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 - Serenity Gardens Assisted Living **DATE SURVEY COMPLETED: October 6, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from October 3, 2025, through October 6, 2025. The facility census on the first day of the survey was twelve (12). The survey sample size totaled four (4). The deficiencies contained in this report are based on observations, interview and review of other facility documentation as indicated. Abbreviations/definitions used in this state report are as follows: ADON – Assistant Director of Nursing; Contract - A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations; ED – Executive Director; HM – House Manager; HR – Human Resources; LLAM – Limited Lay Administration of Medications; RCA – Resident Care Assistant; RN – Registered Nurse; UAI (Uniform Assessment Instrument) - A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.		

Provider's Signature [signature] Title Executive Dir. Date 12/3/25

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3225.0 3225.10.0 3225.10.1 S/S – D	**Assisted Living Facilities** **Contracts** **The assisted living facility shall supply a written contract that is precise, easily understood and readable by a resident, and in compliance with all applicable laws.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that one (R1) out of three residents reviewed for contracts, the facility failed to provide evidence of a signed contract. 10/24/24 – R1 was admitted to the facility. The facility failed to have a contract on file in the resident's record. 10/6/25 – Per interview with E1 (ED) at approximately 9:30 AM, E1 confirmed R1's contract was unable to located. 10/6/25 – Findings were reviewed with E1, E2 (ADON), E3 (HM) and E9 (Owner) at the exit conference beginning at approximately 1:20 PM.	Regulation: The assisted living facility shall supply a written contract that is precise, easily understood and readable by a resident, and in compliance with all applicable laws. Deficiency: Facility failed to provide evidence of a signed resident contract for R1. Regular audits were not being completed to determine any Contract discrepancies. Corrective Action for R1 (the affected resident): R1 has been out of the facility since 10/3/25 and is not returning, as she is being discharged to a higher level of care. Although R1 is no longer residing in the facility, the facility attempted to locate the contractual documentation and confirmed that no signed contract is on file. No further resident impact exists, as R1 is no longer under our care. Identification of Other Residents Who Could Be Affected: A facility-wide audit of 100% of current resident records was completed on 10/6/25 to verify that all residents have signed contracts on file. Any missing or incomplete contracts identified during the audit were immediately corrected and placed in the appropriate records. Systemic Preventive Measures Put in Place A revised Resident Admission & Documentation Procedure has been implemented requiring: Verification of a signed contract prior to physical admission into the facility. Administrative verification that the contract	10/9/25

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		is scanned electronically and retained in a secured digital and hard-copy format. Required staff RN and House Manager were in-serviced on Resident Contract Documentation Requirements on 10/9/25 by Roni Davis. Monitoring to Ensure Ongoing Compliance The ED or designee will review all new admissions within 48 hours of admission to ensure contracts are signed and filed correctly. A monthly random audit of 10% of resident records will be conducted for 6 months to ensure ongoing compliance with contract documentation. Results of each audit will be reported and reviewed during Quality Assurance and Performance Improvement meetings. Any identified discrepancies will be corrected immediately and staff reeducated. Responsible Party: The Executive Director (E1) is responsible for ensuring the implementation of this Plan of Correction and maintaining compliance with resident contract documentation requirements.	
3225.16.0	**Staffing**		
3225.16.14	**Assisted living facility resident assistants shall, at a minimum:**	Under 16 Del. C. Ch. 11, all employees are entitled to resident rights and protections, including reporting mechanisms for abuse, neglect, mistreatment, and financial exploitation, as well as access to the Ombudsman Program. Additionally, employees are required to complete at least 12 hours of annual in-service training.	
3225.16.14.2	**Participate in a facility-specific orientation program that covers the following topics:**		11/15/2025
3225.16.14.2.1	**Fire and life safety, and emergency disaster plans;**		

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3225.16.14.2.2 **3225.16.14.2.3** **3225.16.14.2.4** **3225.16.14.2.5** **3225.16.14.2.6** **3225.16.14.2.7** **3225.16.14.2.8** **3225.16.14.2.9** **3225.16.14.3** **S/S – E**	**Infection control, including Standard Precautions;** **Basic food safety;** **Basic first aid and the Heimlich Maneuver;** **Job responsibilities;** **The health and psychosocial needs of the population being served;** **The resident assessment process; and** **The use of service agreements;** **16 Del.C. Ch. 11, pertaining to residents' rights; reporting of abuse, neglect, mistreatment, and financial exploitation; and the Ombudsman Program;** **Receive, at a minimum, 12 hours of regular in-service education annually which may include but not be limited to the topics listed in 16.14.2;** This requirement was not met as evidenced by: Based on record review and interviews, it was determined that three (E6, E7, E8) out of three employees reviewed for annual trainings, the facility lacked evidence that these three employees did not receive any staff trainings for the years of 2024 or 2025. 1. 11/29/23 – E6 (RCA/LLAM) was hired. These trainings were completed during E6's orientation on 11/29/23. There was no evidence that annual trainings were completed for these topics for the years of 2024 and 2025.	Identified Deficiency: The facility was found to lack evidence of the required annual training for employees E6, E7, and E8 during the years 2024 and 2025. Corrective Actions for Cited Employees: Employees E6 and E7 are no longer employed by the facility. As a result, no further action regarding their training is necessary. Employee E8 remains employed in a part-time capacity. E8 training along with E7 were located in the attic of the facility and dated 12/17/24. All necessary training modules have been assigned via the Relias training system going forward. Audit and Identification of Other Potentially Affected Employees: A comprehensive facility-wide audit of current employee training records was conducted on 10/23/25 and data entered into the Relias system. Any employee identified with incomplete or outdated training was assigned the appropriate modules and given specific completion deadlines. Following this process, it was confirmed that no other currently employed staff members remain out of compliance with training requirements. Systemic Preventive Measures: The facility now utilizes the Relias Learning Management System to reinforce compliance with training requirements. This system is responsible for:	

