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: Dover Place

DATE SURVEY COMPLETED: November 7, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from November 3, 2025, through November 7, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documents as indicated. The facility census on the first day of survey was fifty-four. The survey sample totaled twenty-one residents. Abbreviations/definitions used in this report are as follows: Dexcom – A machine used to measure the amount of sugar in the bloodstream; ED - Executive Director; FAM - Family Member; Hypoglycemia - a lower-than-normal amount of sugar in the bloodstream; Hyperglycemia - a higher-than-normal amount of sugar in the bloodstream; LPN - Licensed Practical Nurse; MT – Medication Technician; RWD - Resident Wellness Director; RN - Registered Nurse; RCP - Resident Care Partner; UAI - Uniform Assessment Instrument an assessment completed by the facility; VED - Visiting Executive Director.		
3225.0	**Assisted Living Facilities**		

Provider's Signature _____ Title __Executive Director____ Date ___12/30/2025_____

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	This requirement was not met as evidenced by:		
3225.8.3	**Medication stored by the assisted living facility shall be stored and controlled as follows:**		
3225.8.3.5	**All expired or discontinued medication, including those of deceased residents, shall be disposed of according to the assisted living facility's medication policies and procedures.**		
S/S – D	**This requirement was not met as evidenced by:** Based on observation and interview it was determined that the facility failed to ensure that all expired medications were disposed of properly. Findings include: The facility policy on Medication Management last updated April 2020 indicated, "Outdated, damaged, and contaminated medications will be checked, identified, returned or destroyed monthly." Review of Manufacturer's instructions on Lantus medication indicated, "How to store your opened Lantus pen; After twenty-eight days throw your opened Lantus pen away." https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf. 11/3/25 9:50 AM - During the inspection of the facility's medication carts two opened Lantus insulin pens one dated 9/25/25 and another dated 9/29/25 were observed in assisted living medication cart one. Printed on both pens was a pharmacy label to discard	A. No specific residents identified. The two opened Lantus pens were immediately removed from cart on 11/3/2025 and disposed. B. All residents with orders for Lantus pens have the potential to be affected. Executive Director or Resident Care Director will re-educate community nurses that Lantus pens must be discarded 28 days after opening or per manufacturer's instructions. C. Resident Care Director or designee will audit each medication cart to ensure that all residents with insulin pens are discarded 28 days after opening or longer per manufacturer's instructions. To ensure ongoing compliance the Resident Care Director or designee will audit each medication cart weekly for 4 weeks and monthly for 2 months to ensure that all residents with insulin pens are discarded 28 days after opening or longer per manufacturer's instructions.	1/20/2026

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	the pens after twenty-eight days after opening. 11/3/25 9:55 AM - E4 (LPN) confirmed the insulin pens were expired and removed them for disposal. 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).	D. Results of these audits will be reviewed by Executive Director weekly for 4 weeks until 100% success for 3 consecutive evaluations; then reviewed monthly by the Executive Director for 3 months at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Attached Documentation: Training sign in sheet; Initial Audit	
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 three (R13, R18 and R22) out of fourteen resident assessments reviewed the facility failed to ensure that a review by a RN was completed thirty days after the initial UAI assessment. 1. Review of R22's clinical record revealed: 4/23/25 - R22 was admitted to the facility.	A. Residents R22, R18, & R13 identified as affected. R22 thirty-day review by an RN following the initial UAI assessment was completed on 12/22/2025. R18 thirty-day review by an RN following the initial UAI assessment was completed on 12/22/2025. R13 thirty-day review	1/20/2026

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	4/21/25 - An initial UAI assessment was completed for R22. 11/7/25 - A review of R18's UAI assessments lacked evidence of the completion of a thirty-day review by an RN following the initial UAI assessment. 2. Review of R18's clinical record revealed: 9/23/25 - R18 was admitted to the facility. 9/23/25 - An initial UAI assessment was completed for R18. 11/7/25 - Review of R18's UAI assessments lacked evidence of the completion of a thirty-day review by an RN following the initial UAI assessment. 3. Review of R13's clinical record revealed: 10/1/25 - R13 was admitted to the facility. 10/1/25 - An initial UAI assessment was completed for R13. 11/5/25 - A review of R13's UAI assessments lacked evidence of the completion of a thirty-day review by an RN following the initial UAI assessment. 11/7/25 9:09 AM - During an interview E3 (RWD) confirmed that the thirty-day assessments by an RN were not completed. 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).	by an RN following the initial UAI assessment was completed on 12/22/2025. B. All current community residents have the potential to be affected. Resident Care Director or designee completed a community wide audit of current residents to ensure that a thirty-day review by an RN was completed following an initial UAI assessment. C. Community RN re-educated by Executive Director that UAI assessment requires a thirty-day review by an RN following the initial UAI assessment. To ensure ongoing compliance Resident Care Director or designee will complete monthly audits for 3 months to ensure that a thirty-day review by an RN was completed following an initial UAI assessment. D. Results of these audits will be reviewed monthly by the Executive Director for at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Attached Documentation: Training Sign In sheet; Initial audit	
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**		

