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: The Vero at Newark **DATE SURVEY COMPLETED: October 28, 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, Complaint and Emergency Preparedness Survey was conducted at this facility from October 21, 2025, through October 28, 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 one hundred eighteen (118). The survey sample totaled fourteen (14) residents. Abbreviations/definitions used in this State Report are as follows: ADOW – Assistant Director of Wellness; AED – Associate Executive Director; Alzheimer's disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Anxiety - general term for several disorders that cause nervousness, fear, apprehension and worrying; Atherosclerosis – hardening and narrowing of arteries due to the buildup of fat, cholesterol, and other substances; BOM/HR – Business Office Manager/Human Resources; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation; Depression - mental disorder with feelings of sadness or a mood disorder that causes a		

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	persistent feeling of sadness and loss of interest; Diabetes Mellitus - a chronic disease associated with abnormally high levels of the sugar glucose in the blood; DOW – Director of Wellness; Dysphagia - a disorder in swallowing; ED – Executive Director; FGM – Former General Manager; FM – Family member; Gait - posture when walking; Hospice- service that provides care to residents that are terminally ill; Hypertension - high blood pressure; Hyperlipidemia- high cholesterol and/or triglycerides (fat proteins) associated with increased risk for heart disease and stroke; Hypokalemia - low potassium level; Immunodeficiency – condition where the immune system is unable to function properly; Interim DC – Intermittent Dietary Chef; LPN – Licensed Practical Nurse; Medtech – Medication Associate; Neuropathy - disease or dysfunction of one or more peripheral nerves that causes numbness or weakness or pain; POA – Power of Attorney;		

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	RA – Resident Associate; Rami – pelvic bones; 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 facility provides. These include lodging, board, housekeeping, personal care, and supervision services; 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 initial and ongoing basis.		
3225.0 **3225. 8.0** **3225.8.6**	**Assisted Living Facilities** **Medication Management** **Within 30 days after a resident's admission and concurrent with all UAI – based assessments, the assisted living facility shall arrange for an on – site review by an RN of the resident's medication regime if he or she self – administers medications. The purpose of the on – site review is to assess the resident's cognitive and physical ability to self – administer medication or the need for assistance with or staff administration of medications.**	**3225.8.6** **A.** The Director of Wellness (RN) completed R12's outstanding quarterly self-medication evaluation on 11/25/2025 (unable to complete earlier due to survey timing).The RN also completed the concurrent self-administration evaluation associated with the 10/22/25 annual UAI on 11/25/2025.Results were documented in R12's clinical record, and herself-administration plan was validated as appropriate. **B.** A facility-wide audit will be conducted on 12/12/2025 of all residents approved for self-administration of medication to ensure quarterly evaluations and concurrent reviews with each UAI were completed and documented.	Completion Date: 12/26/2025.

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3225.8.7 **S/S – D**	**The assisted living facility shall ensure that the review required by section 8.6 is documented in the resident's records, including any recommendations given by the reviewer.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined for one (R12) out of one resident sampled for self – administration of medication, the facility failed to ensure an onsite quarterly review by an RN was completed for R12, who self-administers her medication. In addition, the facility failed to ensure that the quarterly review was documented in R12's resident records. Findings include: Review of R12's clinical record revealed the following: 8/25/23 – R12's initial UAI documented that R12 was oriented to person, place and time and required assistance with medication management. 9/22/23 – R12 was admitted to the facility. 10/23/23 – R12's 30-day UAI indicated that R12 was able to self-administer medications. 5/31/24 – R12 was care planned to self-administer medication and interventions included, but were not limited to, assess R12's ability to self-administer medications upon move in and with each assessment… self-	Any missing evaluations identified through this audit will be completed no later than 12/26/2025. **C.** The root cause was a breakdown in the tracking process for quarterly evaluations and lack of an automated prompt aligned with UAI due dates. To ensure ongoing compliance: a. The Director of Wellness or Assistant Director of Wellness will maintain a list of all residents approved for self-administration of medications. b. This list will include the date of the last assessment and the due date for the next required assessment. **D.** A revised tracking grid was implemented on 11/25/2025 to align quarterly self-medication evaluations with UAI schedules and ensure concurrent completion. Weekly audits of all self-administration evaluation due dates will be completed by the RN or designee for 4 weeks starting 12/12/2025. If discrepancies are identified, weekly audits will continue until four consecutive weeks show 100% compliance; once achieved, monitoring will shift to monthly audits for three months. All findings will be reviewed during monthly QAPI meetings.	

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	medication will be done quarterly and as needed (revised 3/29/25) 10/22/24 – R12's annual UAI documented that R12 was independent with medication management. 12/5/24 – A Self Medication Evaluation revealed that R12 was approved for self-medication. 3/5/25 – A Self Medication Evaluation revealed that R12 was approved for self-medication. 5/5/25 - Self Medication Evaluation revealed that R15 was approved for self-medication. There was a lack of evidence that R12's August 2025 quarterly self-medication evaluation was completed. 10/22/25 – R12's annual UAI documented that R12 was independent with medication management. There was a lack of evidence that R12's self-medication evaluation was completed concurrently with her 10/22/25 annual UAI. 10/22/25 11:58 AM – During an interview, R12 stated that she can take her own oral medications. The physician administers any injections. R12 further stated that she takes supplements, and she keeps her medications in a locked cabinet. R12 confirmed that she used to see the nurse earlier this year		

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	for self – medication evaluation, but not recently. 10/21/25 2:53 PM – In an interview, E7 (Medtech) stated that R12 was independent and was able to administer her own medications. 10/22/25 3:30 PM – In an interview, E3 (DOW) confirmed that she was behind in completing R12's latest self-administration evaluation. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 during the exit conference.	**3225.11.0 & 3225.11.2** **A.** R1, the RN reviewed the 1/9/25 annual UAI with R1's legal representative, obtained required signatures, and refiled the corrected UAI by 12/12/2025. He is do for his annual UAI on 1/9/26. (Unable to correct the original document retroactively; signatures obtained on updated form. R3, The RN could not complete a new UAI to replace the unsigned 11/22/24 document and obtained signatures from the resident representative because resident is deceased. R4, The RN reviewed the 7/21/25 but cannot obtain signature due to resident being deceased. R15, the original RN who completed the original UAI on 4/1/25, no longer working here. New RN reviewed UAI and all signatures will be completed by 12/12/25. **B.** Effective immediately, the facility will implement the following corrective process: Admission-Day Requirement or Initial Assessment Requirement On the day of admission or during the initial assessment, the UAI will be presented to the resident or their legal representative for review and signature. - A written signature will be required. - Verbal agreements will not be accepted as valid consent for services. The Director of Wellness or Assistant Director of Wellness will be responsible for ensuring	
3225.11.0 **3225.11.2** **S/S – D**	**Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for four (R1, R3, R4 and R15) out of thirteen residents reviewed for		**Completion Date: 12/26/2025.**

