DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Foulk Living LLC, Nursing Home

DATE SURVEY COMPLETED: March 21, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from March 17, 2025, through March 21, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day was forty-two (42). The survey sample was twenty-one (21) residents.		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567 - L survey completed March 21, 2025: F697 and F880.	Corrective Action: The facility acknowledges that there was past non-compliance related to mandatory pre-employment drug screening requirements, specifically the failure to include marijuana/cannabis in the screening panel for employees E6 and E7. This was identified during the survey completed on March 21, 2025. The facility recognizes this as a past deficiency and has taken immediate steps to prevent recurrence. As this was a past issue, the facility is unable to retroactively test all previously hired employees; however, measures have been implemented to ensure full compliance going forward. Identification of Other Residents: While no residents were directly harmed, all residents had the potential to be affected due to the facility's failure to follow state-mandated hiring protocols. The facility has reviewed its hiring practices and implemented controls to ensure all future hires meet state and federal compliance requirements, including those outlined in 42 CFR Part 483, Subpart B and Title 16, §1191.	

Provider's Signature _____ Title Executive Director Date 4/11/25

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Title 16 Health and Safety Subchapter IX. Criminal Background Checks; Drug Testing - PPECC §1191. Mandatory drug screening.	**(a)An employer may not employ any 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 screening 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) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations. (e) 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. This requirement was not met as evidenced by: Based on interview and record review it was determined that for two (E6 and E7) out of two (2) employees reviewed the facility failed to complete required pre-employment drug screening. Findings include: 3/21/25 12:20 PM - A desk review of the facility's employee drug test results submitted by E1 (ED), revealed two (E6 and E7) employees out of two (2) reviewed did not have marijuana/cannabis included in their	System Changes: To address the root cause of this issue and ensure compliance moving forward: • The facility's Human Resources department has updated the pre-employment screening policy to require documentation of a complete drug panel that includes marijuana/cannabis and all other required substances. • A compliance checklist is now in place and must be completed and signed off by the HR Director prior to any new hire start date. • All HR personnel and hiring managers have been re-educated on Delaware's Title 16 drug screening requirements. Success Evaluation: The Human Resources Director will be responsible to ensure compliance. Going forward, audits of all new hire files will be conducted: • Weekly for 3 consecutive audit cycles to confirm that each new hire has a completed and compliant pre-employment drug screen, including marijuana/cannabis. • Once 100% compliance is achieved for 3 weeks, audits will shift to bi-weekly for 3 additional cycles. • Thereafter, monthly audits will be conducted for 3 months to ensure sustained compliance. • All audit findings will be reviewed in Quality Assurance and Per-	

Provider's Signature Leslie Johnson Title Executive Director Date 4/11/25

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	pre-employment drug screen testing regimen: 11/4/24 - E7 (Director of Plant Operations) was hired and there was no evidence of a marijuana drug test. 3/3/25 - E8 (CNA) was hired and there was no evidence of a marijuana drug test. 3/21/25 10:00 AM – Findings were discussed and confirmed by E9 (Corporate Nurse). 3/21/25 1:15 PM - Findings were reviewed during the exit.	formance Improvement (QAPI) meetings, and any non-compliance will be addressed immediately.	

Provider's Signature Leslie Shaw Title Executive Director Date 4/14/25

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	085060	A. BUILDING _____ B. WING _____	C 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOULK LIVING	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from date March 17, 2025 through March21, 2025. The facility census was forty-two (42) on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unnanounced Annual and Complaint survey was conducted at this facility from March 17, 2025 through March 21, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day was forty-two (42). The survey sample was twenty-one (21) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; EMR - Electronic Medical Record; ICP - Infection Control Preventionist; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Arthritis - the swelling and tenderness of one or more joints; MDS - Minimum Data Set - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; PPE - personal protective equipment - Specialized clothing and equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses; Pressure ulcer - open wound that occurs from extended pressure to an area on the skin; PRN - as needed; Sacral wound - wound on the tail bone.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R2) out of one resident reviewed for pain management the facility failed to timely and adequately assess the resident's report of pain and failed to offer a non-pharmalogical intervention when the resident reported pain. Findings include: The facility policy related to Pain Management undated, indicated "Pain management is a multidisciplinary care process that includes the	F 697	Corrective Action: Corrective actions have been ensured by the Director of Nursing. All licensed personnel have been educated and trained to assess pain characteristics, including severity, location, duration, and quality of pain. Staff have also been educated to offer appropriate non-pharmacological interventions when needed. All registered personnel have received additional training on the need to	4/30/25