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	and when there is a significant change in the resident's condition. Based on record review and interview the facility failed to ensure that an annual UAI assessment was completed for one (R11) out of fourteen residents' assessments reviewed. Review of R11's clinical record revealed: 6/30/23 - R11 moved into the facility. 5/20/24 - An annual UAI assessment was completed for R11. 11/4/25 - A review of R11's UAI assessments lacked evidence of the completion of annual UAI assessment that should have been completed in May of 2025. 11/7/25 9:25 AM - During an interview E3 (RWD) confirmed that an annual UAI assessment had not been completed for R11. 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).	A. Resident R 11 affected. R11 had annual UAI assessment completed on 12/24/2025. B. All current community residents have the potential to be affected. Resident Care Director or designee completed a community wide audit of current residents to ensure that an annual UAI assessment has been completed annually. C. Community RN re-educated by Executive Director that UAI assessments must be completed annually for residents. To ensure ongoing compliance Resident Care Director or designee will complete monthly audits for 3 months to ensure that annual UAI assessments are completed. D. Results of these audits will be reviewed monthly by the Executive Director for at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Documentation Provided: Training Sign in sheet; Initial Audit	1/20/2026
3225.13.0 **3225.13.1** **S/S – D**	**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.**		

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	This requirement is not met as evidenced by: Based on record review and interview it was determined that for three (R5, R12 and R13) out of fourteen residents service agreements reviewed the facility failed to ensure the service agreement was signed by the resident or responsible party. Findings include: 1. Review of R5's clinical record revealed: 7/1/25 - A service agreement was completed for R5. 11/4/25 - A review of R5's service agreement lacked evidence of a signature from the resident/responsible party. 2. Review of R12's clinical record revealed: 8/8/25 - A service agreement was completed for R12. 11/4/25 - Review of R12's service agreement lacked evidence of a signature from the resident/responsible party. 3. Review of R13's clinical record revealed: 10/3/25 - A service agreement was completed for R13. 11/4/25 - A review of R13's service agreement lacked evidence of a signature from the resident/responsible party. 11/7/25 9:10 AM E3 (RWD) confirmed the absent signatures from residents or the responsible parties on the service agreements.	A. Residents affected R5, R12, & R13. R5's service agreement was sent to family to be reviewed and signed by the resident/responsible party on 12/24/2025. R12's service agreement was sent to family to be reviewed and signed by the resident/responsible party on 12/24/2025. R13's service agreement was sent to family to be reviewed and signed by the resident/responsible party on 12/24/2025. B. All current community residents have the potential to be affected. Resident Care Director or designee completed a community wide audit of current resident service agreements to ensure they were signed by the resident/responsible party. C. Executive Director re-educated clinical management staff that resident service agreements shall be reviewed and signed by the resident/responsible party. To ensure ongoing compliance the Resident Care Director or designee will complete monthly audits for 3 months to ensure that resident service agreements are signed by the resident/responsible party. D. Results of these audits will be reviewed monthly by the Executive Director for at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed	1/20/2026

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	11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).	one more time a month later at QAPI by Executive Director to ensure 100% success rate.	
3225.13.3 **S/S - D**	**The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.**	Documentation Provided: Training sign off sheet; initial audit	
	Based on record review and interview it was determined that for three (R5, R12 and R13) out of fourteen residents service agreements the facility failed to ensure that the resident's attending physician was identified on the service agreement. Findings include: 1. Review of R5's clinical record revealed: 7/1/25 - A service agreement was completed for R5. 11/4/25 - Review of R5's service agreement lacked identification of the resident's attending physician, and physician's contact information. 2. Review of R12's clinical record revealed: 8/8/25 - A service agreement was completed for R12. 11/4/25 - A review of R12's service agreement lacked identification of the resident's attending physician, and the physician's contact information. 3. Review of R13's clinical record revealed: 10/3/25 - A service agreement was completed for R13. 11/4/25 - A review of R13's service agreement lacked identification of the resident's	A. Residents R5, R12, & R13 affected. R5's service agreement was updated to include the resident's attending physician and physicians contact information on 12/23/2025. R12's service agreement was updated to include the resident's attending physician and physicians contact information on 12/23/2025. R13's service agreement was updated to include the resident's attending physician and physicians contact information on 12/23/2025. B. All current community residents have the potential to be affected. Resident Care Director or designee completed a community wide audit of current resident service agreements to ensure it included the resident's attending physician and physicians contact information. C. Executive Director re-educated clinical management staff that residents personal attending physician must be identified in the service agreement by name and contact infor-	1/20/2026

