DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Stockley Center ICF/ID

DATE: SURVEY COMPLETED: December 4, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from December 1, 2025, through December 4, 2025. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-four (34). The survey sample totaled fifteen (15) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**	No deficiencies were identified at the time of the survey; therefore, no additional response is required. All applicable deficiencies and corresponding Plans of Correction were previously identified, implemented, and in effect prior to the survey. This submission is provided to formally document the cross-reference to the Plan of Correction associated with the CMS-2567-L survey completed on December 4, 2025. Corrective actions addressing deficiency tags W122, W148, W149, W153, W154, W156, W194, W249, and W259 are fully detailed within that Plan of Correction. Implementation and ongoing compliance monitoring have been conducted in accordance with the approved corrective measures. The Plan of Correction and supporting documentation remain on file and are available for review by state licensing personnel upon request.	1/18/2026
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference** Cross Refer to the CMS 2567 -L survey completed December 4, 2025: W122, W148, W149, W153, W154, W156, W194, W249 and W259.		
16 Del. Code, Ch.11 Sub-Chapter III	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents .** **§1131 Definitions.**		

Provider's Signature [signature], NHA Title Executive Director Date 12/23/25

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	(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: **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **Based on interview and record review, it was determined for seven (C5, C6, C7, C9, C10, C11 and C12) out of fifteen clients reviewed for resident rights, the facility failed to ensure that clients were free from neglect when care and services were not provided for approximately two or more hours. Findings include:** Review of facility documentation and other facility records revealed the following: 1. 3/3/25 – A facility assignment sheet documented that E12 (CNA) was assigned to Group five clients which included: C5 and C6. 3/3/25 - A facility incident report documented that E12 did not complete incontinence care rounds every two hours for C6 on 3/3/25 from 8:00 AM to 10:00 AM and C5 on 3/3/25 at 12:00 PM to 2:00 PM rounds during the 6:00 AM to 2:00 PM shift. 4/24/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver (E12) on 3/3/25 and revealed that C5 received one out of four completed rounds for incontinence care during the 6:00 AM to 2:00 PM shift.		

Provider's Signature Kari Thurston, NHA Title Executive Director Date 12/23/25

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	4/24/25 – A nursing progress note for C5 documented body checks were completed with no skin breakdown noted. 5/30/25 - A nursing progress note for C6 documented body checks were completed with no skin breakdown noted. 5/30/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver [E12] on 3/3/25 and revealed that C6 received one out of four completed rounds of incontinence care during the 6:00 AM to 2:00 PM shift. Undated - Facility assignment guidelines documented that certified nursing assistants (CNAs) were required to provide toileting or incontinence care at approximately two-hour intervals during assigned shifts for all clients in the facility. This included four expected rounds of care during the 6:00 AM to 2:00 PM shift and four expected rounds during the 10:00 PM to 6:00 AM shift. The aforementioned guideline was provided for each client and is the expectation from all staff to provide incontinence care every two hours for each client in the facility. 2. 3/8/25 - A facility incident report documented that E12 (CNA) did not complete incontinence care rounds every two hours for C11 and C12 on 3/8/25 on the 6:00 AM to 2:00 PM shift. 5/7/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver (E12) on 3/8/25 and revealed that C11 received one out of four completed rounds		

Provider's Signature Kari M Jackson, NHA Title Executive Director Date 12/23/25

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	and C12 received zero out of four rounds of incontinence care during the 6:00 AM to 2:00 PM shift. 5/7/25 - A nursing progress note for C12 documented body checks were completed with no skin breakdown noted. 5/7/25 - A nursing progress note for C11 documented body checks were completed with no skin breakdown noted. 3. 3/9/25 - A facility incident report documented that E12 (CNA) did not complete incontinence care rounds every two hours for C9 and C10 on 3/9/25 on the 6:00 AM to 2:00 PM shift. 5/8/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver (E12) on 3/9/25 and revealed that C9 received one out of four completed rounds and C10 received one out of four rounds for incontinence care during the 6:00 AM to 2:00 PM shift. 5/8/25 - A nursing progress note for C9 documented body checks were completed with no skin breakdown noted. 5/5/25 - A nursing progress note for C10 documented body checks were completed with no skin breakdown noted. 4. 3/23/25 - A facility incident report documented that E12 (CNA) did not complete incontinence care rounds every two hours for C9 and C10 on 3/23/25 during 6:00 AM to 2:00 PM shift.		

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	5/8/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver (E12) on 3/23/25 and revealed that C9 received two out of four completed rounds and C10 received one out of four rounds of incontinence care during the 6:00 AM to 2:00 PM shift. 5/8/25 - A nursing progress note for C9 documented body checks were completed with no skin breakdown noted. 5/8/25 - A nursing progress note for C10 documented body checks were completed with no skin breakdown noted. 5. 3/24/25 - A facility incident report documented that E12 (CNA) did not complete incontinence care rounds every two hours for C9 and C10 on 3/24/25 during the 6:00 AM to 2:00 PM shift. 4/16/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver (E12) on 3/24/25 and revealed that C9 received two out of four completed rounds and C10 received one out of four rounds of incontinence care during the 6:00 AM to 2:00 PM shift. 4/16/25 - A nursing progress note for C9 documented body checks were completed with no skin breakdown noted. 5/8/25 - A nursing progress note for C10 documented body checks were completed with no skin breakdown noted. 6. 3/28/25 - A facility incident report documented that E12 did not complete incontinence care rounds every two hours for C5,		

Provider's Signature [signature] Title Executive Director Date 12/03/25

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	C6, and C7 on 3/28/25 during the 6:00 AM to 2:00 PM shift. 5/15/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver (E12) on 3/28/25 and revealed that C5 received two out of four completed rounds, C6 received one out of four rounds, and C7 received one out of four rounds of incontinence care during the 6:00 AM to 2:00 PM shift. 5/15/25 - A nursing progress note for C5 documented body checks were completed with no skin breakdown noted. 5/15/25 - A nursing progress note for C6 documented body checks were completed with no skin breakdown noted. 5/15/25 - A nursing progress note for C7 documented body checks were completed with no skin breakdown noted. 12/3/25 2:04 PM – During an interview, E2 (DDD) confirmed that E12 did not complete the expected number of rounds for C5, C6, C7, C9, C10, C11 and C12 on the aforementioned dates and stated the video surveillance confirmed incontinence care was not provided. E2 stated E12 was removed from patient care and then terminated on 7/23/25. E2 also stated that clients were not adversely affected by the aforementioned incidents upon assessment by facility staff. 7. 5/21/25 - A facility incident report documented that E3 (former CNA) did not complete incontinence care rounds every two hours for C1, C3 and C4 on 5/20/25 during the 10:00 PM to 6:00 AM shift.		

Provider's Signature [signature], NHA Title Executive Director Date 12/23/25

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	5/27/25 - The facility investigative packet documented that video surveillance was reviewed and determined that assigned caregiver (E3) on 5/21/25 and revealed that C1 received two out of four completed rounds, C3 received one out of four rounds, and C4 received two out of four rounds for incontinence care during the 10:00 PM to 6:00 AM shift. 5/15/25 - A nursing progress note for C1 was documented sent to hospital related to swollen leg on 5/27/25 and unable to complete skin check. 5/27/25 - A nursing progress note for C3 documented body checks were completed with no skin breakdown noted. 5/27/25 - A nursing progress note for C4 documented body checks were completed with no skin breakdown noted. 12/2/25 11:16 AM - An interview with E2 (DDD) confirmed that E3 did not complete the expected number of rounds for C1, C3 and C4 on the aforementioned dates and stated that the video surveillance confirmed incontinence care was not provided. She also revealed that E3 was suspended pending an investigation and they resigned prior to being terminated on 8/19/25. The facility had in-service training and physical return demonstrations with signatures for the trainings that began 4/4/25 and completed 8/17/25. The facility's in-service training documentation included: online, in person and return demonstration trainings that included incontinence care, gait belt, lifts, transfers, abuse, neglect, monitoring for resident safety and culture of care. The facility also relocated key leadership offices		

Provider's Signature [signature] Title Executive Director Date 12/23/25

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	directly to the units, assigned mandatory training to staff in supervisory roles and initiated monthly performance reviews for staff with infractions. Based on the review of the facility's thorough investigation, documented response, completion of in-service training, audits/monitoring, and staff interviews, the incidents related to E12 and E3 were determined to be past non-compliance. The plan of correction was initiated on 4/4/25 and completed on 8/17/25 with continued ongoing monitoring. 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.		