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F 697	Continued From page 2 following: Assessing the potential for pain; Identifying the characteristics of pain; Addressing the underlying causes of pain; Identifying and using specific strategies for different levels and sources of pain. Assess pain using a consistent approach and a standardized pain assesment instrument appropriate to the residents cognitive level. Non-pharmalogical interventions may be appropriate alone or in conjunction with medications." Review of R2's clinical record revealed: 1/29/25 - R2 was admitted to the facility with multiple diagnoses including a pressure ulcer to the sacrum and arthritis. 1/29/25 - A physicians order was written for R2 to be offered non-pharmalogical pain management interventions such as heat, ice, massage, music repositioning, aromatherapy and guided imagery. 1/29/25 - A physician's order was written for R2 to receive Tylenol as needed for mild pain of 1-3. 1/29/25 - A physician's order was written for R2 to receive Morphine as needed every six hours for severe pain; attempt non-pharmalogical interventions first. 2/3/25 - A physician's order was written for R2 to receive oxycodone one time a day for pain. 2/4/25 - An admission MDS assessment documented that R2 experienced severe constant pain. 2/7/25 - A care plan related to increased risks for alteration in comfort related to chronic back pain,	F 697	immediately address and follow up on any resident complaints of pain. Identification of Other Residents: All residents have the potential to be affected by the alleged deficient practice. A comprehensive audit of resident records over the past 30 days was conducted to identify any instances where pain complaints may not have been appropriately assessed or followed up. Any identified concerns have been immediately addressed to ensure resident comfort and safety. System Changes: The root cause of this concern was identified as inconsistent assessment and follow-up of resident-reported pain, and lack of consistent documentation and use of non-pharmacological interventions. All licensed staff have received re-education on proper pain assessment procedures, documentation of pain characteristics, and the implementation of non-pharmacological pain management strategies. Success Evaluation: The Director of Nursing/Designee will conduct 100% audit of resident pain assessments and follow-up documentation has been completed for the past 30 days to ensure compliance. Audits will continue to monitor that pain is assessed thoroughly, documented accurately, and addressed promptly with both pharmacological and non-pharmacological interventions as appropriate. Audits will be completed weekly until 100% compliance is achieved for 3	

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F 697	Continued From page 3 anal spasms, and sacral wound was created for R2. Interventions related to the care plan included, monitor/record pain characteristics: quality (e.g. sharp, burning); severity (1 to 10 scale); anatomical location; onset; duration (e.g., continuous, intermittent); aggravating factors; relieving factors. Notify the physician if the interventions are unsuccessful or if the current complaint is a significant change from residents past experience of pain. Provide me my pain medication as ordered, document and evaluate the effectiveness of my pain medication. Coordinate with my MD, PA or NP to manage pain medication for optimum pain control. Monitor/document my side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphagia; nausea; vomiting; dizziness and falls. Report occurrences to the physician. My physician shall be notified promptly for re-evaluation of my pain regimen if it has been determined that my analgesic is ineffective or pain rating has increased or stayed the same. Referral to the Pharmacist for review and options will be done as needed. Non-pharmacological interventions shall be attempted that work for me to decrease my pain. This would include, but not be limited to, snack, repositioning, resting in bed, increased socialization and participation in activities as a therapeutic use of distraction. 3/6/25 - A physician's order was written for R2 to receive morphine for sacral [wound] pain prior to the dressing change. 3/17/25 10:59 AM - During an interview, R2 reported that at times "the pain gets really bad with my wound an 8 or 9 at times... 3 - 4 is tolerable but they don't always get it [pain	F 697	consecutive evaluations, then every other week until 100% compliance is achieved for 3 additional consecutive evaluations, and then monthly. The goal for all audits will be 100% compliance. Audit results will be reviewed by the Quality Assurance Performance Improvement (QAPI) Team to ensure sustained compliance and address any ongoing concerns.	

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F 697	Continued From page 4 medications] as fast as I want." 3/17/25 11:20 AM - During a dressing change observation, R2 stated to E4 (LPN), "My neck hurts. Can I have some Bengay or something?" E4 responded, "If you get more pain meds now it will put you to sleep." R2 then replied, "Well, no, I don't want that." E4 then stated to the surveyor "[R2] had Morphine twenty minutes ago, so I can't give her anything." E4 did not assess the characteristics of R2's report of neck pain and did not offer R2 any non-pharmalogical interventions for the report of neck pain. E4 immediately confirmed the finding. 3/20/25 11:45 AM - R2's MAR documented the resident was given an as needed dose of morphine for pain of 8/10. 3/20/25 11:55 AM - R2 walked to nurses' station and stated to E5 (LPN) and E3 (RN/UM), "Can you give me something for pain? It hurts very bad." E5 stated, "I will check" and R2 immediately returned to her room. E5 remained at the nurses' station then administered medications to other residents and lastly reported back to R2 at 12:44 PM. 3/20/25 12:44 PM - E5 (LPN) entered R2's room and asked R2, "Are you feeling better?" R2 continued to report pain and reported a new complaint of constipation. E5 (LPN) asked, "What is the level now? An hour ago you said 8?" R2 stated, "It's not gotten better." E5 then checked R2's medical record and reported the resident had a bowel movement the prior day. E5 suggested repositioning on the opposite side and a liquid laxative. R2 declined the liquid laxative. E5 then stated she would call R2's provider.	F 697		