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	attending physician, and the physician's contact information. 11/7/25 9:10 AM - E3 (RWD) confirmed the absent signatures from residents or the responsible parties on the service agreements. 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).	mation. To ensure ongoing compliance the Resident Care Director or designee will complete monthly audits for 3 months of current resident service agreements to ensure it includes the resident's attending physician and physicians contact information. D. Results of these audits will be reviewed monthly by the Executive Director for at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate.	
3225.19.0	**Records and Reports**		
3225.19.5	**Incident reports, with adequate documentation, shall be completed for each incident.**		
3225.19.5.1	**All reportable incidents.**		
S/S – E	**This requirement was not met as evidenced by:** Based on record review and interview it was determined that for seven (R2, R3, R7, R8, R12, R13 and R22) out of seventeen residents reviewed for reportable incidents the facility failed to maintain adequate documentation of an investigation for a reportable incident. Findings include: The facility policy on Abuse Prohibition last updated 2018, indicated "Investigate all incidents and injuries incurred by residents. The Administrator/Executive Director or designee will conduct a thorough investigation of reports of alleged resident abuse or neglect...A written report will be completed and submitted to the Administrator within forty-eight hours of the reported incident."	Documentation Provided: Training Sign In sheet; Initial Audit A. Residents R8, R7, & R22 affected, Reportable Incident completed by Resident Wellness Director on 11/5/2025 for resident-to-resident altercation involving R8 and R22 from 7/23/2025 at 6:57p & 9:47p. Reportable Incident completed by Resident Wellness Director on 11/5/2025 for resident-to-resident altercation involving R8 and R7 from 8/27/25. B. Current community residents potentially affected. Community Executive Director and Resident Wellness Director new to community in Octo-	1/20/2026

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	1. 3/6/25 - A resident-to-resident incident was reported to the State Agency involving R2 and R3. 2. 7/23/25 6:57 PM - A progress note in R8's clinical record documented a resident-to-resident altercation involving R8 and R22. 3. 7/23/25 9:47 PM - A progress note in R8's clinical record documented a second resident-to-resident altercation involving R8 and R22. 4. 8/27/26 9:39 PM - A progress note in R8's clinical record documented a resident-to-resident altercation involving R8 and R7. 5. 10/18/25 - A resident-to-resident incident was reported to the State Agency involving R12 and R13. 11/3/25 - The surveyor requested complete incident reports and investigations regarding all reportable incidents dating back to the prior annual survey of December 2024. 11/4/25 3:35 PM - During an interview E3 (RWD) confirmed the facility lacked evidence of documented incident reports and investigations related to the reportable incidents numbered above. 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).	ber & November 2025. Executive Director and Resident Wellness Director completed self-education on regulation 3225.19.5 & 322.19.51. C. Starting 11/9/25 Executive Director or designee will complete audits of resident notes and community incidents daily x4 weeks and then weekly x 8 weeks to ensure that there are documented incident reports and investigations related to reportable incidents. D. Results of these audits will be reviewed by Executive Director weekly for 4 weeks until 100% success for 3 consecutive evaluations; then reviewed monthly by the Executive Director for 3 months at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Documentation Provided: Retraining sign off; Audits	
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.**		