Provider's Signature Kai[illegible] NHA Title Executive Director Date 12/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKLEY CENTER	26351 PATRIOTS WAY GEORGETOWN, DE 19947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from December 1, 2025 through December 4, 2025. The facility census was thirty-four (34) on the first day of the survey. In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
W 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from December 1, 2025 through December 4, 2025. The deficiencies contained in this report were based on observation, interview, review of clients' records and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-four (34). The survey sample totaled fifteen (15) residents. Abbreviations/definitions used in this report are as follows: ADLs - Activities of Daily Living; ADON - Assistant Director of Nursing; CFA - Comprehensive Functional Assessment; CNA - Certified Nursing Assistant; COTA - Certified Occupational Therapy Assistant; DDD - Developmental Disabilities Director; DHCQ - Division of Health Care Quality;	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DocuSigned by: Kai-Stefan Fountain | Executive Director/ Nursing Home Administrator | 12/24/2025 | 11:47 AM EST

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1	W 000		

DON - Director of Nursing;
DRS - Director of Residential Services;
ED - Executive Director;
IAM - Information About Me;
IG - Instructional Guidelines;
IPP - Individual Program Plan;
ISP - Individual Support Plan;
NHA - Nursing Home Administrator;
PA - Program Administrator;
PCP - Person Centered Plan;
PT - Physical Therapy;
QIDP - Qualified Intellectual Disability Professional;
RN - Registered Nurse;
SSA - State Survey Agency;

Abuse - to hurt, injure or damage;
Ceiling Lift - a motorized device that lifts and transfers a person from point to point along an overhead track that is mounted on a ceiling;
Hoyer Lift - sling-type hydraulic lift;
Incontinence - loss of control of bladder &/or bowel function;
Neglect - the failure of a caregiver to meet a dependent person's basic physical and emotional needs, including the need for shelter, food, clothing, medical care, and emotional support;
Profound intellectual disability - condition where individuals are completely dependent on others for all ADLs and to maintain their physical health and safety;
Sling - a fabric or mesh cradle that wraps around a person, used with a mechanical lift, to safely transfer individuals between surfaces;
Stand and Pivot Transfer - to move from a seated position (like a wheelchair) to another surface (like a bed) by standing up, pivoting (turning on their feet), and then sitting down on the new spot, using their own strength with some caregiver help

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Executive Director/ Nursing Home Administrator 12/24/2025 | 11:47 AM EST

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W 000	Continued From page 2 for balance and guidance.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on record review, review of the facility's investigations, interview, and policy review, the facility failed to ensure three (C1, C3, and C4) out of 15 clients reviewed were not neglected by staff when they were not checked on every two hours as required. The three clients were not checked on throughout the night by staff. This had the potential to cause unmet care needs. Findings include: 1.The facility failed to ensure family members were notified when C1, C3, and C4 were neglected to be checked on every two hours as required. (Refer to W148). 2. The facility failed to implement their policies and procedures when C1, C3, and C4 were neglected to be checked on every two hours as required by staff. (Refer to W149) 3. The facility failed to immediately report allegations of neglect when a staff member neglected to check on C1, C3, and C4 during an entire night shift. (Refer to W153) 4. The facility failed to ensure allegations of neglect were investigated thoroughly for C1, C3, and C4 when it was discovered a staff member failed to check on the clients throughout an entire night shift. (Refer to W153)	W 122	Individual/Resident Impacted-Corrective Action Taken: The identified past practices are not subject to retroactive correction. Upon identification of incidents in which family/ guardian notification was not completed within the required 24-hour timeframe, the Executive Director and the DD Director of Habilitation Services implemented immediate corrective actions. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed and implemented. Beginning that date, education was reviewed with the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Training emphasized the requirement to notify families/ guardians of any significant incident or change in condition as soon as possible, but no later than 24 hours; acceptable methods of communication, including direct phone contact, voicemail requesting a return call, and email communication requiring confirmation of receipt; and comprehensive documentation standards. Staff were instructed to document the date and time of the incident, each contact attempt, the method of communication used, confirmation of receipt when applicable, and efforts to contact alternate emergency contacts when the primary guardian could not be reached. Clear accountability for timely notification and accurate documentation was assigned to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and applicable administrative personnel. Education will continue until 100% of applicable staff have completed training and competency has been verified. On December 4, 2025, the Standards Control Specialist completed a comprehensive review of all incident reports from the previous year to verify that families/legal guardians were notified as soon as possible and no later than 24 hours following each significant incident, and that required follow-up correspondence was completed in accordance with facility policy. Any identified gaps were addressed immediately by the DD Director of Habilitation Services.	01/18/2026

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Executive Director/ Nursing Home Administrator
12/24/2025 | 11:47 AM EST

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		W 122	Additional identified past practices related to incident reporting are also not subject to retroactive correction. Certain incidents were initially identified through the review of surveillance footage during an ongoing investigation and were reported via email correspondence as part of a combined investigation. The facility was subsequently advised by the State Survey Agency (SSA) that each incident represented a distinct incident type and was required to be entered separately into the reporting system. Upon receipt of this clarification, the incidents were entered individually into the reporting system on the next business day. Further, reporting errors occurred during the implementation of a new incident reporting system introduced by DHCQ, for which the facility did not receive sufficient instruction or guidance to ensure full regulatory compliance. The issue was identified several months after system implementation, at which time the facility conducted a root cause analysis and implemented corrective actions to address contributing factors and prevent recurrence. Additionally, delays in the completion of certain incident investigations resulted from directives issued by law enforcement requesting that the facility refrain from interviewing the alleged perpetrator in order to avoid interference with potential criminal investigations. The facility complied with these directives in good faith and in cooperation with law enforcement authorities, which resulted in investigations exceeding the five-working-day internal review timeframe. Identification of other residents with the potential to be affected: The identified past practices are not subject to retroactive correction. Upon identification of incidents in which family/guardian notification was not completed within the required 24-hour timeframe, the Executive Director and the DD Director of Habilitation Services implemented immediate corrective actions. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed and implemented. Beginning that date, education was reviewed with the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management.	

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		W 122	Training emphasized the requirement to notify families/ guardians of any significant incident or change in condition as soon as possible, but no later than 24 hours; acceptable methods of communication, including direct phone contact, voicemail requesting a return call, and email communication requiring confirmation of receipt; and comprehensive documentation standards. Staff were instructed to document the date and time of the incident, each contact attempt, the method of communication used, confirmation of receipt when applicable, and efforts to contact alternate emergency contacts when the primary guardian could not be reached. Clear accountability for timely notification and accurate documentation was assigned to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and applicable administrative personnel. Education will continue until 100% of applicable staff have completed training and competency has been verified. On December 4, 2025, the Standards Control Specialist completed a comprehensive review of all incident reports from the previous year to verify that families/legal guardians were notified as soon as possible and no later than 24 hours following each significant incident, and that required follow-up correspondence was completed in accordance with facility policy. Any identified gaps were addressed immediately by the DD Director of Habilitation Services. Additional identified past practices related to incident reporting are also not subject to retroactive correction. Certain incidents were initially identified through the review of surveillance footage during an ongoing investigation and were reported via email correspondence as part of a combined investigation. The facility was subsequently advised by the State Survey Agency (SSA) that each incident represented a distinct incident type and was required to be entered separately into the reporting system. Upon receipt of this clarification, the incidents were entered individually into the reporting system on the next business day. Further, reporting errors occurred during the implementation of a new incident reporting system introduced by DHCQ, for which the facility did not receive sufficient instruction or guidance to ensure full regulatory compliance. The issue was identified several months after system implementation, at which time the facility conducted a root cause analysis and implemented corrective actions	

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		W 122	to address contributing factors and prevent recurrence. Additionally, delays in the completion of certain incident investigations resulted from directives issued by law enforcement requesting that the facility refrain from interviewing the alleged perpetrator in order to avoid interference with potential criminal investigations. The facility complied with these directives in good faith and in cooperation with law enforcement authorities, which resulted in investigations exceeding the five-working-day internal review timeframe. System Changes-Investigative Processes: The root cause of the identified deficiency was a combination of procedural gaps and staff knowledge deficits related to incident reporting, family/guardian notification, documentation, and investigative timelines. Specifically, the facility lacked standardized training and clearly defined procedures to ensure staff consistently understood and complied with regulatory requirements, including the 24-hour family/guardian notification rule, appropriate reporting of distinct incident types, acceptable methods of communication, and required documentation standards. Additionally, the implementation of a new incident reporting system without sufficient instruction or guidance contributed to reporting errors and delayed compliance. Further contributing factors included reliance on combined incident reporting practices and necessary coordination with law enforcement, which at times impacted the facility's ability to complete internal investigations within prescribed timeframes. Collectively, these factors resulted in inconsistent application of regulatory requirements, demonstrating the need for enhanced staff education, clarified policies and procedures, and strengthened oversight to ensure sustained compliance. To prevent recurrence and ensure ongoing regulatory compliance, the facility will institute revised investigative practices effective immediately. The facility will update its Incident Reporting Policy to reflect these systemic changes, including clarified investigative timelines, communication requirements, and reporting requirements. Policy revisions will be communicated to all applicable staff to ensure	

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		W 122	consistent implementation and sustained compliance. Success Evaluation-Ongoing Monitoring: The Standards Control Specialist (SCS) will conduct a comprehensive review of incidents immediately (within the next business day) following the closure of all investigations. To determine if past practices followed regulatory requirements, the Standards Control Specialist (SCS) will complete the following: • The SCS will complete a random sampling of three residents' investigative files a week for two weeks for 100% compliance, THEN • The SCS will complete a random sampling of three residents' investigative files every two weeks for one month for 100% compliance. THEN • The SCS will complete a random sampling of three residents' investigative files a month for two months for 100% compliance, THEN • The SCS will complete a comprehensive review of all residents' investigative files for 100% compliance thereafter. A monthly review meeting with the facility's Standards Control Specialist (SCS) and PM46 Coordinator will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification is communicated. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	

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Kai-Stefan Fountain
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Executive Director/ Nursing Home Administrator

12/24/2025 | 11:47 AM EST

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 12/04/2025

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W 122	Continued From page 3 5. The facility failed to ensure the results of an investigation regarding neglect of C1, C3, and C4 were reported within five days. (Refer to W156) 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 122		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interviews, record review, and policy review the facility failed to timely notify the family of an incident of neglect for three (C1, C3 and C4) out of 15 clients reviewed for abuse/neglect. This had the potential for the clients to remain in potential unsafe environment. (Cross Reference W149) Findings include: 1. Review of a document provided by the facility titled "Face Sheet" indicated C1 was admitted to the facility on 10/27/05 with diagnoses of profound developmental/intellectual disabilities. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect (lack of incontinent care) which involved E3 (CNA) against C1 was identified on 05/23/25	W 148	Identification of other residents with the potential to be affected: The identified past practice is not subject to retroactive correction. Upon identification of an incident in which family/guardian notification was not completed within the required 24-hour timeframe, the Executive Director and DD Director of Habilitation Services implemented immediate corrective measures. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed to be distributed to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Beginning that date, the education was reviewed with the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Training emphasized the requirement to notify families/guardians of any significant incident or change in condition as soon as possible, but no later than 24 hours, the acceptable modes of communication (direct phone contact, voicemail requesting a call-back, or email requiring confirmation), and thorough documentation requirements. Staff were instructed to document the date and time of the incident, each contact attempt, the method used, confirmation of receipt when applicable, and attempts to contact alternate emergency contacts when the primary guardian could not be reached. Responsibilities for ensuring timely notification and accurate documentation were clearly assigned to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Education will continue until 100% of applicable staff have been trained and competency verified.	01/18/2026

