



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Arden Courts of Wilmington

DATE SURVEY COMPLETED: March 27, 2026

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | Completion Date |
|---------|---|---|--------------------|
| | <p>An unannounced complaint survey was conducted at this facility from March 26, 2026, through March 27, 2026. The deficiencies contained in this report are based on interview, record review and other facility documentation as indicated. The facility census on the first day of the survey was twenty-seven (27). The survey sample totaled four (4) residents.</p> <p>Abbreviations/definitions used in this state report are as follows:</p> <p>BSG – Building Services Coordinator;</p> <p>CG – Caregiver;</p> <p>CSC – Culinary Services Coordinator;</p> <p>Dementia – a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking or disorientation;</p> <p>LPN – Licensed Practical Nurse;</p> <p>NHA – Nursing Home Administrator;</p> <p>RN – Registered Nurse;</p> <p>RSC – Resident Services Coordinator;</p> <p>RSS – Resident Services Supervisor;</p> <p>Service Plan – allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care and supervision services;</p> <p>UAI – a document setting forth standardized criteria developed by the Division to assess</p> | <ol style="list-style-type: none"> 1. R1 was unable to be located for his scheduled safety check on 3/22. Assigned caregiver rounded community and could not locate resident and facility missing resident procedure was called at 9:58 PM. Resident was found on community grounds at 10:20 PM. Resident returned to the community and a head to toe assessment was completed with no areas of concern noted. Resident placed on 1:1 direct supervision utilizing facility care team and placed on alert charting each shift by his assigned caregiver. His service plan was updated. QA meeting was held with IDT team to review. 2. A review of all current residents for potential elopement risk as residents who are exit seeking and are unable to be redirected was conducted by the RSC. New admissions will be assessed for potential elopement risk and placed on increased monitoring of 15 min checks x 3 days. If a resident is noted to be exit seeking and unable to be redirected, staff are to report this directly to the nurse on duty, they will be placed on direct supervision by the care team until reviewed by IDT or provider. 3. Based on a root cause analysis, it was determined that the kitchen door alarm did not sound. The kitchen door was updated with enhanced safety precautions on 3/23. All magnetic lock devices in facility were tested by an electrician and confirmed to be operational. Facility staff also failed to adequately redirect the exit seeking resident. ED and RSC educated | <p>4/15/2026</p> |

Provider's Signature

Jah Paul

Title

Executive Director

Date

4/16/26



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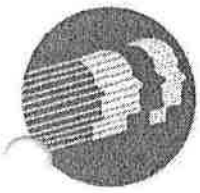
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| <p>3225.0 3225.19.7.5.2</p> <p>Title 16 Health and Safety Chap- ter 11 Long Term Care Facilities and Services Sub- chapter III. Abuse, Neg- lect, Mis- treatment, fi- nancial Ex- ploitation, or Medication Diversion of Patients or Residents.</p> <p>1131. Defini- tions</p> <p>S/S J</p> | <p>each resident's functional, cognitive, physi- cal, medical and psychosocial needs and sta- tus. The assisted living facility shall be re- quired to use the UAI to evaluate each resi- dent on the ongoing basis.</p> <p>Assisted Living Facilities</p> <p>Resident Elopement</p> <p>(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 follow- ing:</p> <p>a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review and re- view of other documentation as indicated, it was determined that for one (R1) out of one resident reviewed for neglect, the facility failed to ensure that R1 did not leave the building unsupervised. This failure put the resident at immediate jeopardy and risk of a serious adverse outcome. R1, a severely cognitively impaired resident, was able to exit the facility into a wooded area behind the building on 3/22/26 at 9:45 PM. An im- mediate jeopardy was called on 3/27/26 at 9:40 AM, with an abatement date of 3/27/26 at 1:00 PM. Findings include:</p> <p>Review of R1's clinical record revealed:</p> <p>3/18/26 – An UAI (Uniform Assessment In- strument) was completed by E2 (RN, RSC). R1's cognitive assessment documented that</p> | <p>all staff on facility missing resident policy and Wandering and Dementia Behaviors. Facility created new policy to address managing residents actively exit seeking. There have been no new hires. All new hires will receive training prior to starting training on the floor by the RN RSC on managing residents who are actively exit seeking, safety and security of residents, and wandering and dementia related be- haviors.</p> <p>4. Missing resident drills will be conducted on varying shifts by the RSC or designee daily x 7 days, weekly x 4 weeks, and monthly x 3 months. RSC or designee will audit current residents weekly x 4 weeks and monthly x 3 months to determine any changes in exit seeking behaviors un- able to be redirected. All new residents will be audited upon admission. CSC or designee will complete daily door audits x 3 months to ensure Kitchen door is properly operating. ED or designee will complete daily door audit x 3 months on front exit door to ensure it is properly functioning. All results will be reviewed by IDT to determine compliance in rela- tion to community policy. If an area of concern is noted, ED will immediately be notified, rectify issue, and repeat cycle.</p> <p>5. Date of compliance 4/15/2026</p> | |