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3225.19.7 **3225.19.7.7** **3225.19.7.7.2** **3225.19.7.7.5** **S/S - D**	**Reportable incidents include:** **Significant Injuries** **Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.** **Medication error or omission which causes or prolongs the resident's discomfort, jeopardizes the resident's health or safety, or requires periodic reassessment of the resident's clinical status by facility professional staff.** Based on record review and interview it was determined that for three (R4, R6, and 10) out of seventeen residents reviewed for reportable incidents the facility failed to ensure fall incidents and medication errors were reported as required. Findings include: 1. 7/9/25 12:50 AM - A facility incident report documented R4 had a fall with injury and was transported to the hospital for evaluation and treatment. Further review of the facility's incident report to the division documented "[R4's] fall with injury was not reported until 12:59 PM more than eleven (11) hours after the fall occurred. R4 was admitted to the hospital with a right hip fracture. 2. 9/16/25 7:30 PM - A facility incident report documented R6 had a fall with a head injury. R6 was transported to the hospital for evaluation and treatment. Further review of the facility's incident report to the	A. Residents R4, R6, and R10 affected. Reportable events reported, however outside required timeframe. B. All current community residents potentially affected. Community staff re-educated that reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the division. C. Starting 11/9/25 Executive Director or designee will complete audits of resident notes and community incidents daily x4 weeks and then weekly x 8 weeks that reportable incidents are reported per regulation 3225.19.6. D. Results of these audits will be reviewed by Executive Director weekly for 4 weeks until 100% success for 3	1/20/2026

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	division documented R6's fall with a head injury was not reported until 9/17/25 at 8:01 AM more than twelve (12) hours after the fall occurred. R6 was admitted to the hospital for shortness of breath. 11/6/25 1:35 PM - During an interview E5 (LPN) confirmed the report had been submitted late. E5 stated, "I think because I forgot about it is why I didn't report it until later on." 11/6/25 3:00 PM - An interview with E3 (RWD) confirmed the facility failed to report the incident and stated, "I was not aware of this as I had not started with the facility until October 2025." 3. 10/2/25 7:30 PM - A facility incident report documented R10 had a fall with injury to the head and right elbow skin tear both were bleeding. R10 was transported to the hospital for evaluation and treatment. Further review of the facility's incident report to the division documented "[R10's] fall with injury was not reported until 7:41 AM twelve hours (12) hours and eleven (11) minutes after the fall occurred. R10 returned to the facility with staples to the head. In, addition the five (5) day follow up report to the division was not submitted until 10/21/25 by E4 (LPN). 11/6/25 3:00 PM - An interview with E3 confirmed the facility failed to report the incident and the five (5) day follow up timely and stated, "Again I was not aware of this I did not start my employment with the facility until October 2025."	consecutive evaluations; then reviewed monthly by the Executive Director for 3 months at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Documentation Provided: Training Sign In Sheet; audits	

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	4. 9/19/25 - The facility failed to report to the state agency [R9's] omitted dose of Novolin 70-30 insulin 100 unit/ml 20 units to be given at 4:00 PM. 11/6/25 3:00 PM - E3 (RWD) confirmed the facility failed to report the incident and stated, "I was not aware this had not been reported, I was not the acting RWD at the time." 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).		
16 Del. Code, Chapter 11, Subchapter II S/S – J	**Rights of Residents§ 1121. Resident's rights. (30) Each resident shall be free from abuse.** **This requirement was not met as evidence by:** This requirement was not met as evidence by: Based on observation, interview and record review it was determined that for two, (R19 and R21) out of seventeen residents housed on the memory care unit the facility failed to provide adequate supervision and reasonable protection from potential physical abuse when the facility permitted two (R8 and R12) residents documented as the aggressors in incidents of resident-to-resident physical abuse to have R19 and R21 as their roommates. On 11/5/25 at 10:15 AM the facility was notified of the identification of an immediate jeopardy (IJ) related to abuse and an immediate jeopardy template was provided to E1 (ED). The IJ was fully abated on 11/5/25 at 5:00 PM. Findings include:	A. Residents R19 & R21 affected. R8 moved to private unit on 10/24/2025. R12 relocated to private unit on 11/5/2025. B. Current Memory Care residents potentially affected. Behavior risk assessments completed by Resident Wellness Director or designee on current residents in memory care. R8 & R12 UAI updated to reflect assaultive behavior and need for private occupancy unit. Community staff re-trained by Resident Wellness Director or designee on incident reporting, incident documentation, and prevention of resident-to-resident abuse.	1/20/2026