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	resident assessment, the facility failed to obtain the resident's or resident representative's signature on the UAI assessment or failed to ensure that the UAI assessment was reviewed and completed by a Registered Nurse (RN). Findings include: 1. Review of R1's clinical record revealed: 12/8/23 – R1 was admitted to the facility with diagnoses including Alzheimer's disease, diabetes mellitus, and hypertension. 1/9/25 – An annual UAI assessment was completed for R1. Required signatures for the resident or the resident's legal representative and registered nurse were missing from the document. 2. Review of R3's clinical record revealed: 1/31/24 – R3 was admitted to the facility with diagnoses including depression, anxiety, and dementia. 11/22/24- An UAI assessment was completed for R3 due to a significant change. Required signatures for the resident or the resident's legal representative and registered nurse were missing from the document. 3. Review of R4's clinical record revealed: 6/14/24 – R4 was admitted to the facility with diagnoses including diabetes mellitus, hypertension, and hyperlipidemia. 7/21/25 – An annual UAI assessment for R4 was completed and signed by E3 (DOW). A required signature for the resident or the	the UAI is signed after completing the assessment. 30 day and annual UAIs will be reviewed and signed by the resident or their legal representative by their due date Acceptable Signers Resident Legal representative with decision-making authority (POA) No admission file will be considered complete until an up to date and signed UAI is obtained and filed. A full audit of all current resident UAI assessments will be completed by 12/12/2025 to ensure each document contains the resident/representative signature and RN signature as required. Any missing signatures identified during this audit were obtained and corrected no later than 12/26/2025. **C.** To ensure ongoing compliance: The Director of Wellness or Assistant Director of Wellness will audit all new admission charts monthly for three months to verify that signed initial UAIs required are present. Subsequently, 30 day UAIs will also be reviewed and signed 30 days after move in. -The Director of Wellness or Assistant Director of Wellness will audit annual evaluations and ensure annual UAIs are updated (as needed), reviewed, and signed weekly for the next 4 weeks. -Any missing documentation identified during these audits will be corrected immediately. Audit findings will be reviewed during Quality Assurance (QA) meetings and documented as part of ongoing compliance monitoring. **D.** A new Resident agreement completion list was implemented on 11/28/2025 that with	

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	resident's legal representative was missing on the UAI assessment form. 10/24/25 – Review of R4's clinical documentation revealed R4's legal representative was FM2. 10/24/25 3:16 PM – During an interview, FM2 stated, "I am not aware of any agreement with the facility being signed on 7/21/25." 4. Review of R15's clinical record revealed the following: 4/1/25 – R15's annual UAI assessment did not contain the RN's name and signature who reviewed and completed the assessment. 10/27/25 3:45 PM – Finding was discussed with E2 (AED). 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 and E3 (DOW) during the exit conference.	annual due dates, 30-day residency agreement. Weekly residency agreement audits will be completed for 4 weeks beginning 12/5/2025. If discrepancies are found, weekly audits will continue until compliance is maintained for four consecutive weeks. After successful weekly audits, monitoring with QAPI. Compliance results will be reported to QAPI.	
3225.11.5 **S/S – D**	**The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** **This requirement was not as met as evidenced by:** Based on record review and interview, it was determined that for seven (R3, R5, R6, R7, R8, R10 and R14) out of thirteen residents reviewed for resident assessment, the facility failed to conduct an UAI assessment after a significant change in the resident's	**3225.11.5** **A.** All identified residents (R3, R5, R6, R7, R8, R10, R14) had their missing or incomplete UAI assessments immediately completed or corrected. Care plans were updated to reflect current needs. **B.** A facility-wide audit of all residents' UAI assessments was completed. Any missing or outdated Initial, 30-day, annual, or significant-change UAIs were updated, and corresponding care plans were brought into compliance. **C.** A UAI tracking log was implemented to monitor admission, 30-day, annual, and significant-change due dates. Staff will be re-educated on Delaware UAI requirements and significant-change triggers by DOW/ED on 12/12/25.	Completion Date: 12/26/2025.

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	condition occurred or failed to complete a 30-day UAI assessment after admission. Findings include: 1. Review of R3's clinical record revealed: 1/31/24 – R3 was admitted to the facility with diagnoses including depression, anxiety, and dementia. 11/22/24 – An UAI assessment completed due to a significant change documented R3 required no transfer assistance and only supervision with mobility. The UAI assessment form did not indicate that R3 had impaired balance, a gait problem, or disorientation. 1/8/25 – A facility Fall Risk Evaluation for R3 documented, "…Mental Status A. Disoriented x 1…Gait/Balance E5. Change in gait pattern when walking…". 4/24/25 – A facility Fall Risk Evaluation for R3 documented, "…Mental Status A. Disoriented x 1…Gait/Balance E2. Balance problem while standing/walking…E5. Change in gait pattern when walking…". 5/11/25 - A facility Fall Risk Evaluation for R3 documented, "…Mental Status A. Disoriented x 1…Gait/Balance E2. Balance problem while standing/walking…E5. Change in gait pattern when walking…". 6/3/25 - A post fall facility Fall Risk Evaluation for R3 documented, "…Mental Status A. Disoriented x 3… Gait/Balance E2. Balance problem while standing/walking…E5. Change in gait pattern when walking…". 10/24/25 – Review of R3's facility fall incident reports revealed that R3 fell seventeen	A new process requires nurses to notify the DOW within 24 hours of any fall, hospitalization, change in transfer status, diet change, hospice admission, or cognitive decline. Weekly chart reviews now include checking for changes requiring UAI updates. **D.** DOW will audit 10% of charts weekly for 4 weeks and monthly for 3 months thereafter to ensure UAI compliance. Audit results will be reviewed in QA. Compliance goal: 100% of required UAI assessments completed on time, demonstrating sustained correction.	

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	times in the six months between 1/5/25 and 7/5/25. An updated UAI was not completed to address a significant change in condition after R3 sustained seventeen falls and four Fall Risk Evaluations that indicated R3 had increased disorientation and problems with gait and balance. 2. Review of R5's clinical record revealed: 6/18/25 – An initial UAI assessment signed by E3 (DOW) for R5 indicated no psychiatric disorders. The section labeled, "…SECTION FOUR – Psychological/Social/Cognitive Information…" on the UAI assessment form was left blank. 6/24/25 – A medical evaluation completed for R5 documented, "…Psychiatric- Depression (unspecified), Anxiety…" The medical evaluation also indicated that R5 was hospitalized within the last year for depression and anxiety. 6/26/25 – R5 was admitted to the facility with diagnoses including diabetes mellitus, hypokalemia, and immunodeficiency. 7/26/25 – A 30-day UAI assessment signed by E3 included a handwritten note stating, "Resident has had a difficult time adjusting- very anxious and paranoid. Seen by PCP +[*sic*] psych [Psychology] but not showing much improvement at this time." Boxes on the UAI assessment form next to E3's signature indicating if R5 had or did not have changes since the initial UAI assessment were both left unchecked.		

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	The 30-day UAI assessment completed on 7/26/25 did not document R5's history of anxiety and depression noted on the 6/24/25 medical evaluation and did not document R5's anxiety and paranoia as a change in condition. 3. Review of R6's clinical record revealed: 11/1/23 – R6 was admitted to the facility with diagnoses including neuropathy, atherosclerosis, and hypertension. 12/1/24 – A completed UAI documented R6 used a wheelchair, required the assistance of one person to transfer from the bed to the wheelchair and required no assistance for bed mobility. 9/9/25 – R6 was hospitalized after sustaining a fall and returned to the facility. 9/9/25 7:40 PM – A Wellness Note was entered in R6's clinical record stating, "…resident was helped to toilet with assist x[*sic*] 3 to 4. resident [*sic*] unable to help with transfers…resident then helped to bed with 3-4 transfer assist. DON made aware of resident's status." 9/27/25 4:18 PM – A Wellness Note was entered into R6's clinical record stating, "…Resident assist x 2 with transfers…". 10/27/25 12:45 PM – During an interview, the Surveyor asked E3 if R6 needed an updated UAI after it was noted that he continued to require increased assistance with transfers. E3 stated, "It should have been updated." 4. Review of R7's clinical record revealed:		

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	2/1/24 – R7 was admitted to the facility with diagnoses including hypertension, anxiety and dysphagia. 3/1/24 – A 30-day UAI assessment completed for R7 documented, "…Diet Information: Mechanically altered mech[*sic*] soft [texture]…nectar thick [liquids]…" The UAI assessment also indicated, "…All Other Problems: dysphagia…". 4/1/24 – A facility dietary order was entered for R7 stating, "Texture modified diet, Mechanical Soft texture, Nectar Thick consistency." 12/24/24 – R7 was admitted to hospice care in the facility. 12/25/24 – A facility dietary order was entered for R7 stating, "Regular diet, Regular texture, Regular Thin liquids consistency." An updated UAI assessment was not completed for a significant change when R7 began receiving hospice care or when the diet order was changed. 3/1/25 – An annual UAI assessment was completed for R7 indicated that he was receiving hospice care. The UAI assessment also included, "…All Other Problems: dysphagia, aspiration…Please specify any special diet(s): Other aspiration, pureed…APPENDIX 1. aspiration, pureed recommended…". 10/27/25 1:15 PM – During an interview, surveyor asked E4 (Interim DC) what were R7's diet orders. E4 stated, "His diet orders were chopped [texture] and thin liquids."		