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	2. 5/16/23 – E7 (HR) was hired. These trainings were completed during E7's orientation on 5/16/23. There was no evidence that annual trainings were completed for these topics for the years of 2024 and 2025. 3. 9/13/20 – E8 (Laundry/RCA) was hired. E8 completed these trainings on 3/1/23 and 3/2/23. There was no evidence that E8 completed any emergency preparedness training since hire of 9/13/20. There was no evidence that annual trainings were completed for these topics for the years of 2024 and 2025. 10/6/25 - Per interview with E1 (ED) at approximately 9:30 AM, E1 stated the facility recently procured an online platform for staff education. E1 stated these topics are all covered at date of hire and orientation and will now prompt employees to complete the trainings via the online platform. 10/6/25 – Per interview with E2 (ADON) at approximately 1:10 PM, E2 stated the trainings had been provided, but E2 was unable to locate the training files for these employees at the time of the survey. 10/6/25 – Findings were reviewed with E1, E2, E3 (HM) and E9 (Owner) at the exit conference beginning at approximately 1:20 PM. **Emergency Preparedness**	Tracking all training assignments and completions, Providing automatic reminders to staff, Flagging overdue training requirements, Maintaining permanent digital training records, Additionally, a new Human Resources policy has been implemented: All orientation trainings are documented within Relias, All annual required trainings must be completed and verified within each calendar year, All training records are stored electronically and securely backed up, Supervisory staff and administrative leadership have received updated training on retrieving and validating training records in Relias Monitoring and Quality Assurance: The Executive Director (ED) or their designee will monitor compliance with training requirements in the Relias system on a monthly basis and follow up with staff who fall behind in training assignments. Training compliance reports will be reviewed quarterly during QAPI meetings. If any employee is found to be non-compliant with required training, corrective action will be taken within 48 hours. Responsible Party: The Executive Director (E1) is responsible for overseeing and ensuring ongoing compliance with training requirements and proper documentation.	

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3225.18.0 **3225.18.6.2** **S/S – F**	**Copies of the FEMA certificate of achievement which demonstrate that at least two active, full-time employees have completed FEMA training in ICS-100 and NIMS-700a in the past 24 months.** This requirement was not met as evidenced by: Based on record review and interviews, it was determined that the two employees having FEMA certification lacked having both the ICS-100 and NIMS-700a certifications. 1. 10/21/24 – E2 (ADON) was hired at the facility. E2 completed the IS-700.b on 9/24/25. There was no evidence that E2 completed the ICS-100 or the NIMS-700a certifications. 2. 7/23/25 - E3 (HM) was hired at the facility. E3 completed the ICS-100 on 9/25/25. There was no evidence that E3 completed the NIMS-700a certification. 10/6/25 – Per interview with E2 at approximately 1:00 PM, E2 confirmed she had only the one certification. 10/6/25 – Per interview with E3 at approximately 1:00 PM, E3 confirmed she had only the one certification. E3 stated she attempted to complete the NIMS-700a certification on 10/3/25 but the website was down. 10/6/25 – Findings were reviewed with E1 (ED), E2, E3 and E9 (Owner) at the exit conference beginning at approximately 1:20 PM.	The facility is required to maintain copies of FEMA certificates that demonstrate at least two active, full-time employees have completed both ICS-100 and NIMS-700a training within the past 24 months. A deficiency was identified because two required employees, E2 and E3, did not have both required FEMA certifications on file. Corrective Action for Affected Employees: Due to a federal government shutdown, the FEMA training portal became temporarily inaccessible, which prevented timely completion of certifications. To address this, E2 (ADON) completed her FEMA ICS-100 on 11/26/2025 and E3 (HM) completed her FEMA IS-700 on 11/24/25. Their FEMA certificates of achievement were printed and maintained in both their personnel files and the facility's digital archive. With these actions, the facility will fulfill the requirement of having at least two full-time employees with valid ICS-100 and NIMS-700a certifications. Identification of Other Employees Who Could Be Affected: A review of all current staff was conducted on 10/7/25. No other staff members are required to meet these certification requirements for compliance. While additional employees may be encouraged to complete FEMA training for redundancy, only two are necessary to satisfy regulatory obligations.	11/20/25

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		Systemic Changes and Preventive Measures: The facility has updated its Emergency Preparedness Policy to specify that FEMA ICS-100 and NIMS-700a training must be completed directly on the FEMA website. Certificates must be downloaded, printed, and stored in both hard-copy personnel files and the facility's digital archive. Human Resources staff and supervisors have been trained on proper documentation procedures and verification of FEMA certificate completion. Serenity will have two additional staff members complete the FEMA ICS-100 and NIMS-700a. The two additional staff members will have FEMA completed by 12/30/25. Monitoring and Quality Assurance: The Executive Director (ED) or a designated staff member will verify FEMA certification status for at least two full-time employees on a quarterly basis, by reviewing both physical and digital certificates. Any lapse or inability to access FEMA training due to federal website outages will be documented, and training will be rescheduled promptly. Compliance will be reviewed during QAPI meetings for a minimum of 12 months. Responsible Party: The Executive Director (E1) is responsible for ensuring both completion and ongoing compliance with FEMA certification requirements.	

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