Provider's Signature T. Yolla Title Executive Director Date 12/30/2025

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	1. Review of R8's clinical record revealed: 4/14/24 - R8 was admitted to the facility's memory care unit in a double occupancy room with a diagnosis of dementia. 7/23/25 6:57 PM - A progress note in R8's clinical record documented a resident-to-resident altercation involving R8 and R22. The note documented that R8 "grabbed [R22] by the arm and pulled, saying don't you walk away from me!". 7/23/25 9:47 PM - A progress note in R8's clinical record documented a second resident-to-resident altercation involving R8 and R22. The note documented that R8 "proceeded to fling the walker a few feet away. She walked away without the walker and ensured pulling on the other resident's arm". 8/27/26 9:39 PM - A progress note in R8's clinical record documented a resident-to-resident altercation involving R8 and R7. The note documented that R8 "began ramming her rollator into the other resident's feet and yelling at them." 9/17/25 - An incident report submitted to the State Agency documented that R8 "hit R7 during an argument. R8 hit R7 so R7 would stop yelling at her. When the staff tried to separate the two ladies R8 grabbed R7's hand and scratched her." 10/24/25 8:54 PM - A progress note in R8's clinical record documented "[R8] received a roommate [R19] this afternoon... Family spoke with management and decided to change to another room." Movement of R8	C. Resident Wellness Director or Designee will complete audits of resident notes and community incidents daily x4 weeks and then weekly x 8 weeks to ensure that the facility provides adequate supervision and reasonable protection from potential physical abuse. D. Results of these audits will be reviewed by Executive Director weekly for 4 weeks until 100% success for 3 consecutive evaluations; then reviewed monthly by the Executive Director for 3 months at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Documentation Provided: Training sign in Sheet; Audits	

Provider's Signature B. Molla Title Executive Director Date 12/30/2025

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	into a single occupancy room was initiated by R8's family for privacy of R8. 11/4/25 2:27 PM - During an interview E17 (MT) confirmed that R8 was the aggressor during the resident-to-residents incidents of physical abuse on 7/23/25. E17 stated, "It was her and [R22] we had to keep re-directing [R8]." 11/5/25 1:13 PM - During an interview E18 (MT) confirmed that R8 was the aggressor during the resident-to-resident incident of physical abuse on 8/27/25. E18 stated, "The was when [R8] rammed her rollator. She gets frustrated with the [R7] over the walkers." 2. Review of R12's clinical record revealed: 8/7/25 - R12 was admitted to the facility's memory care unit with a diagnosis of dementia. R12 was placed in a double occupancy room with and existing resident R21. 10/7/25 - An incident report submitted to the State Agency documented that R12 "Upon awakening, got up and approached R11 striking the resident in the head three times with an open hand." 10/18/25 - An incident report submitted to the State Agency documented that R12 "was holding and shaking R13's right arm and cussing at R13." 11/4/25 11:02 AM – During a tour of the facility it was observed that R12 continued to be housed in a double occupancy despite being the aggressor in two resident-to-resident incidents of physical abuse. R12 shared a room with R21. R21 is cognitively		

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	impaired and wheelchair bound, vulnerable to physical abuse from R12. 11/4/25 2:27 PM - During an interview E17 (MT) stated, "[R12] sometimes wakes up suddenly and seems like he is going to go at us, but we can redirect him." 11/5/25 10:15 AM - The facility was notified of the identification of an immediate jeopardy related to abuse and an immediate jeopardy template was emailed to E1 (ED). 11/5/25 10:53 AM - E3 (RWD) reported the facility will began to implement remediation measures related to the IJ. Immediate corrective actions included relocation of R8 and R12 to private rooms. Behavior risk assessments to be completed for all memory care residents. Psychiatric Provider evaluations to be completed for R8 and R12. Medication evaluations for R8 and R12. Updating of UAI assessments and care plans for all residents that have exhibited assaultive behavior. Staff education on incident reporting, incident documentation, and prevention of resident-to-resident abuse. 11/5/25 3:36 PM - The surveyor toured the memory care unit and confirmed that R12 had been relocated to a single occupancy room. The following interviews were conducted to confirm receiving education regarding the deficient practice the ability to articulate the contents: 11/5/25 4:01 PM - E4 (LPN). 11/5/25 4:03 PM - E6 (LPN).		

Provider's Signature B Hylla Title Executive Director Date 12/30/2025

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16 Del. Code, Chapter 11, Subchapter III **S/S - D**	11/5/25 4:07 PM - E11 (LPN). 11/5/25 4:10 PM - E12 (RCP) and E13 (RCP). 11/5/25 4:14 PM - E14 (RCP) and E15 (RCP). 11/5/25 4:20 PM - E16 (RCP. 11/5/25 4:20 PM - E1 (ED) and E3 (RWD) provided the facility's written abatement plan. 11/5/25 5:00 PM - E2 (VED) and E3 (RWD) confirmed that the IJ was fully abated with seventy out of seventy-three employees having completed education regarding abuse and implementation of all measures documented in the abatement plan. 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD). **(12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **c. Failure to carry out a prescribed treatment plan for a patient or resident.** **This requirement was not met as evidenced by:** Based on an interview and a review of the clinical record, it was determined that the facility failed to ensure that for one (R9) out of six (6) residents sampled for medication review. R9's insulin was not administered and the physician's order was not carried out as directed. Findings include:	A. Resident R9 affected. R9 is no longer a resident at Dover Place. B. Current community residents with orders for insulin potentially affected. Resident Wellness Director completed audit of previous 30 days EMARS for residents ordered insulin to ensure physicians orders were followed. Community nurses re-	1/20/2026