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	10/28/25 1:45 PM - During an interview, E2 (AED) stated, "[R7's] diet orders changed to regular diet, regular texture, and thin liquids when [R7] began hospice care." The surveyor asked E2 why the annual UAI assessment completed 3/1/25 did not document R7's diet order change on 12/25/24. E2 stated, "It should have been changed." 5. Review of R8's clinical records revealed: 6/2/23 – R8's initial UAI documented that R8 was oriented to person, place and time and was independent with toileting, mobility, bed mobility and transferring. R8 did not require assistive device and R8's fall risk assessment indicated that R8 fell in the last 31-180 days with one fall resulting to his broken left arm months prior. 7/3/23 – R8 was admitted to the facility. 8/3/23 – R8's 30-day UAI indicated no change. 7/30/24 – R8's annual UAI documented that R8 was oriented to person, place and time and was independent with toileting, mobility, bed mobility and transferring. R8 did not require assistive device. R8's fall risk assessment indicated that R8 had gait problems, impaired balance and fell in the last 31-180 days with 1 fall resulting to his broken left arm months prior. 2/18/25 – R8's facility quarterly fall risk evaluation score was 5 (if the total score is 10 or greater the resident should be considered at high risk for potential fall and a management protocol should be initiated).		

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	5/18/25 – R8's facility quarterly fall risk evaluation score was 7. Review of R8's facility incident reports revealed that R8 had fallen eight (8) times from February 2025 through August 2025. 8/22/25 3:00 PM – A nurse progress note documented that R8 was transferred to the MC (memory care unit). 8/22/25 – R8's significant change of condition UAI was completed. 10/27/25 12:40 PM – During interview, E3 (DOW) confirmed that she was not able to update R8's UAI when R8 started to fall before 8/22/25. 10/28/25 1:30 PM – Findings were reviewed with E1 (ED), E2 and E3. 6. Review of R10's clinical records revealed: 8/2/24 – R10's annual UAI assessment revealed that she was not receiving hospice care. 5/21/25 – A hospice billing notification form (admission/care level change) documented that R9 was admitted to hospice services. 9/2/25 – R10's annual UAI was completed. 10/22/25 – Further review of R10's records revealed a lack of evidence that R10's annual 9/2/25 UAI was updated to reflect R10's hospice status when she was admitted under hospice services on 5/21/25.		

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	7. Review of R14's clinical records revealed: 5/1/25 – R14's Initial UAI assessment was completed. 5/21/25 – R14 was admitted to the facility. 10/27/25 2:00 PM – Further review of R14's records revealed a lack of evidence that a 30-day UAI assessment was completed. 10/28/25 11:00 AM – Findings were discussed with E3. 10/28/25 3:30 PM – Findings were reviewed with E1, E2, and E3 during the exit conference.		
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S – E**	**Services** **The assisted living shall ensure that:** **Food service complies with the Delaware Food Code; and** **Delaware Food Code** **3-501 Temperature and Time Control** **3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be**	**3-501 Temperature and Time Control** **3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding** **A.** All residents have the potential to be impacted by this deficiency. Deficiency was missing some temps and was not corrected at the time of the survey. **B.** Dining director conducted full audit of all meal service areas was completed once surveyor deficient practice. Any items out of temperature were discarded and all equipment was verified to be functioning properly. **C.** All dining staff will be retrained on hot/cold holding, thermometers, and corrective action. Temperature checks every 2 hours, equipment preheating/cooling procedures, and enhanced logs will be implemented by Chef by 12/12/2025. **D.** Weekly audits for three weeks then monthly audits for three months will be conducted by Chef and/or designee of all Temp	Completion Date: 12/26/2025.

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S/S – F	**held at a temperature of 54°C (130°F) or above; or (2) At 5ºC (41ºF) or less.** **This requirement is not met as evidenced by:** Based on interview, and review of facility documentation, it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 10/22/25 1:35 PM – The review of past 90-day food temperature log revealed that 44 out of total 270 (accounting 16%) meals did not have food temperature record. 10/22/25 2:53 PM - The finding was reviewed with E1 (ED) and E2 (AED). 10/28/25 3:30 PM – Findings were reviewed with E1, E2 and E3 (DOW) during the exit conference. **3-501.17 Ready-to-Eat Time/Temperature Control for Safety Food, Date Marking** **(B) Except as specified in ¶¶ (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded.** **This requirement is not met as evidenced by:**	logs, to ensure compliance with temperature regulation. Findings will be reviewed at QAPI. **3-501.17** **A.** All residents have the potential to be affected by this deficiency. All improperly date-marked items were im-mediately discarded by the dining director upon finding during survey. Fresh replacements were prepared, and a full refrigerator review was conducted. **B.** A full audit of all coolers and prep areas was performed by dining director during survey. Any additional undated or expired items were discarded **C.** All dining staff will be retrained on date marking, 7-day rule, FIFO, and label placement. Color-coded labels and organized refrigerator sections will be implemented by 12/12/2025. We will reeducate staff on 7 day rule, FIFO, and label placement. Education to be completed by Dining Director. **D.** Dining director and/or designee will audit all reach in and fridge to ensure proper labeling. weekly for three weeks, then monthly for three months to ensure all food is properly dated. Findings will be presented in QAPI.	Completion Date: 12/26/2025.

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	Based on observation, interview and review of facility documentation, it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 10/21/25 9:12 AM – During the initial tour, the following opened and undated food items were observed in the reach-in refrigerator: Whip cream pipette bag, bottles of liquid coffee creamers, containers of cottage cheese and sour creams and plastic squeeze bottles of ketchup, mayonnaise, ranch dressing, raspberry vinaigrette, thousand island dressing and tomato juice. 10/21/25 9:25 AM – During an interview, E5 (Dietary Staff) confirmed that the bottles of liquid coffee creamers belonged to the kitchen staff and should not be kept inside the kitchen reach in refrigerator. 10/21/25 9:30 AM – A tour of the walk-in refrigerator revealed the following expired, undated, and unlabeled food items: pineapple cakes, side salads, marinara sauce, a jar of pickle relish, mayonnaise, parmesan cheese, white cheese, shredded cheddar cheese, and ham and bacon inside Ziplock bags dated 10/8/25. 10/21/25 9:31 AM – During an interview, E4 (Interim DC) stated that a bag of cured, preserved and smoked meats was frozen prior to 10/8/25 and then thawed in the refrigerator. E4 also stated that thawed food is good for five days and indicated that the bag of meats should have been thrown away.		

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3225.12.3 **S/S – E**	10/21/25 9:40 AM – A tour of the walk-in freezer revealed the following opened, unlabeled and undated food items: a bag of frozen vegetables, corn shrimp and a tray of salmon steaks. 10/21/25 9:50 AM – An observation in the Memory Care unit reach-in refrigerator revealed the following opened and undated items: a container of milk, jelly in a squeeze bottle and fruit cups. There was a lack of evidence of temperature logs for the reach-in refrigerator. 10/21/25 10:05 AM – Findings were confirmed by E4. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 (DOW) during the exit conference. **The assisted living shall ensure that the resident's service agreement is being properly implemented.** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that for one (R14) out of sixteen residents reviewed for resident assessment, the facility failed to ensure that R14's service agreement was properly implemented. Findings include: Review of R14's clinical record revealed: <u>A. Elopement Risk</u>	**3225.12.3** **A.** All residents are a potential risk to be impacted by the deficiency. R14 cannot be corrected due to resident not being in community. It was identified that resident service agreements were not consistently followed, specifically regarding behavioral interventions. Documentation supporting the required behavioral interventions was incomplete or missing. (i.e. wandering) **B.** Immediate Chart Review: All current residents identified as being affected by this issue will have their charts reviewed to ensure that their service agreements accurately reflect the behavioral interventions required. Any missing or incomplete documentation will be updated promptly by 12/12/2025. For each affected resident, staff will ensure that the behavioral interventions outlined in their service agreements are being followed as written. Documentation will be completed in real time to reflect interventions provided.	Completion Date: 12/26/2025.