Provider's Signature [Signature] Title Executive Director Date 4/16/26



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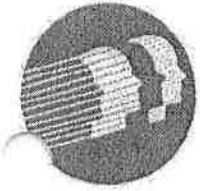
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| | <p>R1 was oriented to person only, had short-term and long-term memory problems and a history of wandering.</p> <p>3/19/26 – R1 was admitted to the facility with diagnoses including but not limited to dementia.</p> <p>3/21/26 – A Service Plan was completed for R1 documented, "...Wandering/Redirection: Moderate issues [sic] Resident has current or history of wandering. Current or history of wandering within the residence of facility. May wander outside; health or safety may be jeopardized...[R1] will receive 15-minute spot checks for safety and monitoring...".</p> <p>3/21/26 9:36 PM – E3 (LPN, RSS) documented in R1's clinical record, "[R1] noted with increased agitation, active exit seeking...".</p> <p>3/22/26 8:50 PM – A nursing progress note entered in R1's clinical record documented, "...[R1] began exit seeking around dinner time. Unable to redirect with food or conversation...".</p> <p>3/22/26 10:23 PM – A facility document entitled "Witness Statement" given by E5 (CG) documented, "At approximately 9:40 PM on 3/22/26, I heard [R1] banging on the door to [name of unit]. I asked him if he wanted to watch TV. [R1] said no, I then walked [R1] down the hall and proceeded to finish my charting. I got a call from E4 [CG] asking if I saw [R1]. I explained I hadn't seen [R1] since I left him in the living room...".</p> | | |

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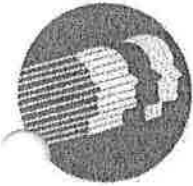
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| | <p>3/23/26 2:00 AM – A facility document entitled, "Witness Statement" given by E4 documented, "I was doing rounds at 9:30 [PM] which included [R1]'s 15-minute check. [R1] then came over to [name of unit] and made his way to the core area. When I went to do his 9:45 PM check, he was nowhere to be found. I began searching the building and the nurse called the "Missing Resident Drill."</p> <p>3/23/26 3:12 AM – E2 documented in R1's clinical record, "...[R1] not able to be found for scheduled spot check at approximately 0945 PM [9:45 PM]. [R1] last noted at 0930 PM [9:30 PM] for his spot check...notified by staff at 0958 PM [9:58 PM] that [R1] was unable to be located...Staff searched throughout the building and premises and was able to locate [R1] at 10:20 PM. [R1] was noted to be near fence [sic] towards back of facility grounds...[R1] immediately placed on 1:1 monitoring for safety and risk of elopement".</p> <p>3/26/26 9:15 AM – Review of an undated facility document entitled, "Timeline of events [sic] 3/22/26" noted, "9:40 PM – [R1] noted on video in kitchen entering through the coded door. 9:42 PM – [R1] exited main kitchen door to the exterior parking lot...".</p> <p>3/26/26 11:15 AM- During an interview, E1 (NHA) stated, "[R1] was able to press the buttons on the coded door to the kitchen and somehow entered the right code to open the door. The kitchen rear exterior door has a "screamer" alarm that was not turned on. The alarm did not go off when the rear door was opened. The alarm is turned off with a key for deliveries and had</p> | | |