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RESPONSE Page 8 of 36

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 148	Continued From page 4 to C1. Per the investigative report the actual date of the lack of care occurred on 05/21/25 between the hours of I2:00 AM and 5:16 AM, per video surveillance. The investigation indicated the family member of C1 was not notified of an allegation of neglect until 05/28/25. 2. Review of a document provided by the facility titled "Face Sheet" indicated C3 was admitted to the facility on 08/28/68 with diagnoses of profound development/intellectual disabilities. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect (lack of incontinent care) which involved E3 was on 05/23/25 to C1. Per the investigative report the actual dated of the lack of care occurred on 05/21/25 between the hours of I2:14 AM and 5:32 AM, per video surveillance. The investigation indicated that the family member of C3 was not notified of an allegation of neglect until 05/28/25. 3. Review of a document provided by the facility titled "Face Sheet" indicated C4 was admitted to the facility on 06/27/12 with diagnoses of profound developmental/intellectual disabilities. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect (lack of incontinent care) which involved E3 was on 05/23/25 between the hours of 11:36 PM and 5:21 AM, per video surveillance. The investigation indicated that the family member of C4 was not notified of an allegation of neglect until 05/28/25.	W 148	On 12/04/2025, the Standards Control Specialist completed a comprehensive review of all incident reports from the previous year to verify whether family/legal guardians were notified as soon as possible and no later than 24 hours following each significant incident. The review also confirmed whether appropriate follow-up letters were issued in accordance with facility policy. Any identified gaps were addressed immediately by the DD Director of Habilitation Services. Identification of other residents with the potential to be affected: The identified past practice is not subject to retroactive correction. Upon identification of an incident in which family/guardian notification was not completed within the required 24-hour timeframe, the Executive Director and DD Director of Habilitation Services implemented immediate corrective measures. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed to be distributed to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Beginning that date, the education was reviewed with the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Training emphasized the requirement to notify families/guardians of any significant incident or change in condition as soon as possible, but no later than 24 hours, the acceptable modes of communication (direct phone contact, voicemail requesting a call-back, or email requiring confirmation), and thorough documentation requirements. Staff were instructed to document the date and time of the incident, each contact attempt, the method used, confirmation of receipt when applicable, and attempts to contact alternate emergency contacts when the primary guardian could not be reached. Responsibilities for ensuring timely notification and accurate documentation were clearly assigned to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Education will continue until 100% of applicable staff have been trained and competency verified.	

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		W 148	On 12/04/2025, the Standards Control Specialist completed a comprehensive review of all incident reports from the previous year to verify whether family/legal guardians were notified as soon as possible and no later than 24 hours following each significant incident. The review also confirmed whether appropriate follow-up letters were issued in accordance with facility policy. Any identified gaps were addressed immediately by the DD Director of Habilitation Services. System Changes-Investigative Processes: The root cause of the identified deficiency was a combination of procedural and knowledge gaps related to family/guardian notification. The facility's past practice of failing to notify families/guardians within the required 24-hour timeframe resulted from insufficient staff understanding of the regulatory requirement, acceptable communication methods, and documentation expectations. At the time of the incident, staff had not received formal, standardized training on timely family/guardian notifications, which contributed to incomplete compliance with the 24-hour notification rule. Collectively, these factors indicated a need for enhanced staff education, clearly defined procedures, and standardized documentation requirements to ensure consistent compliance with incident reporting and notification regulations. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed to be distributed and reviewed with the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Training emphasized the requirement to notify families/guardians of any significant incident or change in condition as soon as possible, but no later than 24 hours, the acceptable modes of communication (direct phone contact, voicemail requesting a call-back, or email requiring confirmation), and thorough documentation requirements. Staff were instructed to document the date and time of the incident, each contact attempt, the method used, confirmation of receipt when applicable, and attempts to contact alternate emergency contacts when the primary	

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		W 148	guardian could not be reached. Responsibilities for ensuring timely notification and accurate documentation were clearly assigned to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Education will continue until 100% of applicable staff have been trained and competency verified. To prevent recurrence and ensure ongoing regulatory compliance, the facility will institute revised investigative practices effective immediately. The facility will update its Incident Reporting Policy to reflect these systemic changes, including clarified investigative timelines, communication requirements, and reporting requirements. Policy revisions will be communicated to all applicable staff to ensure consistent implementation and sustained compliance. Success Evaluation-Ongoing Monitoring: The Standards Control Specialist (SCS) will conduct a comprehensive review of incidents immediately (within the next business day) following the closure of all investigations. To determine if past practices followed regulatory requirements, the Standards Control Specialist (SCS) will complete the following: • The SCS will complete a random sampling of three residents' investigative files a week for two weeks for 100% compliance, THEN • The SCS will complete a random sampling of three residents' investigative files every two weeks for one month for 100% compliance. THEN • The SCS will complete a random sampling of three residents' investigative files a month for two months for 100% compliance, THEN • The SCS will complete a comprehensive review of all residents' investigative files for 100% compliance thereafter. A monthly review meeting with the facility's Standards Control Specialist (SCS) and PM46 Coordinator will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification is communicated. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	

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W 148	Continued From page 5 During an interview on 12/04/25 at 8:32 AM, E2 (DDD) confirmed C1, C3, and C4 family were not notified of the allegation of neglect since the facility reports only on business days and the day before they actually notified the families was a holiday and not a business day. Review of a facility policy titled "Reporting and Investigation . . . (Abuse, Neglect, Mistreatment, Review of a facility policy titled "Reporting and Investigation Procedure For. . . (Abuse, Neglect, Mistreatment. . .and Injuries of Unknown Source" dated 05/10/23 indicated ". . . Immediately (within 2 hours) . . . Calls and notifies the family or Guardian(s) if the RN or Psychiatric Social Worker II is unavailable. . . After Hours Family Guardian Contacts. (A) Determines with the nurse in charge, who will attempt to make initial contact with the family/guardian/surrogate decision maker and ensures the contact is made immediately (within 2 hours) . . . " 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 148		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to implement their abuse/neglect prevention policy to protect three (C1, C3 and C4) out of of 15 sampled clients from abuse/neglect. This failure had the potential to delay implementation of corrective measures	W 149	Individual/Resident Impacted-Corrective Action Taken: The identified past practice is not subject to retroactive correction. The incidents were discovered during the review of surveillance footage as part of an ongoing investigation. At the time, the facility reported the incidents via email correspondence and combined them with the existing investigation. The facility later learned from the State Survey Agency (SSA) that each incident must be entered separately into the reporting system, as they represented distinct incident types. The incidents were entered into the reporting system on the next business day following this clarification.	01/18/2026

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W 149	Continued From page 6 recommended in the investigations. Findings include: 1. Review of a document provided by the facility titled "Face Sheet" indicated C1 was admitted to the facility on 10/27/2005. 2. Review of a document provided by the facility titled "Face Sheet" indicated C3 was admitted to the facility on 08/28/1968. 3. Review of a document provided by the facility titled "Face Sheet" indicated C4 was admitted to the facility on 06/27/2012. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect (lack of incontinent care and the lack of checking on clients every two hours) which involved E3 (CNA) and C1, C3 and C4 was on 05/23/25. The facility's investigation revealed that the families of each client were not notified of the allegation of neglect until 05/28/25, five days later. The investigative report included that the facility initially notified the State Survey Agency (SSA) on 05/27/25 which was five days after the date of discovery of 05/23/25 of the allegation of neglect by E3. In addition, there was no evidence that the facility's E1 (NHA) was provided with a summary of the facility's investigation within five days after the allegation was formulated. Included in the investigation file was an email from E2 (DDD) dated 05/23/25 that revealed that the Administrator (E1) was provided with an initial report of the allegations of abuse/neglect of the three clients.	W149	Upon identification of an incident in which family/ guardian notification was not completed within the required 24-hour timeframe, the Executive Director and DD Director of Habilitation Services implemented immediate corrective measures. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed to be distributed to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Beginning that date, the education was reviewed with the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Training emphasized the requirement to notify families/guardians of any significant incident or change in condition as soon as possible, but no later than 24 hours, the acceptable modes of communication (direct phone contact, voicemail requesting a call-back, or email requiring confirmation), and thorough documentation requirements. Staff were instructed to document the date and time of the incident, each contact attempt, the method used, confirmation of receipt when applicable, and attempts to contact alternate emergency contacts when the primary guardian could not be reached. Responsibilities for ensuring timely notification and accurate documentation were clearly assigned to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Education will continue until 100% of applicable staff have been trained and competency verified. On 12/04/2025, the Standards Control Specialist completed a comprehensive review of all incident reports from the previous year to verify whether family/legal guardians were notified as soon as possible and no later than 24 hours following each significant incident. The review also confirmed whether appropriate follow-up letters were issued in accordance with facility policy. Any identified gaps were addressed immediately by the DD Director of Habilitation Services.	

