11/25/25 – R14's medication record included, "Acetaminophen 325mg, take 3 tablets by mouth three times a day for pain, melatonin 3mg, take one tablet by mouth at bedtime for sleep, senna 8.6mg, take 2 tablets daily for constipation, cal-gest (calcium tablets) take 200/500mg tablet daily for the stomach." 6/1/26 to 6/23/26 – R14's clinical record lacked evidence that the senna 8.6 mg, two tablets, were administered on 6/1, 6/14, 6/16, 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, and 6/26, for a total of 10 out of 30 opportunities. R14's clinical record also lacked evidence that the provider was informed that the medication was not administered. 6/6/26 to 6/28/26 – R14's clinical record lacked evidence that the Aspercreme was administered on 6/6 (PM), 6/12 (PM), 6/13 (AM and PM), 6/20 (AM and PM), 6/24 (AM), 6/27 (AM and PM) and 6/28 (PM) for a total of 14 out of 60 opportunities. R14's clinical record also lacked evidence that the physician was notified that the medication was not administered. 8/1/26 to 8/25/26 - R14's clinical record lacked evidence that the acetaminophen		

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	325mg (three tablets) were administered on 8/1 at 1:00 PM, 8/5 at 8:00 AM, 8/6 at 8:00 AM and 1:00 PM, 8/24 at 8:00 AM and 1:00 PM and 8/25 at 8:00 PM and 1:00 PM for a total of 9 out of 75 opportunities. R14's clinical record also lacked evidence that the physician was informed that the medication was not administered. 8/25/26 10:00 AM During an interview, the Surveyor asked E4, Medication Assistant (MA), about the process when medications are not available. E4 stated, "We tell the nurse or the Health Services Director." 8/25/26 11:00 – During an interview, E2 (DCS) stated, "We are working on a system to ensure that the medications are available." 8/26/26 3:20 PM – Findings were reviewed with E1 (ED), E2 (HSD) and E3 (RDRC) during the Exit Conference.		

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Executive Director

Date

9/10/26

