DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: AL- Paramount Senior Living at Newark **DATE SURVEY COMPLETED:** May 7, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint Visit was conducted at this facility from May 2, 2025, through May 7, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documents, as indicated. The facility census on the day of the survey was eighty-one (81). The survey sample totaled eight (8) residents.	**3225.13.1** A. R2 and R8's service agreements were reviewed, signed and a copy given to R2 and R 8's responsible party on 5/30/25. **Responsible: Administrator/designee**	Date given
3225.0	**Regulations for Assisted Living Facilities**		5/30/25
3225.13.0	**Service Agreements**		
3225.13.1 **S/S – D**	**A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement, and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.** This requirement was not met as evidenced by: Based on record review and interview it was determined that for one (R2 and R8) out of eight residents reviewed the facility failed to ensure that the service agreement was signed by a person able to comprehend the agreement. Findings include: 1.Review of R8's clinical record revealed: 2/20/25 – An annual UAI assessment documented R8 had memory problems and dementia.	B. **To ensure the deficient practice does not reoccur, the administrator/designee will conduct a 100% audit of service agreements for all residents in the facility. Corrective action will be taken to ensure compliance with 3225.13.1 for all residents in the facility** C. An in-service education will be conducted by the Corporate RN, on regulation 3225.13.1 with the Administrator, Resident Care Manager, Assistant Resident Care Manager and Admissions Manager to ensure compliance with 3225.13.1 **Root Cause:** Policy did not state "All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement". Policy 73.0 was revised to ensure compliance with regulation 3225.13.1. **Policy attached** D. To ensure ongoing compliance with 3225.13.1 all new admission, annual and significant change service agreements. Will beaded to the QAPI program and monitored by the administrator. **The administrator/designee will conduct random audits of 10% of the service agreements 3x a week until we**	**6/6/25** 6/2/25 **8/18/25**

Provider's Signature _____ Title Executive Director Date 6/4/25

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	2/20/25 – An annual service agreement was completed for R8 then signed by the resident. 2. Review of R2's clinical record revealed; 4/10/25 – An admission UAI assessment documented that R2 had memory problems and dementia. 4/13/25 – R2 was admitted to the facility with multiple diagnoses including mild cognitive impairment. 4/13/25 – An admission service agreement for was completed for R2 and signed by the resident. 5/7/25 11:31 AM – During an interview E2 (RCM) confirmed the findings. 5/7/25 11:45 AM – Findings were reviewed during the exit conference with E1 (ED) and E2 (RCM).	**consistently reach 100% success at 3 consecutive evaluations, the once a week over 3 consecutive successes, then once a month and if we remain successful, we can conclude we have successfully addressed the problem.** **Responsible person: Administrator/designee** **3225.13.5** A. The Resident Care Manager updated R8's service agreement to include the diagnosis and interventions for herpes viral infection The Resident Care Manager added the herpes Viral Infection to the Infectious Disease Disorder section of the UAI for R8	5/7/25
3225.13.5 **S/S - D**	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** This requirement was not met as evidenced by: Based on record review and interview it was determined that for one (R8) out of eight residents reviewed the facility failed to ensure that the service agreement was developed consistent with the residents' unique physical needs. Findings include: 1.Review of R8's clinical record revealed:	B. All residents have the potential to be affected by the deficient practice. **The Resident Care Manager/designee will conduct a 100% audit of Service agreements and UAI of all residents in the facility to ensure all current diagnosis are listed and, interventions address the resident's unique physical and psychosocial needs in relation to their diagnosis.** **Root Cause:** **An error of omission by the Resident Care Manager** C. The Resident Care Manager will be inserviced by the corporate RN on regulation 3225.13.5 to ensure the deficient practice does not reoccur. D. To ensure compliance with regulation 3225.13.5, The Resident Care Manager will add Service agreement and UAI's, to the QAPI program. Service agreements	**6/9/25** 6/4/25

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	3/30/2011 – R8 was admitted to the facility with multiple diagnoses including herpes viral infection. 2/20/25 – A physician plan of care form with attached diagnoses and medication orders documented that R8 had herpes viral infection. 2/20/25 – An annual UAI assessment completed for R8 lacked evidence that R8's herpes infection was documented in the Infectious disease disorders section. The area was left blank. 2/20/25 – An annual service agreement was completed for R8. The medical diagnosis section lacked evidence of documentation of the herpes diagnosis as well as any plans for services related to potential needs during an outbreak. 5/7/25 11:31 AM – During an interview E2 (RCM) confirmed the finding. 5/7/25 11:45 AM – Findings were reviewed during the exit conference with E1 (ED) and E2 (RCM).	and UAI will be monitored for completion of all diagnosis and interventions. **The RCM will monitor 10% of all service agreements and UAI's 3x a week until we consistently reach 100% success at 3 consecutive evaluations, then once a week over 3 consecutive evaluations, and then once a month and if we reach 100%, we can conclude that we have successfully addressed the problem** **Responsible person: Resident Care Manager** **3225.19.1** The clinical records for R2 cannot be corrected for 4/15 and 4/30 (omission of documentation) **Root Cause: Error of omission by Nursing Assistant**	6/13/25
3225.19.0 **3225.19.1** **S/S -D**	**Records and Reports** **The assisted living facility shall be responsible for maintaining appropriate records for each resident.** This requirement was not met as evidenced by: Based on record review and interview it was determined that for two (R2 and R8) out of seven residents reviewed the facility failed to	A. The Resident Care Manager audited R2's ADL sheets from May 1-28 to ensure compliance with documentation of overnight wellness checks for R2. See attached **B.** All residents have the potential to be affected by the deficient practice. The **Resident Care Manager/designee will conduct a 100% audit the ADL sheets for all residents who required extensive supervision and corrective action will be taken to ensure compliance with 3225.19.1** C. All Nursing Assistants will be in-service by the RCM on Regulation 3225.19.1 to ensure the deficient practice does not reoccur	5/28/25 **6/6/25** 6/4/25