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		W149	Identification of other residents with the potential to be affected: The identified past practice is not subject to retroactive correction. The incidents were discovered during the review of surveillance footage as part of an ongoing investigation. At the time, the facility reported the incidents via email correspondence and combined them with the existing investigation. The facility later learned from the State Survey Agency (SSA) that each incident must be entered separately into the reporting system, as they represented distinct incident types. The incidents were entered into the reporting system on the next business day following this clarification. Upon identification of an incident in which family/guardian notification was not completed within the required 24-hour timeframe, the Executive Director and DD Director of Habilitation Services implemented immediate corrective measures. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed to be distributed to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. On 12/04/2025, the Standards Control Specialist completed a comprehensive review of all incident reports from the previous year to verify whether family/legal guardians were notified as soon as possible and no later than 24 hours following each significant incident. The review also confirmed whether appropriate follow-up letters were issued in accordance with facility policy. Any identified gaps were addressed immediately by the DD Director of Habilitation Services. System Changes-Investigative Processes: The root cause of the identified deficiency was a combination of procedural and knowledge gaps related to incident reporting and family/guardian notification. The facility's past practice of combining multiple incidents into a single report occurred because staff were not fully aware that each incident type must be entered separately into the reporting system, as clarified later by the State Survey Agency (SSA). This procedural gap delayed accurate reporting.	

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		W149	Additionally, the failure to notify families/guardians within the required 24-hour timeframe resulted from insufficient staff understanding of the regulatory requirement, acceptable communication methods, and documentation expectations. At the time of the incident, staff had not received formal, standardized training on timely family/guardian notifications, which contributed to incomplete compliance with the 24-hour notification rule. Collectively, these factors reflect a need for improved staff education, clear procedural guidance, and formal documentation requirements to ensure consistent compliance with incident reporting and notification regulations. On December 4, 2025, an educational flyer titled "Timely Family/Guardian Notification Requirements – 24-Hour Rule" was developed to be distributed and reviewed with the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Training emphasized the requirement to notify families/guardians of any significant incident or change in condition as soon as possible, but no later than 24 hours, the acceptable modes of communication (direct phone contact, voicemail requesting a call-back, or email requiring confirmation), and thorough documentation requirements. Staff were instructed to document the date and time of the incident, each contact attempt, the method used, confirmation of receipt when applicable, and attempts to contact alternate emergency contacts when the primary guardian could not be reached. Responsibilities for ensuring timely notification and accurate documentation were clearly assigned to the Case Manager II, Facility Charge, Nurse Charge, Certified Investigators, and administrative personnel involved in incident management. Education will continue until 100% of applicable staff have been trained and competency verified. To prevent recurrence and ensure ongoing regulatory compliance, the facility will institute revised investigative practices effective immediately. The facility will update its Incident Reporting Policy to reflect these systemic changes, including clarified investigative timelines, communication requirements, and reporting requirements. Policy revisions will be communicated to all applicable staff to ensure consistent implementation and sustained compliance.	

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W 149	Continued From page 7 During an interview on 12/02/25 at 1:58 PM E2 stated he/she was unable to resolve the lack of an investigative summary to be provided with the Administrator (E1). E2 stated that the facility was required to do a five-day update according to the Delaware stated code PM46 and was aware of the federal requirement to submit a five-day summary to the facility's Administrator. E2 stated the SSA was notified by an email dated 05/23/25 and stated there has been some confusion with the on-line facility reporting line. During an interview on 12/04/25 at 8:32 AM, E2 confirmed the families of C1, C3 and C4 were notified on 05/28/25 instead of 05/23/25. Review of a facility policy titled "Reporting and Investigation . . . (Abuse, Neglect, Mistreatment, Review of a facility policy titled "Reporting and Investigation Procedure For. . . (Abuse, Neglect, Mistreatment. . .and Injuries of Unknown Source" dated 05/10/23 indicated ". . . To establish a process for reporting, investigating, and taking administrative action . . .cases for alleged or suspected abuse, neglect, with known or potential negative impact, mistreatment, financial exploitation, medication diversion and significant injury and injuries of unknown source to residents of [name of facility] . . ." 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 149	Success Evaluation-Ongoing Monitoring: The Standards Control Specialist (SCS) will conduct a comprehensive review of incidents immediately (within the next business day) following the closure of all investigations. To determine if past practices followed regulatory requirements, the Standards Control Specialist (SCS) will complete the following: • The SCS will complete a random sampling of three residents' investigative files a week for two weeks for 100% compliance, THEN • The SCS will complete a random sampling of three residents' investigative files every two weeks for one month for 100% compliance. THEN • The SCS will complete a random sampling of three residents' investigative files a month for two months for 100% compliance, THEN • The SCS will complete a comprehensive review of all residents' investigative files for 100% compliance thereafter. A monthly review meeting with the facility's Standards Control Specialist (SCS) and PM46 Coordinator will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification is communicated. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as	W 153	Individual/Resident Impacted-Corrective Action Taken: The identified past practice is not subject to retroactive correction. The incidents were discovered during the review of surveillance footage as part of an ongoing investigation.	01/18/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 8 injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review, interview, and policy review the facility failed to ensure an allegation of neglect was reported immediately to the State Survey Agency (SSA) for three (C1, C3 and C4) out of 15 sampled clients who were reviewed for abuse/neglect. This failure had the potential for continued emotional and physical distress of clients who reside in the facility. (Cross Reference W149). Findings include: 1. Review of a document provided by the facility titled "Face Sheet" indicated C1 was admitted to the facility on 10/27/05. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect which involved E3 (CNA) against C1 was identified on 05/23/25 in which was discovered that E3 had not provided incontinent care to C1 on 05/21/25 between the hours of 12:00 AM and 5:16 AM, per video surveillance. Included in the facility's investigative file was a checklist and this checklist indicated the SSA was not notified of the allegation of neglect until 05/27/25. 2. Review of a document provided by the facility titled "Face Sheet" indicated C3 was admitted to the facility on 08/28/68 with diagnoses of profound development/intellectual disabilities. Review of a document provided by the facility	W 153	At the time, the facility reported the incidents via email correspondence and combined them with the existing investigation. The facility later learned from the State Survey Agency (SSA) that each incident must be entered separately into the reporting system, as they represented distinct incident types. The incidents were entered into the reporting system on the next business day following this clarification. Identification of other residents with the potential to be affected- The identified past practice is not subject to retroactive correction. The incidents were discovered during the review of surveillance footage as part of an ongoing investigation. At the time, the facility reported the incidents via email correspondence and combined them with the existing investigation. The facility later learned from the State Survey Agency (SSA) that each incident must be entered separately into the reporting system, as they represented distinct incident types. The incidents were entered into the reporting system on the next business day following this clarification. System Changes-Investigative Processes: The root cause of the identified deficiency was the implementation of DHCQ's new incident reporting system without adequate instruction or guidance provided to the facility to ensure a full understanding of regulatory requirements and internal investigation timelines. This lack of clear direction resulted in inconsistent application of reporting and investigation procedures. To prevent recurrence and ensure ongoing regulatory compliance, the facility will institute revised investigative practices effective immediately. The facility will update its Incident Reporting Policy to reflect these systemic changes, including clarified investigative timelines, communication requirements, and reporting requirements. Policy revisions will be communicated to all applicable staff to ensure consistent implementation and sustained compliance.	

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Kai-Stefan Fountain Executive Director/ Nursing Home Administrator 12/24/2025 | 11:47 AM EST
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 12/04/2025

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W 153	Continued From page 9 titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect which involved E3 was on 05/23/25 in which was discovered E3 had not provided incontinent care to C3 on 05/21/25 between the hours of 12:14 AM and 5:32 AM, per video surveillance. Included in the facility's investigative file was a checklist and this checklist indicated the SSA was not notified of the allegation of neglect until 05/27/25. 3. Review of a document provided by the facility titled "Face Sheet" indicated C4 was admitted to the facility on 06/27/12 with diagnoses of profound developmental/intellectual disabilities. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect which involved E3 was on 05/23/25 in which was discovered not to have provided incontinent care to C4 on 05/21/25 between the hours of 11:36 PM and 5:21 AM, per video surveillance. The investigation indicated that the family member of C4 was not notified of an allegation of neglect until 05/28/25. Included in the facility's investigation file was a checklist and this checklist indicated the SSA was not notified of an allegation of neglect until 05/27/25. During an interview on 12/02/25 at 1:58 PM, the Development Disabilities Director of Habilitation Services/Employee (E) 2 stated the facility notified the SSA by telephone and by fax. Review of a facility policy titled "Reporting and Investigation . . . (Abuse, Neglect, Mistreatment, Review of a facility policy titled "Reporting and Investigation Procedure For. . . (Abuse, Neglect, Mistreatment. . .and Injuries of Unknown Source"	W 153	Success Evaluation-Ongoing Monitoring: The Standards Control Specialist (SCS) will conduct a comprehensive review of incidents immediately (within the next business day) following the closure of all investigations. To determine if past practices followed regulatory requirements, the Standards Control Specialist (SCS) will complete the following: • The SCS will complete a random sampling of three residents' investigative files a week for two weeks for 100% compliance, THEN • The SCS will complete a random sampling of three residents' investigative files every two weeks for one month for 100% compliance. THEN • The SCS will complete a random sampling of three residents' investigative files a month for two months for 100% compliance, THEN • The SCS will complete a comprehensive review of all residents' investigative files for 100% compliance thereafter. A monthly review meeting with the facility's Standards Control Specialist (SCS) and PM46 Coordinator will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification is communicated. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	

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W 153	Continued From page 10 dated 05/10/23 indicated ". . . Immediately (within 2 hours) reports the incident to the Division of Health Care Quality (DHCQ)/Division of Long-Term Care Residents Protection) by calling the 24-hour toll free hotline number at l-877-453-0012. AND Reporting can be accomplished through the Executive Director/Designee or Facility Charge to DHCQ via the hotline number and email. . ." The facility's policy failed to address that all abuse/neglect allegations were to be reported by a website portal provided by the SSA. 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review, policy review, and interviews, the facility failed to ensure a thorough and complete investigation on neglect for three (C1, C3 and C4) out of 15 sampled clients reviewed for abuse and neglect. This failure increased the risk of verbal and/or physical abuse for all clients. Findings include: 1. Review of a document provided by the facility titled "Face Sheet" indicated C1 was admitted to the facility on 10/27/2005. Review of a document provided by the facility titled "Investigative Report of Findings" dated	W 154	Individual/Resident Impacted-Corrective Action Taken: The identified past practice is not subject to retroactive correction. The incidents were identified during the investigation of a separate incident involving the same alleged perpetrator, at which time law enforcement issued a directive requesting that the facility refrain from interviewing the alleged perpetrator so as not to interfere with a potential criminal investigation. The facility complied with this directive, which resulted in internal investigations exceeding the five working days permitted for completion. These actions were taken in good faith and in cooperation with law enforcement authorities. Prior to law enforcement granting clearance to conduct an interview, the alleged perpetrator voluntarily resigned. Following the resignation, the facility investigator made documented attempts to contact the former employee to obtain a verbal and/or written statement; however, no response was received. The investigation was subsequently closed based on available evidence, including review of surveillance footage, which substantiated staff noncompliance with facility protocol related to the investigative matter.	01/18/2026

