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: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: October 21, 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 20, 2025, through October 21, 2025. 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 forty-three (43). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this state report are as follows: c/o – complaint of; DON – Director of Nursing; ED -Executive Director; EMR – electronic medical record; mcg – micrograms; **Title 16 Health and Safety**		
3225	**Assisted Living Facilities**		
3225.8.0	**Medication Management**	**3225.8.0 – Medication Management**	12/5/2025
3225.8.1.5.3	**Review of each resident's medication regimen with written report noting any identified irregularities or areas of concern.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for medication management, the facility failed to have a quarterly pharmacy review in September 2025. Findings include:	**#1 Corrective Action** The Facility is unable to correct the action for R1. **#2 Identification of Other Residents** All newly admitted residents have the potential to be affected by this deficient practice. **#3 System Changes** R1 was not included on the 9/22/2025	

Provider's Signature Virginia C. Gray Title Executive Director Date November 20, 2025

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	7/10/25 – R1 was admitted to the facility. 7/10/25 - R1 was started on Eliquls 5 mg (milligrams), Ergocalciferol 1.25 mg, escitalopram oxalate 10 mg, melatonin 10 mg, lorazepam 0.5 mg, midodrine 10 mg, Namenda 10mg, Synthroid 88 mcg (micrograms) and a multiple vitamin oral medications. 7/10/25 – R1 was ordered Gemtesa 75 mg oral medication. 7/11/25 – C2 (MD) ordered Centrum Silver 50+ Women, Florastor and turmeric oral supplements. 7/22/25 – C2 ordered Donepezil 5 mg at bedtime for R1. 7/24/25 – C2 ordered calcium citrate 250 mg and levothyroxine 75 mcg daily for R1. 7/29/25 - R1's Synthyroid 88 mcg was discontinued. 9/22/25 – C1 (pharmacist) completed the quarterly consultant pharmacist review of the residents in the facility. This 10-page Consultant Pharmacist Quarterly Report Listed out each resident's room number, name, age physician and number of medications along with any area of concern or irregularities. For R1, the list only contains the room number and name. The facility failed to have R1's medications regimen reviewed and documented.	Pharmacy report due to R1's admission date of 7/10/2025, which was outside of the Consultant Pharmacist's quarterly review schedule. R1's medication reconciliation was handwritten but not documented in the electronic record. The Director of Nursing/Designee is responsible for reviewing the quarterly pharmacy report. Since an RN is the only licensed professional responsible for overseeing quarterly pharmacy visits, the Director of Nursing/RN Designee, will ensure that every resident who resides in the Facility at the time of assessment will be reviewed and documented for medication reconciliation, via electronic medical record, during the time of each quarterly review. **#4 Evaluation of Success** The Director of Nursing/Designee will audit records of all new admissions, to verify every resident has been scheduled for each upcoming quarterly medication review. The Director of Nursing/RN Designee, will ensure residents' medication has been reviewed and documented. Audits will be conducted weekly, for four (4) weeks until 100% compliance has been achieved, then monthly for three (3) months or until 100% compliance is achieved. The results of these audits will be reviewed by the Director of Nursing/Designee, during the community's Quarterly Quality Assurance Meetings.	

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	10/21/25 3:00 PM – The findings were reported to the E1 (ED) and E2 (DON) during the exit conference.		
3225.19.0	**Records and Reports**		
3225.19.7	**Reportable Incidents include:**		
3225.19.7.7	**Significant injuries**		
	Based on record review and interview, it was determined that for one R5 out of one resident reviewed for falls, the facility failed to report R5's fall with significant injury. Findings include:		
	9/15/24 – R5 was admitted to the facility.		
	8/6/25 10:39 AM – E2 (DON) documented in R5's EMR (electronic medical record), "Resident assessed status post fall last evening. Resident while in bathroom lost balance and fell. Resident sustained an apparent soft tissue injury to left elbow, area swollen. Resident seen by hospice RN last evening with no new orders. Hospice RN today visited and ordered warm compresses to left elbow and a prophylactic antibiotic ordered for 7 days. Resident medicated with Tylenol for c/o (complaint of) discomfort with relief."		
	8/15/25 1:58 PM – E2 (DON) documented in R5's EMR, "Received x-ray report from [radiology company], x-ray ordered by hospice for left elbow swelling. Results – avulsion fracture from the olecranon process of the ulna dorsally and soft tissue swelling in the region of the olecranon bursa. To follow up with orthopedics- family aware."	**3225.19.7.7 Significant Injuries** **#1 Corrective Action** The Facility is unable to correct the lack of timely reporting of R5's injury. **#2 Identification of Other Residents** All residents have the potential to be affected by this deficient practice.	

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	The facility failed to report a significant injury which was the result of R5's 8/5/25 fall. 10/21/25 2:15 PM – During an interview, E2 stated that she did not report the fall with resultant left elbow fracture because it did not meet the criteria of the regulations for being reportable. E2 stated that initially the elbow injury was thought to be a soft tissue injury and when the swelling and pain persisted, an x-ray revealed a fracture. 10/21/25 3:00 PM – The findings were reported to the E (ED) and E2 (DON) during the exit conference.	**#3 System Changes** The root cause of this deficient practice is that the Facility determined the injury was not reported to the Division because under 19.7.7 Delaware Code for "Significant Injuries", this incident did not meet the requirement for state reporting. The Director of Nursing/Designee will report all resident falls with injuries which require periodic reassessment of the resident's clinical status by facility professional staff for up to 48-hours or upon knowledge that the injury resulted in a fracture. The Director of Nursing/Designee will re-educate nursing staff on all reportable incidents outlined in Delaware Code 19.7.7-19.7.13.2 of the Assisted Living Facility Regulations. **#4 Evaluation of Success** The Director of Nursing/Designee will audit all residents with falls, resulting in injuries and ensure that such findings requiring a re-assessment have been reported to the State upon knowledge of the 48-hour assessment. Audits will be conducted weekly, for four (4) weeks, until 100% compliance is achieved, then monthly for three (3) months or until 100% compliance is achieved. The results of these audits will be reviewed by the Director of Nursing/Designee, during the community's Quarterly Quality Assurance Meetings.	

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