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	5/29/25 – R14's initial Service Plan Report (service agreement) documented that R14 had cognitive deficits. R14's interventions included needing assistance and approaches due to disorientation or memory loss. 5/21/25 – R14's elopement risk evaluation revealed that R14 had a moderate risk for wandering. 10/27/25 2:00 PM – A review of R14's Kardex (plan of care for individual residents) revealed that R14 was to be monitored for wandering. 10/27/25 2:05 PM – A review of R14's "Wandering" task flowsheets in the EHR (electronic health record) found the following questions with no entries (answers): - Has the resident wandered? - Does the wandering place the resident at significant risk of getting to a potentially dangerous place? - Does the wandering significantly intrude on the privacy of activities of others? There was a lack of evidence that R14 was monitored for wandering as necessary from June 2025 through July 2025. 10/21/25 10:06 AM – Findings were discussed with E1 (ED), E2 (AED) and E3 (DOW). <u>B. Bedtime Checks</u> 5/29/25 (revised 6/3/25) – R14's initial Service Plan Report documented that R14 had	**C.** Staff Education and Training: All direct care staff and relevant team members will receive education on proper documentation procedures by 12/12/2025 and will be conducted by DOW/ADOW related to behavioral interventions, including: o How to identify behaviors requiring intervention o How to document interventions accurately and thoroughly o The importance of aligning documentation with each resident's service agreement 2. Documentation Expectations Reinforced: Staff will be instructed that documentation for behavioral interventions must be recorded accurately, consistently, and promptly moving forward. **D.** Monthly Audits: Beginning immediately, monthly audits for three months will be conducted on charts of residents with behavioral interventions listed in their service agreements. These audits will verify: a. That interventions are being completed as outlined b. That documentation is accurate, complete, and timely 2. Follow-Up and Correction: Any deficiencies identified during the monthly audits will be addressed immediately through staff retraining, chart correction, or resident service agreement updates as appropriate. 3. Ongoing Oversight: The Director of Wellness or Assistant Director of Wellness will review audit results weekly for the next 4 weeks to ensure continued compliance and make further adjustments to processes if necessary.	

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	sleep pattern disturbance. R14's interventions include to provide two checks per night or bedtime safety checks x2. 10/27/25 – A review of R14's July 2025 electronic bedtime safety checks x2 and PRN (when necessary) flowsheets lacked evidence that R14 was checked on 7/13/25. 7/13/25 6:45 AM – A facility incident report documented that R14 entered another resident's room [R11] and had a physical altercation where both residents were transported to the emergency room. 10/28/25 3:30 PM – Findings were reviewed with E1, E2 and E3 during the exit conference.		
3225.13.0 **3225.13.1** **S/S – E**	**Service Agreements** **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 six (R2, R3, R4, R5, R9 and R11) out of thirteen residents reviewed for resident assessment, the facility	**3225.13.0- 3225.13.1** **A.** All residents could potentially be affecting this deficiency. R2, R3, R4, R5, R9, R11 did not have resident assessments signed properly by resident or POA. All residents currently living in the facility who were identified as having unsigned service agreements will have their service agreements reviewed, signed, and properly filed by 12/26/25. This will be completed by the Administrator or designee. **B.** Effective immediately, the facility will implement the following corrective process: a. Admission-Day Requirement On the day of admission, the service agreement will be presented to the resident or their legal representative for review and signature. - A written signature will be required. - Verbal agreements will not be accepted as valid consent for services. The Director of Wellness or Assistant Director of Wellness will be responsible for ensuring the service agreement is signed prior to completing the admission. b. Acceptable Signers - Resident	Completion Date: 12/26/2025.

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	failed to obtain a resident's or a resident legal representative's signature on the service agreement. Findings include: 1. Review of R2's clinical record revealed: 6/23/25 - An initial UAI assessment was completed for R2. The UAI assessment was signed by both R2 and E3 (DOW). R2 was documented as being oriented to person, place and time. 6/23/25 - A service agreement for R2 was completed and signed by E3 (DOW). On the last page of the document, R2's name was printed and "Verbally agrees" was handwritten in place of the resident's signature. The service agreement was not signed by the resident or the resident's legal representative. 2. Review of R3's clinical record revealed: 1/31/24 – R3 was admitted to the facility with diagnoses including depression, anxiety, and dementia. 11/22/24- An UAI assessment was completed for R3 due to a significant change. R3's orientation to person, place, and time was not documented on the assessment. 10/24/25 – An undated service agreement for R3 was provided to the surveyor along with R3's 11/22/24 UAI assessment. The service agreement did not have the resident's, the resident representative's or registered nurse's signature. 3. Review of R4's clinical record revealed:	- Legal representative with decision-making authority No admission file will be considered complete until a written, signed service agreement is obtained and filed. **C.** The RN or Administrator will audit all new admission charts weekly for the next 4 weeks to verify that signed service agreements. Any missing documentation identified during these audits will be corrected immediately. Audit findings will be reviewed during Quality Assurance (QA) meetings and documented as part of ongoing compliance monitoring. **D.** The facility will achieve and maintain full compliance with Tag 3225.13.0 / 3225.13.1 within 30 days of submission. Weekly audits will be completed for 4 weeks beginning 12/5/2025. If any discrepancies occur, weekly audits will continue until four consecutive weeks demonstrate full compliance, then transition to monthly audits for 3 months. Audit results will be reviewed in QAPI and incorporated into the community's quality dashboard.	

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	7/14/25 - An annual UAI assessment was completed for R4. R4's orientation to person, place and time was not documented on the assessment. 7/21/25 - A service agreement for R4 was completed and signed by E3 (DOW). On the last page of the document, "POA [Power of Attorney]" was handwritten in place of the resident's name and "Verbally agrees" was handwritten in place of the resident's signature. 10/24/25 – Review of R4's clinical documentation revealed R4's legal representative is FM2. 10/24/25 3:16 PM – During an interview, FM2 stated, "I am not aware of any agreement with the facility being signed on 7/21/25." 4. Review of R5's clinical record revealed: 6/18/25 – An initial UAI assessment was completed for R5. The UAI assessment was signed by both R5 and E3 (DOW). R5's orientation to person, place or time was not documented on the UAI assessment. 6/18/25 – A service agreement for R5 was completed and signed by E3. On the last page of the document R5's name was printed and "Verbally agrees" was handwritten in place of the resident's signature. The service agreement was not signed by the resident or the resident's legal representative. 5. Review of R9's clinical record revealed:		

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3225.13.3 **S/S – D**	2/19/25 – An annual Service Plan Report (service agreement) was completed for R9. Review of this service agreement lacked evidence of a signature from R9 or R9's responsible party. 10/28/25 11:00 AM – During an interview E3 (DOW) confirmed the finding. 6. Review of 11's clinical record revealed: 7/21/25 – A significant change in condition Service Plan Report (service agreement) was completed for R11. Review of this service agreement lacked evidence of a signature from R11 or R11's responsible party. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 during the exit conference. **The resident's personal attending physician(s) shall be identified in the service agreement by name, address and telephone number.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for one (R11) out of thirteen residents reviewed for resident assessment, the facility failed to ensure that R11's personal attending physician's address and telephone number were identified in the service agreement. Findings include: Review of R11's clinical record revealed: 7/21/25 – A significant change in condition Service Plan Report (service agreement) was	**3225.13.3** **A.** During Division survey, it was identified that Primary Care Providers (PCPs) were not consistently documented in residents' service agreements at the time of admission. During state survey it was identified that the primary care provider for R11 was not in their file. All resident could be at a potential risk of this deficiency. The Director of Wellness (DOW) and/or Assis-tant Director of Wellness (ADOW) will con-duct a comprehensive review of all current resident charts immediately to be completed no later then 12/12/25. **B.** It was found during our review of resident charts and pcc. That in fact other residents where affected. All residents pcc and chart have been updated since to include the physician in the formation required by the state. Re-in-service medical concierge on requirements done by RN to be completed by 12/12/25. **C.** Effective immediately, nursing staff admitting a new resident will be required to document the PCP in PointClickCare during the admission process. The system configuration in PCC ensures that once the PCP is entered, it will auto-populate	Completion Date: 12/26/2025.