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W 154	Continued From page 11 10/21/25 indicated the date of discovery of neglect which involved E3 (CNA) against C1 was identified on 05/23/25 in which was discovered E3 had not provided incontinent care to C1 on between the hours of 12:00 AM and 5:16 AM on 05/21/25 per video surveillance. The investigation failed to contain evidence that E3 was interviewed as part of the facility's investigation. 2. Review of a document provided by the facility titled "Face Sheet" indicated C3 was admitted to the facility on 08/28/1968 with diagnoses of profound development/intellectual disabilities. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect which involved E3 was on 05/23/25 in which E3 was discovered between the hours of 12:14 AM and 5:32 AM not to have provided incontinent care to C3 on 05/21/25, per video surveillance. The investigation failed to contain evidence that E3 was interviewed as part of the facility's investigation. 3. Review of a document provided by the facility titled "Face Sheet" indicated C4 was admitted to the facility on 06/27/12. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect which involved E3 was on 05/23/25 in which E3 was discovered not to have provided incontinent between the hours of 11:36 PM and 5:21 AM, on 05/21/25 per video surveillance. The investigation failed to contain evidence that E3 was interviewed as part of the facility's investigation.	W 154	Identification of other residents with the potential to be affected- The identified past practice is not subject to retroactive correction. The incidents were identified during the investigation of a separate incident involving the same alleged perpetrator, at which time law enforcement issued a directive requesting that the facility refrain from interviewing the alleged perpetrator so as not to interfere with a potential criminal investigation. The facility complied with this directive, which resulted in internal investigations exceeding the five working days permitted for completion. These actions were taken in good faith and in cooperation with law enforcement authorities. Prior to law enforcement granting clearance to conduct an interview, the alleged perpetrator voluntarily resigned. Following the resignation, the facility investigator made documented attempts to contact the former employee to obtain a verbal and/or written statement; however, no response was received. The investigation was subsequently closed based on available evidence, including review of surveillance footage, which substantiated staff noncompliance with facility protocol related to the investigative matter. System Changes-Investigative Processes: The root cause of the identified deficiency was the facility's inability to complete internal incident investigations within the required timeframe due to compliance with law enforcement directives instructing the facility to refrain from interviewing the alleged perpetrator during an active criminal investigation. This restriction limited the facility's ability to obtain all investigative statements promptly. A contributing factor was the resignation of the alleged perpetrator prior to law enforcement clearance to conduct an interview, which further prevented the collection of a verbal or written statement. Although the facility made documented attempts to contact the former employee, no response was received. As a result, the investigation relied on alternative evidence, including surveillance footage, which substantiated staff noncompliance with facility protocols.	

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		W 154	To prevent recurrence and ensure ongoing regulatory compliance, the facility will exercise due diligence to ensure investigations are completed within the five working-day regulatory timeframe based on the evidence available at the time of review. Investigations will be formally closed within the required period, even when external investigative limitations exist. The alleged perpetrator will remain removed from all resident care responsibilities until final clearance is obtained from law enforcement and both verbal and written statements have been collected as part of the investigation. If additional information or evidence becomes available following the conclusion of an investigation, the facility will submit a comprehensive supplemental report to the appropriate regulatory licensing and reporting agency. The facility will also update its investigative processes and Incident Reporting Policy to reflect these procedural changes and ensure consistent compliance moving forward. Success Evaluation-Ongoing Monitoring: The Standards Control Specialist (SCS) will conduct a comprehensive review of incidents immediately (within the next business day) following the closure of all investigations. To determine if past practices followed regulatory requirements, the Standards Control Specialist (SCS) will complete the following: • The SCS will complete a random sampling of three residents' investigative files a week for two weeks for 100% compliance, THEN • The SCS will complete a random sampling of three residents' investigative files every two weeks for one month for 100% compliance. THEN • The SCS will complete a random sampling of three residents' Investigative files a month for two months for 100% compliance, THEN • The SCS will complete a comprehensive review of all residents' investigative files for 100% compliance thereafter. A monthly review meeting with the facility's Standards Control Specialist (SCS) and PM46 Coordinator will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification is communicated.	

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W 154	Continued From page 12 During an interview on 12/03/25 at 3:26 AM, Certified Nurse Aide/E3 stated he/she was unaware of the allegations of not providing C1, C3 and C4 with incontinent care. E3 stated the facility never asked him/her for a written statement or for an interview. During an interview on 12/03/25 at 12:49 PM, E2 (DDD) stated he/she was instructed by the local police department not to interview E3 since it was considered an obstruction of law. Review of a facility policy titled Reporting and Investigation Procedure For. . . (Abuse, Neglect, Mistreatment. Financial Exploitation. . .Medication Diversion. and Significant Injury) and Injuries of Unknown Source" dated 05/10/23 indicated ". . . Collects written and verbal statements from all appropriate staff and any physical evidence. . ." 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 154	All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the results of an investigation of neglect which involved three of three clients (C1, C3 and C4) out of a sample of 15 reviewed for abuse and neglect were reported to the Facility	W 156	Individual/Resident Impacted-Corrective Action Taken: The identified past practice is not subject to retroactive correction. The error occurred as a result of DHCQ implementing a new incident reporting system, for which the facility was not provided with adequate instruction or guidance to ensure a full understanding and regulatory compliance. The issue was identified several months after implementation, at which time the facility conducted a root cause analysis to identify contributing factors and implement corrective actions. Additionally, delays in the completion of several incident investigations occurred due to directives from law enforcement requesting that the facility refrain from interviewing the alleged perpetrator so as not to interfere with potential criminal investigations. The facility complied with these directives, which resulted in investigations exceeding the five working days	01/18/2026

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W 156	Continued From page 13 Administrator within five working days. This failure had the potential to delay implementation of corrective measures recommended in each investigation. (Cross Reference W149). Findings include: 1. Review of a document provided by the facility titled "Face Sheet" indicated C1 was admitted to the facility on 10/27/05. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect which involved E3 (CNA) against C1 was identified on 05/23/25 in which E3 was discovered not to have provided incontinent care to C1 on between the hours of 12:00 AM and 5:16 AM on 05/21/25 per video surveillance. The investigation failed to contain evidence that the facility's Administrator (E1) was provided with a summary of the facility's investigation. b. Review of a document provided by the facility titled "Investigative Report of Findings" documented an incident that occurred on 5/21/25, which recorded a discovery of neglect involving C1 who required visual supervision and was left unsupervised in the unit hallway from 8:03 AM to 8:14 AM. The facility report was dated 5/27/25, with a follow-up date of 7/3/25 32 days later. The facility failed to complete the required follow-up within five (5) days. 2. Review of a document provided by the facility titled "Face Sheet" indicated C3 was admitted to the facility on 08/28/68 with diagnoses of profound development/intellectual disabilities. Review of a document provided by the facility titled "Investigative Report of Findings" dated	W 156	permitted for internal review. These actions were taken in good faith and in cooperation with law enforcement authorities. Identification of other residents with the potential to be affected- The identified past practice is not subject to retroactive correction. The error occurred as a result of DHCQ implementing a new incident reporting system, for which the facility was not provided with adequate instruction or guidance to ensure a full understanding and regulatory compliance. The issue was identified several months after implementation, at which time the facility conducted a root cause analysis to identify contributing factors and implement corrective actions. System Changes-Investigative Processes: The root cause of the identified deficiency was the implementation of DHCQ's new incident reporting system without adequate instruction or guidance provided to the facility to ensure a full understanding of regulatory requirements and internal investigation timelines. This lack of clear direction resulted in inconsistent application of reporting and investigation procedures. Another contributing factor was the facility's compliance with directives from law enforcement requesting that staff refrain from interviewing the alleged perpetrator to avoid interference with potential criminal investigations. Adherence to these directives delayed completion of internal investigations beyond the required five working days. These delays occurred despite the facility's intent to comply with both regulatory obligations and law enforcement instructions. To prevent recurrence and ensure ongoing regulatory compliance, the facility will institute revised investigative practices effective immediately. The facility will develop a structured investigative reporting process to ensure continuous administrative oversight throughout the investigation period. This process will include submission of an initial report of findings to the Administrator upon receipt of the allegation, documented updates throughout the five-day investigation period, and a final investigative report detailing results and outcomes.	