Provider's Signature *[Signature]*

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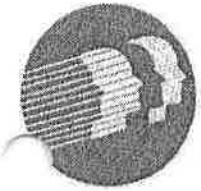
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| | <p>to be turned back on. We had new keypads and Mag [magnetic] locks installed on the kitchen door and the back kitchen door.”</p> <p>3/26/26 12:07 PM – During an interview, E4 stated, “I did a check at 9:30 PM. I went to do his 10:00 PM check and realized he was missing. I went and told E3. I didn’t hear any alarms go off that night.”</p> <p>3/26/26 12:20 PM – During an interview, E6 (CSC) stated, “We request for the kitchen exterior door alarm to be temporarily turned off for deliveries on Mondays and Thursdays. We ask E7 [BSC] to cut the alarm off. I think E7 has a key. Deliveries usually come at 7:00 AM. When I’m done with the delivery, E7 comes to cut the alarm back on.”</p> <p>3/26/26 12:35 PM – During an interview, E5 stated, “I was walking from the nurse’s station down the Garden Hall and heard the alarm go off. I turned the alarm off. [R1] was banging on the exit door trying to get out. I approached and redirected [R1]. I asked him if he wanted to watch TV. [R1] said no and walked down the hall back to the common area. I went back to finishing charting. It was about five minutes later when [E4] asked if I had seen [R1]. I told [E4] that [R1] was banging on the Garden door trying to get out. We found [R1] on the other side of the gate going towards the woods.”</p> <p>3/26/26 1:15 PM – During an interview, E3 stated, “It was about 9:50 PM. [E4] came in the office and said that he couldn’t find [R1]. I instructed everyone to start looking. We found [R1] on the other side of the fence behind the building. We knew [R1] was actively</p> | | |

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| | <p>exit seeking. I heard [E4] ask [R1] to stop banging on the kitchen door around 9:30 PM when [E4] did the 9:30 PM check."</p> <p>The facility failed to adequately monitor R1 after he was noted to be actively seeking exit. Staff also observed R1 trying to gain access to the kitchen door and activate an exterior door alarm minutes before gaining access to the kitchen and eloping from the building.</p> <p>3/26/26 2:00 PM – During an interview, E7 (BSC) stated, "I usually unlock the kitchen door alarm for deliveries. I haven't unlocked it since a couple of weeks before the elopement." The surveyor asked, "When did you last lock the kitchen exterior door alarm?" E7 stated, "I last locked it maybe three weeks ago."</p> <p>3/27/26 9:40 AM – An immediate jeopardy was called for neglect of R1.</p> <p>3/27/26 12:00 PM – The facility's abatement plan for the immediate jeopardy included:</p> <ul style="list-style-type: none"> - Installation of alarm system coded keypads on kitchen entrance door and exterior kitchen door connected to facility alarm system. Magnetic lock was installed on kitchen door. - All magnetic lock devices in facility were tested by an electrician and confirmed to be operational. - Staff in-service reeducation on Safety and Security of Residents policy | | |

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| | <ul style="list-style-type: none"> - Staff in-service education on Wandering and Dementia Behaviors - Implementation of daily audit of kitchen door security to be completed by dietary staff - All residents audited for potential exit seeking behavior and inability to be redirected from elopement - Staff in-service training in Managing Actively Exit Seeking Residents, which included immediate 1:1 monitoring - Missing resident drills will be continued daily for seven days, weekly for four weeks and monthly for three months. <p>3/27/26 12:45 PM – Staff interviews were conducted, and in-service education and training was verified. After review of implementation of measures outlined in the abatement plan, the immediate jeopardy was abated at 1:00 PM.</p> <p>3/27/26 2:30 PM – Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.</p> | | |

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[Handwritten Signature]

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