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	ensure that records were complete and accurate. Findings include: 1. Review of R2's clinical records revealed: 4/10/25 – An admission UAI assessment documented that R2 had memory problems and dementia. 4/13/25 – An admission service agreement was completed for R2. The agreement documented that R2 required extensive supervision. April 2025 – Review of R2's ADL completion sheet lacked documentation of overnight wellness checks. Entries for 4/15/25 - 4/30/25 were blank. 5/2/25 1:20 PM – During an interview E3 (ARCM) confirmed the findings. 2. Review of R8's clinical records revealed: 2/20/25 – A physician plan of care form with attached diagnoses and medication orders documented that R8 had herpes viral infection. 2/20/25 – An annual UAI assessment completed for R8 lacked evidence that R8's herpes infection was documented in the Infectious disease disorders section. The area was left blank. 5/7/25 11:29 AM – During an interview E2 (RCM) confirmed that documentation regarding R8's herpes diagnosis was omitted from the UAI in error.	**D.** To ensure compliance with regulation 3225.19.1. The Resident Care Manager will add ADL sheets to the QAPI program. **The RCM/designee will conduct random audits of 10% of ADL sheets for documentation of wellness checks for all residents requiring extensive supervision 3 x a week until we consistently reach 100% success at 3 consecutive evaluations, then once a week over 3 consecutive successes, then once a month and if 100% has been reached we can conclude we have successfully addressed the problem** **Responsible party: Resident Care Manager** A. The Resident Care Manager added the diagnosis of Herpes Viral Infection to the Infectious Disease Disorder section of the UAI for R8 B. All residents have the potential to be affected by the deficient practice. **The Resident Care Manager/designee will conduct a 100% audit of the UAI for all residents to ensure completion of all diagnosis and compliance with regulation 3225.19.1 6/14/25** C. The Resident Care Manager will be in-service by the corporate RN, on regulation 3225.19.1 so the deficient practice does not reoccur. D The Resident Care Manager will add UAI completion to the QAPI program. **The RCM/designee will conduct random audits of 10% of UAI 3x a week until we consistently reach 100% success at 3 consecutive evaluations, then once a week for 3 consecutive successes, then once a month, if 100% has been**	**8/18/25** 5/7/25 **6/6/25** 6/2/25 **8/18/25**

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	5/7/25 11:45 AM – Findings were reviewed during the exit conference with E1 (ED) and E2 (RCM).	**reached, we can conclude we have successfully addressed the problem** **Responsible Party: Resident Care Manager**	
3225.19.6	**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.** This requirement was not met as evidenced by: Based on record review and interview it was determined that for two (R1 and R2) out of seven residents reviewed for abuse the facility failed to immediately report an allegation of abuse to the State agency. Findings include: The facility policy on abuse last updated 2/1/19 indicated that cases of abuse and neglect are reported to the Department of Health and Social Services. 4/26/25 8:00 PM – A progress notes in R1's clinical record documented an alleged incident of sexual abuse involving R1 and R2 and that the incident was "Immediately reported to E2 (RCM)". 4/28/25 1:24 PM – An incident report alleging abuse was reported to the State Agency. 5/7/25 10:07 AM During an interview E2 (RCM) confirmed the alleged incident of abuse was disclosed at the time of occurrence but not reported because she was not in the facility. 5/7/25 11:45 AM – Findings were reviewed during the exit conference with E1 (ED) and E2 (RCM).	**3225.19.6** **A The failure to timely report the allegation of sexual abuse involving R1 and R2 on 4/26/25 to the State Agency was unable to be corrected** **Root Cause: RCM was not aware of regulation 3225.19.6** A. The Administrator, RCM and ARCM were in-serviced by the corporate RN on regulation 3225.19.6 as well as and Paramount's Policy for Abuse and Neglect Reporting. The policy was revised to bold time frames for reporting B All resident has the potential to be affected by the deficient practice. The Administrator/designee, will audit all reportable Incident reports to ensure timely reporting occurred C All direct care employees will be in-service on regulation 3225.19.6 and Paramount's Abuse and Neglect Policy to ensure the deficient practice does not reoccur. All new employees are educated upon hire and annually on Regulation 3225.19.6 D. To ensure compliance with regulation 3225.19.1, The administrator will add Reportable Incidents to the QAPI program. **The administrator will monitor all reportable incidents of abuse for timely reporting.** **The administrator/designee will conduct a 10% audit of all reportable incident 3x a week for 3 consecutive successes, then once a**	6/2/25 6/4/25 6/4/25 **8/18/25**

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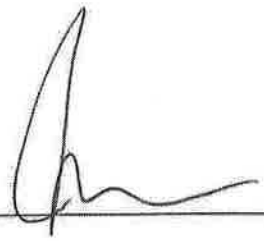
		week for 3 consecutive successes, the once a month and if 100% success is achieved, we can conclude we have successfully concluded we have successfully addressed the problem Responsible party: Administrator/designee	

Provider's Signature  Title Executive Director Date 6/4/25