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W 156	Continued From page 14 10/21/25 indicated the date of discovery of neglect which involved E3 was on 05/23/25 in which E3 was discovered between the hours of 12:14 AM and 5:32 AM not to have provided incontinent care to C3 on 05/21/25, per video surveillance. The investigation failed to contain evidence that E1 was provided with a summary of the facility's investigation. 3. Review of a document provided by the facility titled "Face Sheet" indicated C4 was admitted to the facility on 06/27/12. Review of a document provided by the facility titled "Investigative Report of Findings" dated 10/21/25 indicated the date of discovery of neglect which involved E4 was on 05/23/25 in which E3 was discovered not to have provided incontinent between the hours of 11:36 PM and 5:21 AM, on 05/21/25 per video surveillance. The investigation failed to contain evidence that E1 was provided with a summary of the facility's investigation. During an interview conducted on 12/03/25 at 12:49 PM, E2 (DDD) confirmed there was no five-day summary provided to E1 for C1, C3, and C4. 4. Review of a document provided by the facility titled "Face Sheet" indicated C8 was admitted to the facility on 10/24/58. Review of a document provided by the facility titled "Investigative Report of Findings" documented an incident that occurred on 05/12/25 involving an allegation of neglect. The report indicated CNA/Employee (E6) refused to assist C8 with a required treatment. A facility	W 156	Additionally, the Administrator will continue to receive a memo of findings and the final results of the investigation, along with the completed final investigative report. The Administrator will review and formally sign off on the progressive investigative report, memo of findings, and final investigative report to document active oversight and ensure the Administrator remains duly informed throughout the investigative process. The facility will also update its Incident Reporting Policy to reflect these systemic changes, including clarified investigative timelines, communication requirements, administrative oversight responsibilities, and coordination with law enforcement. Policy revisions will be communicated to all applicable staff to ensure consistent implementation and sustained compliance. To further strengthen investigative capacity, the facility has hired a casual/seasonal Incident Analyst whose primary responsibility will be the timely review, investigation, and documentation of reported incidents in accordance with regulatory requirements and facility policy. Success Evaluation-Ongoing Monitoring: The Standards Control Specialist (SCS) will conduct a comprehensive review of incidents immediately (within the next business day) following the closure of all investigations. To determine if past practices followed regulatory requirements, the Standards Control Specialist (SCS) will complete the following: • The SCS will complete a random sampling of three residents' investigative files a week for two weeks for 100% compliance, THEN • The SCS will complete a random sampling of three residents' investigative files every two weeks for one month for 100% compliance. THEN • The SCS will complete a random sampling of three residents' investigative files a month for two months for 100% compliance, THEN • The SCS will complete a comprehensive review of all residents' investigative files for 100% compliance thereafter. A monthly review meeting with the facility's Standards Control Specialist (SCS) and PM46 Coordinator will take place to review the findings of the reviews, ensure immediate corrective	

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W 156	Continued From page 15 incident report was submitted to the Division on 05/13/25; however, the five-day follow-up investigation report was not submitted until 05/30/25, which was 12 days late. The investigation failed to demonstrate timely submission of findings to the Facility Administrator. Review of a document provided by the facility titled "Face Sheet" indicated C13 was admitted to the facility on 07/11/23. 5. Review of a document provided by the facility titled "Investigative Report of Findings" documented an incident that occurred on 04/19/25 involving an allegation of verbal abuse. The report indicated CNA/Employee (E16) used profanity in the presence of C13. A facility incident report was submitted to the Division on 04/21/25; however, the five-day follow-up investigation report was not submitted until 05/07/25, which was 11 days late. The facility failed to ensure timely reporting of investigation results. 6. Review of a document provided by the facility titled "Face Sheet" indicated C15 was admitted to the facility on 10/24/58. Review of a document provided by the facility titled "Investigative Report of Findings" documented an incident that occurred on 04/19/25 involving an allegation of verbal abuse. The report indicated an inappropriate verbal exchange occurred between Employee (E17), Unit Manager, and CNA/Employee (E18) in the presence of C15. A facility incident report was submitted to the Division on 03/26/25; however, the five-day	W 156	action on any noted deficiencies, and ensure proper notification is communicated. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	

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W 156	Continued From page 16 follow-up investigation report was not submitted until 04/22/25, which was 22 days late. During an interview conducted on 12/03/25 at 1:35 PM, the Developmental Disabilities Director (E2) confirmed that the five-day follow-up investigation reports for clients C1, C8, C13, and C15 were not submitted within required timeframes. E2 stated the facility would implement a process to ensure timely submission of investigation follow-up reports. On 12/04/25 at 3:59 PM, findings were reviewed with the Executive Director (E1) and the Developmental Disabilities Director (E2) during the exit conference. 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 156		
W 194	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure one (C3) out of 15 sampled client's had an accurate Individual Support Plan (ISP) that the facility identified as "Information About Me [IAM]." The facility failed to demonstrate knowledge of the client's transfer requirements. (Cross Reference W259) Findings include:	W 194	Individual/Resident Impacted-Corrective Action Taken: The Physical Therapist completed an addendum to the Physical Therapy Comprehensive Assessment (C3-DZ on Chandler) on 12/3/2025 to resolve the discrepancies identified regarding the correct sling specified for the resident. Identification of other residents with the potential to be affected-Assessment Review: The Physical Therapist will conduct a comprehensive review of all residents' Physical Therapy Comprehensive Assessments and person-centered Instructional Guidelines to ensure that the correct sling and related support needs are accurately reflected. Any discrepancies identified will be corrected immediately. All identified changes resulting from Physical Therapy Comprehensive Assessments and updates to Instructional Guidelines will be formally communicated to staff through a management-issued email and documented in the Residential Services Communication Book. These communication methods will be used to ensure that staff are promptly informed of changes to resident support needs and are able to implement the updated directives consistently.	01/18/2026

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Executive Director/ Nursing Home Administrator 12/24/2025 | 11:47 AM EST

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 12/04/2025

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W 194	Continued From page 17 1. Review of a document provided by the facility titled "Face Sheet" indicated C3 was admitted to the facility on 08/28/68. Review of a document provided by the facility titled "IAM" under a section titled " Comprehensive Functional Assessments That Tell You Who I AM and What I Need to Succeed" dated 04/08/25 indicated C3 used a yellow sling during transfers. During an observation on 12/02/25 at 9:30 AM, E4 (CNA) and E5 (CNA) entered C3's room. The two staff members pulled out a black sling with green piping around the edges. E4 stated the staff could find out what type of transfer a client was by looking at their care plan book, located on a bedside table in the client's room. E4 confirmed the sling that the two staff members used was black with green piping. The transfer took place with a ceiling mechanical lift into C3's wheelchair. During an interview on 12/02/25 at 12:13 PM E6 (CNA) stated she has used the green sling and the yellow sling and stated it depended on what was available. E6 stated she normally used the black sling with yellow piping. During an interview on 12/03/25 at 8:44 AM, E10 (Physical Therapist) stated it was important to use the correct sling since it made a client more comfortable during a two-person transfer, and this includes safety. E10 reviewed a document located in the computer confirmed C3 was to use a yellow sling. E10 stated the black sling with green piping was larger than the yellow. E10 stated that using a green sling instead of yellow would be more of a comfort issue than a safety	W 194	The Qualified Intellectual Disabilities Professional (QIDP) will review all resident support needs and any identified changes resulting from Physical Therapy and Occupational Therapy Comprehensive Assessments. Based on this review, the QIDP will update the resident's person-centered plan of care (I AM) and the Snapshot of Resident Supports to ensure that all required supports are accurately identified, clearly documented, and consistently reflected across interdisciplinary records. This process will ensure alignment between clinical recommendations and day-to-day support implementation. Identification of other residents with the potential to be affected- Environmental Sweep/Equipment Verification: On 12/03/2025 during the 3:00 p.m.–11:00 p.m. shift, the Active Treatment Supervisor conducted a comprehensive sweep of all residents' slings to verify that the sling present in each resident's room matched the sling specified in the resident's person-centered Instructional Guidelines. Any sling found to be inconsistent with the documented guidelines was removed immediately, and the correct sling was placed in the resident's room without delay. System Changes-Staff Education: The root cause of the cited deficiency was staff utilization of an incorrect mechanical lift sling size during a resident transfer, despite the resident's person-centered plan of care specifying a different sling size and level of support. This resulted in noncompliance with the resident's assessed needs and established care directives. Staff failed to verify and adhere to the resident's individualized transfer requirements before initiating the lift, and the person-centered plan of care did not effectively guide staff decision-making at the point of service. To address the identified root cause and prevent recurrence, the facility corrected an inconsistency for all residents and has implemented an educational flyer titled "Strictly Follow Instructional Guidelines for Lifts and Transfers," which was developed on December 3, 2025. Beginning the evening of December 3, 2025, this educational material was reviewed by the DD Program Administrator with all direct care staff, including Nursing Supervisors, Program Administrators, Registered Nurses, Licensed Practical Nurses, Active Treatment Supervisors, Certified Nursing Assistants, and Activity staff. Education will continue until all direct care staff have been instructed and competency has been reinforced.	

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		W 194	As an additional precaution, the facility will implement enhanced visual cues for resident-specific equipment labeling. Mechanical lift remotes will be clearly labeled by the appropriate color-coded sling identified in the person-centered plan of care, to assist staff in selecting the appropriate sling in accordance with the person-centered plan of care. The Adaptive Equipment Technician II will install the color-coded identifier to the mechanical lift remotes in each resident's bedroom. The facility is also updating the current Lift, Transfers, and Gait Belt Competency to reflect the importance of checking and utilizing the proper equipment as identified in the resident's person-centered plan of care. Success Evaluation-Ongoing Monitoring: Physical Therapy Assessment Monitoring: The Physical Therapists (PTs) will complete a comprehensive review of resident support needs and ensure support needs are reflected clearly and appropriately to cover all residents. • The PTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines a week for four weeks for 100% compliance, THEN • The PTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines every two weeks for one month for 100% compliance. THEN • The PTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines a month for four months for 100% compliance, THEN • The PTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines once a quarter for two quarters for 100% compliance. A monthly review meeting with the facility's Quality Improvement team and Therapy team will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification was communicated.	