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	completed for R11. Review of this service agreement lacked the information of R11's personal attending physician's address and telephone number. 10/28/25 11:00 AM – During an interview E3 (DOW) confirmed the finding. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 during the exit conference.	into the resident's service plan, reducing manual entry errors. The DOW/ADOW will verify that all nurses are re-educated on: a. The requirement to obtain and document PCP information at admission. b. Where and how to enter PCP information in PCC. c. The importance of PCP documentation in ensuring continuity of care. **D.** As part of the existing service plan review workflow: a. The DOW or ADOW will audit the service plan prior to presenting it to the resident or legal representative for signature. b. The service plan will not be considered complete and will not proceed to signature if the PCP field is missing. c. Any missing PCP information identified during weekly audits for the next four weeks will be corrected immediately, and the responsible staff member will receive follow-up education. All nursing and admissions staff will receive re-education by 12/12/25 on: a. The revised admission workflow. b. How PCP documentation integrates into the service plan.	
3225.13.6 **S/S – E**	**Service Agreements** **The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for four (R8, R9, R10 and R14) out of thirteen residents reviewed for resident assessments, the facility failed to ensure that the residents' service agreements were updated to address the residents' identified needs. Findings include: 1. Review of R8's clinical record revealed: 7/3/23 - R8's initial service agreement documented that R8 was low risk for falls. 2/24/25 10:00 AM – R8 had a fall 6/2/25 2:00 PM – R8 had a fall.	**3225.13.6** **A. A**ll resident are at risk for this deficiency was identified that new Uniform Assessment Instruments (UAIs) were not consistently completed when residents experienced a significant change in condition. This resulted in some assessments not fully reflecting residents' current care needs. R8, R9, R10, R14 did not have and updated care need after a significant change in condition.	Completion Date: 12/26/2025.

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	6/3/25 – R8's Service Plan Report (service agreement) documented that R8 had an actual fall with minor injury related to decreased balance. Interventions included, but were not limited to, checking on R8 at frequent intervals to see if any assistance is needed and to offer reassurance. 7/13/25 3:32 PM – A nurse progress note documented, "[R8] continues with increased confusion. [R8] agitated, yelling and cursing at staff and other residents. 1:1 and redirection ineffective." Further review of R8's incident reports revealed that R8 had subsequent multiple falls on the following days: 7/3/25 6:00 AM 7/5/25 10:00 AM 7/9/25 6:30 PM 7/15/25 4:10 PM 8/8/25 7:20 AM 8/8/25 1:30 PM 8/28/25 2:20 PM 10/18/25 6:57 AM 7/13/25 3:32 PM – A nurse progress note documented, "[R8] continues with increased confusion. [R8] agitated, yelling and cursing at staff and other residents. 1:1 and redirection ineffective." 8/12/25 3:41 PM – A nurse progress notes documented, "[R8] continues with increased confusion and increased agitation. 1:1 and redirection given as needed." 8/22/25 - R8's significant change service agreement was completed; however, it	R8, RN revived file couldn't make any changes due to residents passing. R9, RN assessed resident and found that there was no adjustment needed due to her injury. R10, Original service agreement was conducted by Previous RN, After state visit current RN reviewed resident and resident file will be correcting service agreement by 12/12/25 R14, Rn couldn't make any changes due to resident not being in our community any more. **B.** All current residents who experienced a sig-nificant change in condition and did not have an updated UAI will have their UAIs reviewed and revise by 12/12/2025. Each UAI will be adjusted appropriately to reflect any changes in the resident's condition and care needs. Updated UAIs will be signed and placed in the resident's record by 12/26/2025. **C.** Effective immediately, when a resident experiences a change in condition, the following steps will be implemented: 1. A Family Care Plan Meeting will be scheduled to review the change in condition and discuss updates to the resident's service plan. 2. A new UAI will be completed to reflect the resident's updated condition. 3. The completed UAI will be reviewed, signed, and added to the resident's medical record. 4. All interdisciplinary team members involved in the resident's care will be notified of any changes outlined in the updated UAI. This process will ensure resident assessments remain accurate, complete, and compliant with regulatory expectations	

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	lacked evidence that R8's fall and behavior interventions were updated. 10/27/25 12:45 PM – During interview, E3 (DOW) confirmed that she was not able to update R8's significant change of condition service agreement to include R8's fall and behavior interventions. 10/28/25 1:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3. 2. Review of R9's clinical record revealed: 9/22/25 12:08 AM – A facility reported incident submitted to the state agency documented that R9 rang her pendant. The aide was going to answer the pendant call and found R9 on the bathroom floor on her knees in front of the toilet. 9/28/25 – A facility follow up report documented that R9 was sent to the hospital for evaluation and discovered that R9 had a neck fracture (broken bone). R9 was placed in a cervical collar. For corrective actions, the facility documented, "[R9] is now on fall risk/safety precautions. We have the management risk agreement in place … staff will assist [R9] with ADLs as needed given the physical restriction of the cervical collar." 10/22/25 10:00 AM – During observation, R9 was seen in her room, seated on her recliner with neck collar in use. When asked if she was able to access her pendant (a medical alert necklace pendant that R9 presses to activate and is used to communicate to nursing staff when requesting assistance), R9 stated that she was not sure if she had.	**D.** The Director of Wellness and Assistant Director of Wellness will conduct weekly audits for three months of all residents who experienced a change in condition. Each audit will verify: · Whether the resident had a documented change in condition · Whether a corresponding significant change UAI was completed · Whether the UAI was reviewed, signed, and accurately reflects the resident's needs Audit results will be reviewed during leadership meetings, and corrective actions will be implemented immediately if deficiencies are identified DOW/ADOW will identify in our weekly at risk meetings to see if any residents need a changce in condition.	

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	R9's pendant was not visible. R9 was observed reaching for her neck to feel the cord of her pendant but had difficulty moving her right hand upright. Next, R9 was observed putting her right hand inside her blouse, but the button got in the way and she had difficulty reaching for the cord. The pendant was stuck underneath R9's bra and she had difficulty pulling it out with her hand. R9 stated, "It's hard to move with this collar around my neck." The Surveyor had to intervene. 10/28/25 – Review of R9's annual Service Plan Report (service agreement), effective 2/19/25, lacked evidence that it was updated to reflect R9's need for additional assistance with ADLs, to include interventions for falls and to address R9's difficulty accessing her pendant to alert staff since wearing the cervical collar. 10/28/25 1:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 (DOW). 3. Review of R10's clinical record revealed: 5/21/25 – R10 was admitted for hospice services. 9/2/25 – R10's annual Service Plan Report (service agreement) was completed. 10/22/25 – Further review of R10's records revealed a lack of evidence that R10's annual service agreement was updated to reflect R10's hospice status. 10/28/25 1:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 (DOW).		