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F 697	Continued From page 5 3/20/25 1:05 PM - During an interview, E5 (LPN) confirmed the delay and lack of identification of pain characteristics in the assessment of pain from when R2 reported pain at 11:55 AM to E5's response and assessment of R2's pain at 12:44 PM almost an hour later. E5 stated, "I knew she had just gotten Morphine and I was concerned about the time for closeness of the medications, but I will call the provider to see if the easing the constipation will help with the pain." 3/21/25 9:06 AM - During an interview, E3 (RN/UM) confirmed that staff is expected to assess pain severity and other characteristics when a resident complains of pain. 3/21/25 1:15 PM - Findings were reviewed during the exit conference with E2(DON).	F 697		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		4/30/25

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F 880	Continued From page 6 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 7 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R2) out of one resident reviewed for pressure ulcers, the facility failed to adhere to infection control practices to reduce risk of infection when performing dressing changes. Findings include: The CDC recommendations for handwashing indicated to"Wash hands before and after treating a wound...for at least 20 seconds" https://www.cdc.gov/clean-hands/about/. The facility infection control policy related to enhanced barrier precautions last reviewed on December 2024 indicated, "Enhanced barrier precautions (EBP) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug resistant organisms (MDRO) during high contact resident care activities... Examples of high contact resident care activities requiring the use of gown and gloves for EBP's include wound care (any skin opening requiring a dressing)." The facility policy on wound care undated, indicated, "Preparation: Assemble the equipment and supplies needed. Equipment and Supplies: PPE. Steps in the Procedure: Place all items to	F 880	Corrective Action: Corrective actions have been ensured by the Director of Nursing. All licensed personnel have been trained and re-educated on infection control practices to reduce the risk of infection during dressing changes. This includes proper hand hygiene—washing hands with soap and water for at least 20 seconds before and after wound care—and adherence to enhanced barrier precautions to reduce the risk of transmission of multidrug-resistant organisms (MDROs) during high-contact resident care activities. Identification of Other Residents: All residents receiving wound care have the potential to be affected by the deficient practice. A facility-wide audit of dressing change documentation and infection control compliance over the past 30 days was conducted to identify any instances of non-compliance. Any deviations from protocol were immediately corrected, and residents were monitored for signs of infection. System Changes: The root cause of the concern was	

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F 880	Continued From page 8 be used during the procedure. Arrange supplies so they can easily be reached. Wash your hands thoroughly. Position Resident. Place disposable cloth next to the resident under the wound. Put on exam gloves, remove the dressing. Pull glove over the dressing and discard. Wash and dry your hands thoroughly. Put on exam gloves...." Review of R2's clinical record revealed; 1/29/25 - R2 was admitted to the facility with a pressure ulcer that required wound care and dressing changes. 1/29/25 - A physician's order was written for R2 to receive daily dressing changes and to be placed on enhanced barrier precautions related to the sacral wound. 1/29/25 - A care plan was written for R2's potential to spread multi-drug resistant organisms to others related to a pressure ulcer wound. Interventions related to the care plan included enhanced barrier precautions, apply gloves and gowns before performing the high contact resident care. 3/17/25 11:18 AM - During a dressing change observation, E4 (LPN) entered R2's room, performed hand hygiene using hand sanitizer and donned a pair of gloves. E4 did not don any other personal protective equipment. E4 then positioned R2 for removal of clothing to access R2's wound on top of R2's personal comforter. E4 walked into R2's bathroom grabbed the trash-can with four fingers inside the trash-can and thumb outer side of trash-can and placed it at R2's bedside then removed R2's soiled dressing. Next, E4 cleaned R2's wound and replaced a new	F 880	determined to be inconsistent adherence to established infection control protocols during dressing changes. In response, the facility has reinforced training on infection prevention, including mandatory hand hygiene procedures and the use of enhanced barrier precautions during high-contact care tasks. Updated wound care procedures have been implemented, including clear guidance on personal protective equipment (PPE) use. Success Evaluation: The Director of Nursing/Designee will conduct 100% audit of wound care documentation and hand hygiene compliance has been completed for the past 30 days to ensure adherence to proper infection control procedures. Ongoing audits will be conducted weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week for 3 additional evaluations with 100% compliance, and finally monthly for 3 consecutive evaluations. The goal of each audit cycle is 100% compliance with infection control protocols during dressing changes. Results of all audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Team, and immediate corrective action will be taken as needed to ensure continued compliance and resident safety.	

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FOULK LIVING	1212 FOULK ROAD WILMINGTON, DE 19803

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F 880	Continued From page 9 dressing, E4 continued wearing the same gloves that were donned we entering R2's room. At the conclusion of the dressing change. E4 removed the gloves and performed four seconds of hand washing. 3/17/25 11:28 AM - E4 (LPN) confirmed the findings. 3/21/25 9:25 AM - During an interview, E2 (DON/ICP) stated "We did a lot of education with that [EBP]. Dressing changes, high contact activities, residents with catheters and peg tubes." E2 then confirmed that staff was expected to adhere to EBP and wear a gown during dressing changes. 3/21/25 1:15 PM - Findings were reviewed during the exit conference with E2(DON).	F 880		