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W 194		W 194	Qualified Intellectual Disability Professional Person-Centered Plan of Care Monitoring: The Qualified Intellectual Disability Professionals (QIDPs) will complete Program Book Audits for their respective residential support areas to cover all residents: • The QIPDs will complete a random sampling of three residents' Program Books a week for four weeks for 100% compliance, THEN • The QIDPs will complete a random sampling of three residents' Program Books every two weeks for one month for 100% compliance, THEN • The QIDPs will complete a random sampling of three residents' Program Books every month for four months for 100% compliance, THEN • The Standards Control Specialist (SCS) will complete a random sampling of at least a third of the census of residents' Program Books every quarter thereafter. A monthly review meeting with the facility's Quality Improvement team and Residential team will take place to review the findings of the audits and ensure immediate corrective action on any noted deficiencies occurs. Day-to-Day Monitoring: The Active Treatment Supervisors (ATSs) will conduct a random sampling of six residents each shift to verify that the sling present in the resident's bedroom matches the sling identified in the person-centered Instructional Guidelines. Findings from the sampling will be documented on the Active Treatment Supervisor's Shift Monitoring Report. Any discrepancies identified will be corrected immediately, and all corrective actions taken will be clearly documented in the report. The Therapy Aides (TAs) will conduct a review of each resident's equipment needs for their respective residential support areas to cover all residents to verify that the proper equipment, especially the sling, is present in the resident's bedroom, the equipment is available as required per the person-centered Instructional Guidelines, and in proper working order to ensure the safety of the residents: • The TAs will conduct a review of all therapy equipment for all residents three times a week for four weeks for 100% compliance using the Therapy Monthly Equipment Check form, THEN	

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W 194	Continued From page 18 issue. During an interview on 12/03/25 at 12:49 PM, Developmental Disabilities Director Habilitation Services/E2 stated that there were instructional images in the plan of care for the clients. E2 stated that therapy was to ensure that the client's needs were met through the therapy assessment. Review of a facility policy titled "Person Centered Planning" dated 07/14/24, indicated ". . . Person Centered Plan (PCP) - A person centered plan is a plan developed with the person receiving services, his/her family or guardian, and other individuals providing support that outlines in detail the individuals' preferences, support needs, and lifestyle choices. . ." 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 194	• The TAs will conduct a review of all therapy equipment for all the residents every week for four weeks for 100% compliance using the Therapy Monthly Equipment Check form, THEN • The TAs will conduct a review of all therapy equipment for all the residents every two weeks for two months for 100% compliance using the Therapy Monthly Equipment Check form, THEN • The TAs will conduct a review of all therapy equipment for all the residents every month thereafter for 100% compliance using the Therapy Monthly Equipment Check form. The Nursing Supervisors (RN Sups), Facility Charge (FCs), and Active Treatment Supervisors (ATSs) will complete Lift, Transfers, and Gait Belt Competencies to cover all residents: • The RN Sups, FCs, and ATSs will each complete one Lift, Transfers, and Gait Belt Competency a week for four weeks for 100% compliance, THEN • The RN Sups, FCs, and ATSs will each complete one Lift, Transfers, and Gait Belt Competency every two weeks for one month for 100% compliance, THEN • The RN Sups, FCs, and ATSs will each complete one Lift, Transfers, and Gait Belt Competency every month for four months for 100% compliance, THEN • The RN Sups, FCs, and ATSs will each complete one Lift, Transfers, and Gait Belt Competency every quarter thereafter. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined that for one (C9) out	W 249	Individual/Resident Impacted-Corrective Action Taken: The lift and transfer method utilized on C9 by E13 during the referenced incident was not an approved or authorized lift and transfer procedure in accordance with facility policy and did not align with the resident's identified support needs at the time of the incident. The resident's (C9) lift and transfer support needs have changed over time; the supports identified at the beginning of 2025 differ from those required at the end of 2025, reflecting the resident's evolving functional status and individualized care needs. The Physical Therapist completed a new evaluation and an addendum to the Physical Therapy Comprehensive Assessment (C9-TT on McCabe) on 12/22/2025 to resolve the discrepancies identified regarding the correct sling specified for the resident. Identification of other residents with the potential to be affected-Assessment Review: The Physical Therapist will conduct a comprehensive review of all residents' Physical Therapy Comprehensive Assessments and person-centered Instructional Guidelines to ensure that the correct sling and related support needs are accurately reflected. Any discrepancies identified will be corrected immediately. All identified changes	01/18/2026

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W 249	Continued From page 19 of fifteen sampled clients, the facility failed to implement interventions identified on the individual program plan (IPP) . Findings include: Review of C9's clinical record revealed: 8/27/24 - C9 was admitted to the facility with diagnoses including, but not limited to, profound intellectual disability. 9/27/24 - The instructional guidelines (IG) documented that C9 required transfer with a universal regular sling and two person assist at all times. 2/14/25 - A physical therapy evaluation documented that C9 was to be transferred with a one to two person assist or using a mechanical lift as needed. The evaluation further documented that two people assist is required due to C9's inconsistent weight bearing abilities and unpredicatable behavior. 2/21/25 - An occupational therapy comprehensive evaluation documented that C9 was non-ambulatory that requires dependent assist of one staff member for wheelchair mobility and dependent assis of two staff for transfer using an overhead mechanical lift. 4/15/25 2:56 PM - A facility reported incident documented an allegation that E12 (CNA) transferred C9 improperly and did not follow proper protocol for transfers. 4/15/25 - A facility investigative packet documented a timeline of camera footage for the date of 3/24/25 where E12 was observed entering C9's room to complete care and lacked evidence	W 249	resulting from Physical Therapy Comprehensive Assessments and updates to Instructional Guidelines will be formally communicated to staff through a management-issued email and documented in the Residential Services Communication Book. These communication methods will be used to ensure that staff are promptly informed of changes to resident support needs and are able to implement the updated directives consistently. The Occupational Therapist will conduct a comprehensive review of all residents' Occupational Therapy Comprehensive Assessments and associated person-centered Instructional Guidelines to ensure that Physical Therapy-related lift and transfer support needs are not included within Occupational Therapy Comprehensive Assessments. All lift and transfer determinations and support levels will be documented exclusively within Physical Therapy Comprehensive Assessments, as the Physical Therapist is the licensed professional responsible for establishing care and support requirements related to lifts and transfers. Any identified inconsistencies will be promptly corrected to ensure clarity, role delineation, and alignment across interdisciplinary documentation. All identified changes resulting from Occupational Therapy Comprehensive Assessments and updates to Instructional Guidelines will be formally communicated to staff through a management-issued email and documented in the Residential Services Communication Book. These communication methods will be used to ensure that staff are promptly informed of changes to resident support needs and are able to implement the updated directives consistently. System Changes-Staff Education: The root cause of the cited deficiency was staff utilization of an incorrect lift and transfer during a resident transfer, despite the resident's person-centered plan of care and level of support. This resulted in noncompliance with the resident's assessed needs and established care directives. Staff failed to verify and adhere to the resident's individualized transfer requirements before initiating the lift, and the person-centered plan of care did not effectively guide staff decision-making at the point of service.	

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W 249	Continued From page 20 of a second person required for proper transfer. 12/3/25 2:04 PM - During an interview, E2 (DDD) stated that the improper transfers were confirmed by surveillance footage when E12 entered C9's to perform a transfer without a second person. 12/4/25 12:58 PM - During an interview, E13 (CNA) stated that C9 had two ways to transfer properly: stand and pivot or hoyer lift. E13 stated that C9 will stand and pivot with one to two person assist if she can weight bear but if she is unable to weight bear then she would require a hoyer lift transfer. 12/4/25 2:30 PM - During an interview, E14 (COTA) stated that C9 was no longer a stand and pivot transfer and required a two person assist with hoyer lift. E14 stated that staff had made concerns related to C9 having difficulty weight bearing and nursing had requested a physical therapy evaluation for safety reasons. 12/4/25 2:40 PM - During an interview, E10 (PT Director) stated that C9 had two ways to transfer and depended on ability to bear weight but PT does recommend the hoyer transfer for safety. The facility failed to implement interventions identified on C9's IPP when E12 performed a transfer without two person assist. 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 during the exit conference.	W 249	To address the identified root cause and prevent recurrence, the facility corrected an inconsistency for all residents and has implemented an educational flyer titled "Strictly Follow Instructional Guidelines for Lifts and Transfers," which was developed on December 3, 2025. Beginning the evening of December 3, 2025, this educational material was reviewed by the DD Program Administrator with all direct care staff, including Nursing Supervisors, Program Administrators, Registered Nurses, Licensed Practical Nurses, Active Treatment Supervisors, Certified Nursing Assistants, and Activity staff. Education will continue until all direct care staff have been instructed and competency has been reinforced. Success Evaluation-Ongoing Monitoring: Physical Therapy and Occupational Therapy Assessment Monitoring: The Physical Therapists (PTs) and Occupational Therapists (OTs) will complete a comprehensive review of resident support needs and ensure support needs are reflected clearly and appropriately to cover all residents. • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines a week for four weeks for 100% compliance, THEN • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines every two weeks for one month for 100% compliance. THEN • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines a month for four months for 100% compliance, THEN • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines once a quarter for two quarters for 100% compliance. A monthly review meeting with the facility's Quality Improvement team and Therapy team will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification was communicated. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional	W 259	Individual/Resident Impacted-Corrective Action Taken: The Physical Therapist completed an addendum to the Physical Therapy Comprehensive Assessment (C3-DZ on Chandler) on 12/3/2025 to resolve the discrepancies identified regarding the correct sling specified for the resident.	01/18/2026