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	4. Review of R14's clinical record revealed: 5/29/25 – R14's initial Service Plan Report (service agreement) documented that R14 had cognitive deficits. R14's interventions included needing assistance and approaches due to disorientation or memory loss. 7/13/25 6:45 AM – A facility incident report documented that R14 entered another resident's room [R11] and had a physical altercation where both residents were transported to the emergency room. The facility failed to update R14's service agreement to address R14's increasing wandering, agitation and socially disruptive behaviors. 10/21/25 10:06 AM – Findings were discussed with E1 (ED), E2 (AED) and E3 (DOW). 10/28/25 3:30 PM – Findings were reviewed with E1, E2 and E3 during the exit conference.		Completion Date: 12/26/2025.
3225.18.0 **3225.18.4** **S/S – D**	**Emergency Preparedness** **The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in conspicuous places at each nursing station.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for two (P1 and P2) out of nine employees reviewed, the facility	**3225.18.4** **A.** The contract Physical Therapist involved has now completed the required emergency preparedness training. The Rehabilitation Director verified completion and uploaded documentation to the contractor's personnel file. The therapist was not permitted to provide resident care until training was completed. **B.** A facility-wide audit of all contract staff personnel files will be completed by	

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	failed to ensure that P1 and P2 completed their emergency preparedness training. Findings include: Review of the employee training records revealed the following: 1. 4/8/25 – P1's first day in the facility assigned to work as contract Physical Therapist. There was a lack of evidence that P1 completed her emergency preparedness training. 2. 9/2/25 – P2's first day in the facility assigned to work as contract Certified Occupational Therapist Assistant. There was a lack of evidence that P1 completed her emergency preparedness training. 10/24/25 4:15 PM – In an interview, E18 (BOM/HR) confirmed that P1 and P2 did not complete the emergency preparedness training. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 (DOW) during the exit conference.	12/12/25 to identify missing emergency preparedness training. Any contractors lacking documentation were notified and completed training before providing or continuing resident care. All active contract staff files are now updated. **C.** Lack of a standardized process to verify and document emergency preparedness training during contract staff onboarding. Revised Onboarding Process All contract personnel must complete emergency preparedness training before providing care. A revised Contract Staff Onboarding Checklist will be implemented, and the Rehabilitation Director will verify and upload documentation on the first day. Auditing Procedures New contract staff files will be audited weekly for 3 weeks, then monthly for 3 months, to confirm required training documentation. Policy Review and Revision Emergency preparedness and contract staff onboarding policies will be reviewed and revised to clearly define training requirements, timeframes, documentation expectations, and responsible parties. Staff & Vendor Education HR staff, department directors, and vendor partners will be educated on revised processes, this education will be completed by BOM. Updated materials, policies, checklists, and sign-in sheets will be completed by 12/26/2025. Responsibility The HR Director, with the Rehabilitation Director, will ensure implementation and ongoing compliance. **D.** The HR Director will maintain an audit log of all new contract staff and verify training	
3225.19.0 **3225.19.6** **S/S – D**	**Records and Reports** **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:**		Completion Date: 12/26/2025.

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	Based on record review and interview, it was determined that for two (R8 and R11) out of five residents reviewed for records and reports, the facility failed to submit follow up incident reports within five days. Findings include: 1. Review of R11's clinical record revealed: 8/29/25 2:32 PM – R8's incident report was submitted to the Division. The 5 day follow up report was due on 9/8/25. The facility submitted the follow up report on 9/25/25, 17 days after the due date. 2. Review of R8's clinical record revealed: 7/13/25 1:04 PM – R11's incident report was submitted to the Division. The 5 day follow up report was due on 7/18/25. The facility submitted the follow up report on 7/22/25, 4 days after the due date. 10/28/25 1:10 PM – In an interview, E3 confirmed that the facility failed to comply with the Division's requirement to submit the 5 day follow up reports for the incident reports submitted on 7/13/25 for R11 and on 8/29/25 for R8. 10/28/25 3:30 PM – Findings were reviewed with E19 (ED), E2 (AED) and E3 (DOW) during the exit conference. **Reportable incidents include:** **Injury from a fall which results in transfer to an acute care facility for treatment or**	completion. Audit results will be reviewed with Leadership. Any deficiencies will result in immediate retraining. Compliance maintained over 90 days will indicate successful correction. We will conduct audits weekly for the next 4 weeks. **3225.19.6** **A.** The late 5-day follow-up incident reports for Residents R8 and R11 have now been submitted to the Division. Both reports were reviewed by the Director of Nursing and Executive Director to ensure accuracy and completeness. No negative resident outcomes occurred due to the reporting delays **B.** A facility-wide audit of all reportable incidents occurring within the past 90 days was conducted to identify any additional 5-day follow-up reports that may have been submitted late or not submitted. All identified follow-ups have now been completed and submitted to the Division. No other delays were identified. **C.** The root cause was a lapse in tracking and oversight of 5-day follow-up deadlines. To prevent recurrence, the facility will implement the following: Revised Reporting Process A standardized Incident Reporting Tracking Log will record all incidents, initial report times, and 5-day due dates. The DOW will maintain the log, and the ED/AED will review it daily. Policy Update The Incident Reporting Policy will be revised to clarify 8-hour initial report requirements, 5-day follow-up deadlines, assigned responsibilities, and documentation expectations. Staff Education	
3225.19.7 **3225.19.7.7.2** **S/S – E**			

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	evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours. **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for four (R2, R4, R8 and R9) out of five residents reviewed for records and reports, the facility failed to ensure that falls that resulted in injuries and resident transfer to the hospital were reported to the Division within eight hours of occurring. Findings include: 1. A review of R2's clinical record revealed: 8/7/25 11:36 PM - A Fall Note entered for R2 documented, "Unwitnessed fall…he had a large laceration on his left forearm actively bleeding…". 8/8/25 6:16 AM – A Wellness Note documented, "Resident returned around 0545 [5:45 am] with son-in-law from CCH [Hospital]." 8/8/25 4:36 PM – A Wellness Note documented, "…17 sutures noted to left forearm…". The resident fall was not reported to the Division. 2. A review of R4's clinical record revealed: 2/18/25 4:45 PM – A Wellness Note entered for R4 documented, "…resident had an unwitnessed fall…resident grimacing at [*sic*] R [right] hip. Some pain noted…911 called sent out for further evaluation…".	All reporting staff will be re-trained on state reporting timelines, documentation, and escalation procedures to be conducted by ED. Training records and updated policies will be maintained to be completed by 12/12/25. **D.** ED will review state reportable to ensure that everything is filed in a timely manner. Findings will be reported during monthly QA/QAPI meetings to ensure ongoing oversight. Continued compliance for 90 days will be considered evidence of sustained correction. Any deviation from timely reporting will trigger immediate investigation, retraining, and corrective action. **3225.19.7.7.2** **A.** R2 state surveyor identified R2 incident as a state report that was not reported initially. ED and DOW asked state if they should report to the state. State advised it was already too late to report. For Residents R4, R8, and R9, retrospective incident reports have now been submitted to the Division. Each fall event was reviewed by the Executive Director (ED) and Director of Wellness (DOW) to ensure accurate documentation of the incident, injury, and subsequent care. No additional resident harm resulted from the delayed reporting. Staff involved in these incidents were individually re-educated on immediate reporting requirements. B. A 90-day retrospective audit of all falls and other reportable incidents will be completed by 12/12/25 to determine whether any additional fall-related injuries requiring hospitalization were not reported within the required	**Completion Date: 12/26/2025.**