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	R9's clinical record revealed: 6/25/25 - R9 was admitted to the facility with a diagnosis of diabetes. 6/26/25 - A physician's order for R9 documented "Novolin 70-30 Flex pen 100 unit/ml subcutaneous suspension pen-injector inject twenty (20) units at 4:00 pm for diabetes type II. 9/19/25 - A review of the facility's "Resident Log" for leave of absence from the facility documented "[R9] left the facility at 8:29 AM with FAM1 and returned to the facility at 10:36 AM." 9/19/25 - A review of R9's MAR revealed "[R9] had not received insulin at 4:00 PM. 9/19/25 - A review of a facility provided counselling report for E5 (LPN) titled "HR Communication Form" documented "Resident missed dinner and insulin." 9/19/25 - A review of a facility provided counselling report for E6 (LPN) titled "HR Communication Form" documented "Resident did not receive dinner and insulin." 9/21/25 - A review of a facility provided counselling report for E11 (RCP) titled "HR Communication Form" documented "[E11] knocked on [R9's] door and the resident did not answer and did not enter R9's room based on being told that R9 was out of the facility. 11/7/25 10:06 AM - During an interview E5 reported R9 went out for an appointment that morning and came back early in the	trained by Resident Wellness Director and Executive Director on following prescribers order in reference to insulin as well as protocol to ensure resident is in community to receive medications. C. Effective 11/9/2025 Resident Wellness Director or designee will complete daily audits for 30 days and weekly for 8 weeks to ensure residents prescribed insulin receive insulin per physician orders. D. Results of these audits will be reviewed by Executive Director weekly for 4 weeks until 100% success for 3 consecutive evaluations; then reviewed monthly by the Executive Director for 3 months at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Documentation Provided: Training sheet; Audit	

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	day. E5 stated, "We thought she was still out of the building." 11/7/25 10:39 AM - During an interview E6 reported it was my first day of orientation I was on Med Cart 2 and then I was switched to Med Cart 1 it was an overlook I was not looking at the correct time for the insulin to be administered. E6 stated, "I was given a coaching and now I under-stand how to look at the orders and the timeframe for medications to be given." 11/7/25 11:04 AM - An interview with E7 (Dietary Manager) revealed "[R9] was provided a sandwich and juice to take on an appointment on 9/19/25 and every other Friday per FAM1 request. E7 reported R9 returned to the facility and ate 100% of lunch. E7 then stated, "[E9] was provided a sandwich, soup, fruit and juice around 7:40 PM by the evening E8 (Cook). 11/7/25 11:27 AM - During an interview E8 (Cook) reported "I was told [R9] was out of the building but then someone came back and told me [R9] was in the building. I know that [R9] is a diabetic and needed to eat I made a chicken salad sandwich, soup, a drink and fruit around 7:40 PM. E8 con-firmed "[R9] ate." 11/7/25 11:33 AM - An interview with E4 (LPN) confirmed E5, E6 and E11 had re-ceived counselling/education related to [R9's] insulin not being administered and missing the dinner time meal. 11/7/25 11:50 AM - E3 (RWD) confirmed and stated, "I was not aware of the missed insulin, but I also was not the acting RWD		

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	at the time this happened. E3 then stated, "On 11/6/25 an education was provided to all nurses related to medication administration, missed medications and diabetic medication management." 11/7/25 2:05 PM - During an interview E10 (LPN) reported "I am the nurse that worked that night I do recall being in-formed that [R9] had not had insulin nor dinner but later I was told a meal was pro-vided later after dinner time. R9 had a Dexcom so I checked the blood glucose reading it was around 240 much within the resident's baseline. There were no signs or symptoms of hypoglycemia or hyperglycemia. I told [R9] that I would keep watch through the night and that if needed I would call the physician, [R9] said "I'm ok you don't need to call the doctor." 11/7/25 3:25 PM - Findings were reviewed during the exit conference with E2 (VED) and E3 (RWD).		

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