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W 259	Continued From page 21 assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on interview, record review and a review of other facility documentation as indicated, it was determined for two (C3 and C9) out of fifteen sampled clients, the facility failed to update the comprehensive functional assessment (CFA) to reflect the client's current needs. Findings include: 1. Review of C9's clinical record revealed: 8/27/24 - C9 was admitted to the facility with diagnoses including, but not limited to, profound intellectual disability. 9/27/24 - The instructional guidelines (IG) documented that C9 required transfer with a universal regular sling and two person assist at all times. 2/14/25 - A physical therapy evaluation documented that C9 was to be transferred with a one to two person assist or using a mechanical lift as needed. The evaluation further documented that two people assist is required due to C9's inconsistent weight bearing abilities and unpredicatable behavior. 2/21/25 - An occupational therapy comprehensive evaluation documented that C9 was non-ambulatory that requires dependent assist of one staff member for wheelchair mobility and dependent assist of two staff for transfer using an overhead mechanical lift. 12/4/25 12:58 PM - During an interview, E13	W 259	The Physical Therapist completed a new evaluation and an addendum to the Physical Therapy Comprehensive Assessment (C9-TT on McCabe) on 12/22/2025 to resolve the discrepancies identified regarding the correct sling specified for the resident. Identification of other residents with the potential to be affected- Assessment Review: The Physical Therapist will conduct a comprehensive review of all residents' Physical Therapy Comprehensive Assessments and person-centered Instructional Guidelines to ensure that the correct sling and related support needs are accurately reflected. Any discrepancies identified will be corrected immediately. All identified changes resulting from Physical Therapy Comprehensive Assessments and updates to Instructional Guidelines will be formally communicated to staff through a management-issued email and documented in the Residential Services Communication Book. These communication methods will be used to ensure that staff are promptly informed of changes to resident support needs and are able to implement the updated directives consistently. The Occupational Therapist will conduct a comprehensive review of all residents' Occupational Therapy Comprehensive Assessments and associated person-centered Instructional Guidelines to ensure that Physical Therapy-related lift and transfer support needs are not included within Occupational Therapy Comprehensive Assessments. All lift and transfer determinations and support levels will be documented exclusively within Physical Therapy Comprehensive Assessments, as the Physical Therapist is the licensed professional responsible for establishing care and support requirements related to lifts and transfers. Any identified inconsistencies will be promptly corrected to ensure clarity, role delineation, and alignment across interdisciplinary documentation. All identified changes resulting from Occupational Therapy Comprehensive Assessments and updates to Instructional Guidelines will be formally communicated to staff through a management-issued email and documented in the Residential Services Communication Book. These communication methods will be used to ensure that staff are promptly informed of changes to resident support needs and are able to implement the updated directives consistently.	

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W 259	Continued From page 22 (CNA) stated that C9 had two ways to transfer properly: stand and pivot or hoyer lift. E13 stated that C9 will stand and pivot with one to two person assist if she can weight bear but if she is unable to weight bear then she would require a hoyer lift transfer. 12/4/25 2:30 PM - During an interview, E14 (COTA) stated that C9 was no longer a stand and pivot transfer and required a two person assist with hoyer lift. E14 stated that staff had made concerns related to C9 having difficulty weight bearing and nursing had requested a physical therapy evaluation for safety reasons. 12/4/25 2:40 PM - During an interview, E10 (PT Director) reviewed the IG and confirmed that it did not reflect the current transfer status for C9. E10 also stated that the expectation would be after each quaterly assessment or status change therapy is responsible to update the IG to reflect current client's needs. E10 confirmed that current updates were not reflected in C9's current IPP or in the CFA (comprehensive functional assessment). 12/4/25 3:25 PM - During an interview, E15 (QIDP) stated the client's IPP should document all circumstances in the plan that effect direct care and should be updated as changes are made to the CFA. E15 stated the expectation is for all departments to meet with the QIDP to discuss any changes and the QIDP is responsible to ensure changes are reflected in the IPP. The facility failed to update the CFA to reflect C9's current transfer status. 2. Review of a document provided by the facility	W 259	The Qualified Intellectual Disabilities Professional (QIDP) will review all resident support needs and any identified changes resulting from Physical Therapy and Occupational Therapy Comprehensive Assessments. Based on this review, the QIDP will update the resident's person-centered plan of care (I AM) and the Snapshot of Resident Supports to ensure that all required supports are accurately identified, clearly documented, and consistently reflected across interdisciplinary records. This process will ensure alignment between clinical recommendations and day-to-day support implementation. Identification of other residents with the potential to be affected-Environmental Sweep/Equipment Verification: On 12/03/2025 during the 3:00 p.m.–11:00 p.m. shift, the Active Treatment Supervisor conducted a comprehensive sweep of all residents' slings to verify that the sling present in each resident's room matched the sling specified in the resident's person-centered Instructional Guidelines. Any sling found to be inconsistent with the documented guidelines was removed immediately, and the correct sling was placed in the resident's room without delay. System Changes-Staff Education: The root cause of the cited deficiency was staff utilization of an incorrect mechanical lift sling size during a resident transfer, despite the resident's person-centered plan of care specifying a different sling size and level of support. This resulted in noncompliance with the resident's assessed needs and established care directives. Staff failed to verify and adhere to the resident's individualized transfer requirements before initiating the lift, and the person-centered plan of care did not effectively guide staff decision-making at the point of service. To address the identified root cause and prevent recurrence, the facility corrected an inconsistency for all residents and has implemented an educational flyer titled "Strictly Follow Instructional Guidelines for Lifts and Transfers," which was developed on December 3, 2025. Beginning the evening of December 3, 2025, this educational material was reviewed by the DD Program Administrator with all direct care staff, including Nursing Supervisors, Program Administrators, Registered Nurses, Licensed Practical Nurses, Active Treatment Supervisors, Certified Nursing Assistants, and Activity staff. Education will continue until all direct care staff have been instructed and competency has been reinforced. As an additional precaution, the facility will implement enhanced visual cues for resident-specific equipment labeling. Mechanical lift remotes will be clearly labeled by the appropriate color-coded sling identified in the person-centered plan of care, to assist staff in selecting the appropriate sling in accordance with the person-centered plan of care. The Adaptive Equipment Technician II will install the color-coded identifier to the mechanical lift remotes in each resident's bedroom.	

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Kai-Stefan Fountain
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Executive Director/ Nursing Home Administrator 12/24/2025 | 11:47 AM EST

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G001	A. BUILDING _____ B. WING _____	C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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		W 259	Success Evaluation-Ongoing Monitoring: Physical Therapy and Occupational Therapy Assessment Monitoring: The Physical Therapists (PTs) and Occupational Therapists (OTs) will complete a comprehensive review of resident support needs and ensure support needs are reflected clearly and appropriately to cover all residents. • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines a week for four weeks for 100% compliance, THEN • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines every two weeks for one month for 100% compliance. THEN • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines a month for four months for 100% compliance, THEN • The PTs and OTs will complete a random sampling of three residents' Comprehensive Evaluations and Instructional Guidelines once a quarter for two quarters for 100% compliance. A monthly review meeting with the facility's Quality Improvement team and Therapy team will take place to review the findings of the reviews, ensure immediate corrective action on any noted deficiencies, and ensure proper notification was communicated. Qualified Intellectual Disability Professional Person-Centered Plan of Care Monitoring: The Qualified Intellectual Disability Professionals (QIDPs) will complete Program Book Audits for their respective residential support areas to cover all residents: • The QIPDs will complete a random sampling of three residents' Program Books a week for four weeks for 100% compliance, THEN • The QIDPs will complete a random sampling of three residents' Program Books every two weeks for one month for 100% compliance, THEN • The QIDPs will complete a random sampling of three residents' Program Books every month for four months for 100% compliance, THEN • The Standards Control Specialist (SCS) will complete a random sampling of at	

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W 259	Continued From page 23 titled "Face Sheet" indicated C3 was admitted to the facility on 08/28/68. Review of a document provided by the facility titled "IAM" for C3 dated 04/08/25 indicated the client required the assistance of two staff members for mechanical transfers. In addition, under a section titled "Comprehensive Assessment" directed staff to use a medium (yellow border) universal sling. The document also revealed that staff were to use a large sling during mechanical transfers. Under a section titled "Transfer" directed the staff to use a large sling for all transfers. In addition, the document also directed staff to use a large sling with green piping. An observation was conducted on 12/02/25 at 9:30 AM, Certified Nurse Aide/Employee (E)4 and Certified Nurse Aide/E5 entered C3's room and completed a two-person transfer with a black sling with green piping (large). During an interview on 12/03/25 at 8:44 AM, Physical Therapist/Employee (E)10 stated C3 used a yellow sling, a universal medium sling for the ceiling mechanical lift. E6 stated a large sling was to be used on a mobile mechanical lift. During an interview on 12/03/25 at 2:59 PM Development Disabilities Director Habilitation Services/E2 confirmed there was conflicting information C3's his/her comprehensive assessment for C3 and the use of the sling. 12/4/25 3:59 PM - Findings were reviewed with E1 (ED) and E2 (DDD) during the exit conference.	W 259	least a third of the census of residents' Program Books every quarter thereafter. A monthly review meeting with the facility's Quality Improvement team and Residential team will take place to review the findings of the audits and ensure immediate corrective action on any noted deficiencies occurs. Day-to-Day Monitoring: The Active Treatment Supervisors (ATSs) will conduct a random sampling of six residents each shift to verify that the sling present in the resident's bedroom matches the sling identified in the person-centered Instructional Guidelines. Findings from the sampling will be documented on the Active Treatment Supervisor's Shift Monitoring Report. Any discrepancies identified will be corrected immediately, and all corrective actions taken will be clearly documented in the report. The Therapy Aides (TAs) will conduct a review of each resident's equipment needs for their respective residential support areas to cover all residents to verify that the proper equipment, especially the sling, is present in the resident's bedroom, the equipment is available as required per the person-centered Instructional Guidelines, and in proper working order to ensure the safety of the residents: • The TAs will conduct a review of all therapy equipment for all residents three times a week for four weeks for 100% compliance using the Therapy Monthly Equipment Check form, THEN • The TAs will conduct a review of all therapy equipment for all the residents every week for four weeks for 100% compliance using the Therapy Monthly Equipment Check form, THEN • The TAs will conduct a review of all therapy equipment for all the residents every two weeks for two months for 100% compliance using the Therapy Monthly Equipment Check form, THEN • The TAs will conduct a review of all therapy equipment for all the residents every month thereafter for 100% compliance using the Therapy Monthly Equipment Check form. All documentation will be submitted to the Standards Control Specialist for tracking, review, and retention in the official records to ensure accuracy, completeness, and regulatory compliance.	

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