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	2/22/25 6:34 PM – A Wellness Note entered for R4 documented, "…imaging results from status post ER visit on 2/18 r/t [related to] unwitnessed fall…Impression: Fractures of the R superior and inferior rami…". The resident fall was not reported to the Division. 3. A review of R8's clinical record revealed: 3. a. 8/8/25 7:20 AM – R8 had a fall, hit his head and obtained skin tears on his right elbow, left upper arm and abrasion to his scalp. R8's's top of left foot was red, tender, warm, open and draining. R8 was noted with increase confusion and agitation and was sent to the ER for evaluation and treatment. There was a lack of evidence that this incident was reported to the Division. 3.b. 8/28/25 2:20 PM – R8 had a fall with injury. On 8/29/25, facility was notified by R8's family that R8 was admitted for a compression fracture in middle section of his spine. Also, on 8/29/25 at 2:32 PM, the facility filed an incident report with the Division that R8 had fallen. A report was filed 24 hours after the incident. 4. A review of R9's clinical record revealed: 9/22/25 12:08 AM – R9, who was on blood thinner medication, had a fall and hit her head. R9 was transferred to the hospital for evaluation and treatment. On 9/22/25 at 10:30 AM, facility confirmed R9's admission to the hospital for fracture of her neck. On	eight-hour timeframe. All identified incidents have been reviewed and any missing reports were submitted immediately. No other cases of late reporting were identified. C. The root cause of this deficient practice was identified as inconsistent adherence to state reporting requirements, inadequate internal communication during and after fall events, and the absence of a reliable tracking system to ensure timely submission of incident reports. To prevent recurrence, the following systemic improvements will be implemented: Revised Immediate Reporting Workflow The facility will implement a Revised Critical Incident Response Protocol requiring that: • Nursing staff notify the ED, AED, and DOW immediately following any fall with injury, head impact, or transfer to the hospital. • The incident be entered into the facility's electronic incident reporting system in a timely manner of event discovery. • The ED or designee submit the report to the Division within the required eight-hour window. Dual-Verification System A dual-verification step will require the DOW and ED to validate that: • Any fall with injury or hospital transfer is reviewed immediately, and • The incident is submitted to the Division within eight hours. If the ED is off-site, the AED will serve as the secondary reviewer. policies related to incident reporting, fall management, and critical event escalation will be reviewed and updated to clearly define: • What constitutes a reportable fall • Timeframes for reporting (within 8 hours) • Required documentation	

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TITLE 16 Health and Safety Regulatory Provisions Concerning Public Health CHAPTER 11. Long-Term Care Facilities and Services Subchapter II. Rights of Residents. **S/S – G PNC**	9/22/25 at 1:45 PM, the facility filed an incident report with the Division that R9 had fallen. A report was filed 13 hours after the incident. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 (DOW) during the exit conference. **§ 1121. Resident's rights.** **(30) Each resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep**. **This requirement is not met as evidenced by:** Based on interview, record review, and review of other documentation, it was determined that for two (R11 and R14) out of six residents reviewed for abuse, the facility failed to ensure that both residents were free from physical abuse resulting in transport to the emergency room for evaluation and treatment. R11 sustained a right arm fracture and swollen eye while R14 sustained a right elbow skin tear. As a result of this resident – to – resident altercation and serious injury, R11 was harmed. Based on record review and review of the facility's corrective measures completed on 7/31/25 and no further incidents have occurred, it was determined that this incident was past non – compliance. Findings include: A. Review of R11's clinical record revealed: 2/29/24 – R11 was admitted to the facility.	• Notification hierarchy and responsible roles • Expectations for follow-up and monitoring Should any essential elements be missing, a new policy will be created specifically addressing immediate reporting of falls with injury. All licensed nurses, supervisors, and DOW/ADOW will be re-educated by 12/12/25 on: • Reportable incident definitions • Eight-hour reporting requirement • Documentation procedures • The updated incident response workflow The education will be conducted by ED/AED Education will be provided via in-service training, written instructions, and updated procedural documents. Sign-in sheets, training outlines, and updated policies will be retained. The Executive Director (ED) and Director of Wellness (DOW) will oversee implementation and ensure system adherence. HR will ensure new hires receive training on incident reporting expectations during onboarding.	**10/28/25**

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	6/18/24 – R11's change in condition UAI (Uniform Assessment Instrument) revealed that R11 had dementia, was oriented to person and was moved to the MC (Memory Care) unit due to exit seeking behavior. R11 was independent with mobility, bed mobility and transfer. 9/3/24 – R11's elopement risk evaluation revealed that R11 was combative and severely agitated. B. Review of R14's clinical record revealed: 5/1/25 – R14's initial UAI revealed that she was independent with mobility, bed mobility and transfer. R14 was oriented to place, had a history of wandering and was disruptive with demanding behaviors and "demanding to go places." 5/21/25 – R14 was admitted to the facility with diagnoses including history of TBI from brain surgery, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. 5/29/25 – R14's Service Plan Report documented that R4 was on psychotropic medications for behavior. 5/29/25 – R14's Service Plan Report documented that R14 had cognitive deficit/status and had interventions that included needing assistance and special approaches due to disorientation or memory loss. 5/29/25 (revised 6/3/25) – R14's Service Plan Report documented that R14 was on psychotropic medications and interventions included administer meds as ordered.		

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	There was a lack of evidence that R14's identified targeted behaviors of wandering and agitation were included in R14's Service Plan Report or in R14's Wandering task flowsheet in the electronic health record (EHR). Review of R14's nurse progress notes revealed the following documentation: 6/2/25 9:59 AM – "[R14] was wandering around the facility all shift" 6/2/25 11:36 AM – "PRN given for agitation, ineffective. [R14] observe patting a resident's head and almost hitting another resident. Continues to be agitation (sic)" 6/2/25 12:41 PM – "[R14] came to nurse's station agitation (sic) and grab nurse phone trying to call her husband" 6/3/25 7:36 PM – "[R14] was agitated and anxious…" 6/4/25 3:04 PM – "Behaviors x3 this shift, monitor [R14] for exit seeking and getting into with other resident." 6/10/25 10:46 PM – "[R14] entering other resident's rooms and disorganizing their closet". 6/11/25 12:12 PM – "… [R14] needs several reminders not to get too close to other resident and be in their personal space. [R14] keeps getting into physical altercation with resident in [room, unidentified] both has [*sic*] to be consistently monitored and kept apart."		

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	6/19/25 1:58 PM – "… monitor [R14] for increased anxiety and exit seeking and setting off door alarms" 6/21/25 7:17 AM – "Patient [R14] was agitated this morning and verbally/physically abusive to staff. Patient was unable to be redirected, patient was hitting and kicking nurse station door. Patient slapped a caregiver in the back". 6/21/25 7:41 PM – "[R14] continues with aggressive behaviors, hitting, punching, kicking staff and resident. Pulling door, undressed herself, very hard to keep under control DON made aware…." 6/21/25 7:01 AM – "[R14] up early this morning and noted to be very disrupted by getting into resident faces, pulling things apart and pulling the electrical cord and plugs… observed walking in the halls and very anxious". 6/23/25 10:22 PM – "[R14] observed displaying increased restlessness and pacing intermittently around the unit. Attempted to exit multiple times. Emptying out the tea and sugar containers at the serving area. Noted unsafely lifting the coffee maker and spilling the water. [R14] approaching other residents unawares (sic) and getting them agitated. Knocking on the sleeping residents' doors startling them, [R14] moving the furniture in the unit around and leaving it in unsafe areas. Staff continue to monitor for safety". 7/13/25 1:04 PM – A facility reported incident submitted to the state agency documented that on 7/13/25 at 6:42 AM, "… the 11-7 aid [E15] was across the hall about to		

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	provide care to another resident when she heard yelling and arguing coming from (R11's room). Upon entering the room, the [E15] found [R14] with a circular skin tear to the right arm that was bleeding. [R11] was yelling at [R14] that this was not her room, and she was a "Son of a Bitch". At that time, [R14] tackled [R11] to the floor. [R11] landed on her right side… As per [E15], [R11] hit the right side of her face on the floor but was uncertain if she hit the edge of her dresser. [R11] complained of right arm pain…. nurse assessed and called 911 for evaluation to ED (Emergency Department). Then nurse came to [R14] who complained of pain on her right arm. [R14's] skin tear was cleaned and dressed. Sent out to the hospital for further evaluation." 7/13/25 – An untimed written witness statement by E17 (LPN) documented that the aid E15 called her to inform that two residents were fighting and that one resident R14 tackled the other resident R11 to the floor. 7/13/25 – An untimed written witness statement by E15 documented that R11scratched R14's arm and gave her a skin tear. R14 tackled R11. R11 hurt her arm and her eye was swollen. R14 went into R11's room and R11 was trying to get R14 out. 7/13/25 1:04 PM – R11's incident report was submitted to the Division. 7/14/25 8:27 PM – R14 was back from the hospital. 7/14/25 - An ED note documented that R14 was seen for dementia with mood disturb-		

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	ance, a skin tear of upper extremity and elbow pain. R14 was evaluated by the psych team. 7/15/25 1:51 PM – A nurse progress note documented that R11sustained a fracture to the right upper arm from the incident and was also kept for seven (7) days in the hospital for medical and behavior observations. The 5 day follow up report was due on 7/18/25. The facility submitted the follow up report on 7/22/25, 4 days after the due date. 7/31/2025 2:09 PM – A nurse progress note documented that R14 was discharged from this facility and was transferred to another facility for needing increased level of care. The facility failed to ensure that R14 was free from physical abuse by R11 and subsequently, the facility failed to ensure that R11 was free from physical abuse by R14 when on 7/13/25 during an altercation, R11 scratched R14's right elbow and R14 obtained a skin tear. R14 tackled R11 to the floor resulting in R11's fractured right upper arm. 10/28/25 11:00 PM – Findings were discussed with E1 (ED) and E2 (AED). 10/28/25 1:30 AM – Findings were discussed with E3 (DOW). CORRECTIVE ACTIONS: - Staff intervened quickly to separate residents and provide reassurance. - Residents were assessed for injuries and emotional well – being.		

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	- Families and appropriate leadership at (facility) were notified. - Additional monitoring was implemented post – event. - Review and update both residents' individualized care plans to address behavioral triggers and outline appropriate mitigation strategies. - Increase purposeful engagement and structured activities to reduce idle time and minimize agitation (e.g. "Day in the Life of Wellspring" program). - Collaborate with clinical providers to review behavioral tracking data and determine the need for behavioral health or medication adjustments (resident has been assessed by PCP and Psych NP). - Implement 24/7 private duty aid support for the resident identified as the perpetrator. - Provide refresher trainer for all memory care staff on: - Resident on resident altercations Charting and documentation Routine resident checks and hourly check forms Behavior roundtable discussion Managing challenging behaviors - Increase observation and presence of staff in designated "high-risk" common areas during peak meal/activity times.		

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	- Adjusting staffing assignments to ensure continuity of care: assign staff who are familiar with resident behavior profiles. - Implement incident – tracking and trend – analysis to monitor for repeating patterns of altercation or agitation and identify when additional interventions are needed. - Event was discussed on the Wednesday post incident at the weekly at-risk meeting and will be discussed at the quarterly quality meeting in December. - Date of substantial compliance: July 31, 2025. 10/28/25 1:00 PM – Observation in the MC unit revealed majority of the residents were engaged in activities. No occurrences of abuse – verbal, physical and mental were observed between resident to resident. 10/28/25 1:26 PM through 1:40 PM – Interviews with nurse (E14 LPN) activity staff (E21) and resident assistants (E13, E16, E20, E21, E22, E23 and E24) all confirmed that they received the education on resident - to-resident abuse, managing challenging behaviors in dementia patients and hourly monitoring and behavior documentation. Staff further confirmed that there were no other incidents of resident-to-resident physical abuse or altercations after the 7/13/25 incident. No immediate action required related to facility correction and no further occurrences after the incident on 7/13/25. This was verified by interviews with staff about resident - to - resident physical abuse education, spot		

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	inspection for resident interactions and inspection of the facility abuse incident reports. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 (DOW) during the exit conference.		
§ 1144. Influenza immunizations. Title 16 - Health and Safety Page 124 Part II Regulatory Provisions Concerning Public Health Chapter 11 Long-Term Care Facilities and Services (81 Del. Laws, c. 206, § 1.) Subchapter I **S/S – E**	**§ 1144. Influenza immunizations. (a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1 and extending through March 1 of a calendar year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine. (b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination. (c) [Repealed.] (81 Del. Laws, c. 346, § 1; 82 Del. Laws, c. 141, § 18; 83 Del. Laws, c. 306, § 1.)** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for nine (E25, E26, E19, E27, E3, E28, E12, P1 and P2) out of nine facility and contract employees randomly selected for influenza vaccination review, the facility failed to provide evidence of a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination. Findings include: 10/24/25 2:30 PM – An interview with E18 (BOM/HR) confirmed that for the randomly selected employees E25 (LPN), E26 (Envi-	**1144** **A.** All employee files identified as missing Influenza vaccination documentation have been reviewed. The required documentation—vaccination record, medical exemption, or declination—has been obtained and placed in the respective personnel files. Employees without documentation were notified and required to submit the appropriate form immediately. All files will be completed by 12/2/25.	

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	ronment), E19 (RN), E27 (Resident Associate), E3 (Wellness Director), E28 (Server), E12 (Housekeeping), P1 (PT) and P2 (COTA), the facility failed to have evidence of a signed statement from each employee stating they were offered an influenza vaccination and either accepted or declined the vaccination. 10/28/25 3:30 PM – Findings were reviewed with E1 (ED), E2 (AED) and E3 (DOW) during the exit conference.	**B.** A facility-wide audit of all employee health files, including contracted staff, was conducted to identify any additional missing or incomplete Influenza vaccination documentation, to be completed by 12/12/25. Any staff members found to be out of compliance were immediately contacted and required to provide consent, declination, or vaccination documentation. All audited files have now been updated. **C.** The root cause of this deficient practice was identified as inconsistent HR onboarding procedures and the absence of a standardized, centralized tracking process for Influenza immunization documentation. To prevent recurrence, the following systemic changes will be implemented: Revised Onboarding Workflow HR will obtain Influenza vaccination documentation, consent, or declination for every newly hired employee as part of the onboarding packet. The Wellness Nurse Manager will verify all received documentation before the employee begins regular duties. Policy and Procedure Review & Revision Policies related to employee health records and annual immunization requirements will be reviewed and updated to clearly define: • Required Influenza documentation • Timelines for collection (hire date and annual deadline) • Follow-up process for non-compliant staff • Designated responsible personnel If gaps are identified, a new policy dedicated to annual Influenza documentation will be developed. Education and Training	

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		HR staff, supervisors, and nursing leadership will receive education regarding the updated processes and documentation expectations through in-service training, written guidance, and distributed instructions. Training will be conducted by BOM on 12/12/15 Training materials, sign-in sheets, and updated policies will be retained as evidence of completion. Sustained Monitoring HR and the Wellness Nurse Manager will jointly conduct monthly audits of Influenza documentation during the vaccination season and quarterly audits the remainder of the year. Any missing or incomplete documentation will be addressed within 48 hours. Responsible Personnel The Human Resources Director, in collaboration with the Wellness Nurse Manager, will be responsible for implementing and maintaining all corrective actions. **D.** Auditing existing and new hire employees for the next 3 months and will discuss in QA/QAPI meetings for the next 3 months. Ongoing compliance will be monitored through quarterly audits and annual review prior to the flu season. Sustained compliance for a minimum of 90 days will be considered evidence of effectiveness. Any future lapses will result in immediate retraining and corrective action.	

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Provider's Signature _____ Title _____ Date _____

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date

Provider's Signature _____ Title _____ Date _____

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

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		This citation was determined to be past non-compliance no plan of correction required.	

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