



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: Brookdale Dover

DATE SURVEY COMPLETED: February 25, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
<p>3225.0</p> <p>3225.1.0</p>	<p>An unannounced Annual and Complaint Survey was conducted at this facility from February 20, 2026, through February 25, 2026. The deficiencies contained in this report are based on interview, record review and review of other facility and partnering services documentation as indicated. The facility census on the first day of the survey was 36 (thirty-six). The survey sample totaled ten (10) residents, plus an additional 11 (eleven) subsampled residents.</p> <p>Abbreviations/definitions used in this state report are as follows:</p> <p>ED - Executive Director;</p> <p>HWD – Health & Wellness Director;</p> <p>LPN – Licensed Practice Nurse;</p> <p>MT – Med Tech;</p> <p>RN – Registered Nurse;</p> <p>SAM – Self Administration of Medications;</p> <p>UAI (Uniform Assessment Instrument) - A document setting forth standardized criteria developed by the Division to assess each resident’s functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these</p> <p>Assisted Living Facilities</p> <p>Purpose</p> <p>The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facilities.</p>		

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<p>3225.8.0 3225.8.6 S/S – D</p>	<p>These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The regulations establish the minimal acceptable level of services for residents of assisted living facilities.</p> <p>Medication Management</p> <p>Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication.</p> <p>Based on record review and interview, it was determined that for two (R9 and R19) out of four residents reviewed for SAM assessments by the RN, the facility failed to provide evidence of the resident's SAM assessment done concurrently with the UAI-based assessment. Findings include:</p> <p>1. 2/5/25 – R7 was admitted to the facility. 6/22/25 – R7's annual UAI was completed. The facility failed to provide evidence of a 6/22/25 SAM assessment.</p> <p>2. 7/22/24 -- R19 was admitted to the facility.</p>	<p>A. All residents are at risk of this deficient practice.</p> <p>B. No residents were harmed as a result of this deficient practice. Residents who self-administer medications will be audited by the Health & Wellness Director (HWD) and/or designee to confirm they have the most up to date SAM in their chart. If the SAM is not present, one will be completed immediately.</p> <p>C. RCA –R7 is presently in the hospital. She will have a SAM performed upon her return. This will be performed by the Health & Wellness Director. Ongoing compliance, residents who self-administer medication will have SAM assessment completed on date of UAI assessment by the HWD or designee.</p> <p>D. Residents who self-administer medications will have their charts audited by the Executive Director (ED) and/or their designee daily for five (5) days or until 100% compliance is achieved, then weekly for one (1) month or until 100% compliance is achieved, and then monthly for two (2) months or until 100% compliance is achieved. The audits will be incorporated into our quarterly QAPI meetings.</p>	<p>3-25-2026</p>

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<p>3225.9.0</p> <p>3225.9.5</p> <p>3225.9.5.1</p> <p>S/S – D</p>	<p>7/10/25 – R19’s annual UAI was completed. The facility failed to provide evidence of a 7/10/25 SAM assessment.</p> <p>2/25/26 2:00 PM – Per interview with E2 (HWD), E2 confirmed the SAM assessment with the most recent UAIs were not in evidence. E2 stated these were completed prior to her hire at the facility.</p> <p>2/25/26 - Findings were reviewed with E1 (ED) and E2, at the exit conference, beginning at approximately 2:30 PM.</p> <p>Infection Control</p> <p>Requirements for tuberculosis and immunizations:</p> <p>The facility shall have on file the results of tuberculin testing performed on all newly placed residents.</p> <p>Based on record review and interview, it was determined that for one (R7) out of 10 residents reviewed for tuberculosis testing, the facility failed to provide evidence of the resident’s tuberculin testing prior to admission. Findings include:</p> <p>2/5/25 – R7 was admitted to the facility.</p> <p>2/5/25 – The Physician medical exam documentation did not include information regarding tuberculosis testing. The facility failed to obtain tuberculin testing prior to admission.</p> <p>2/25/26 2:00 PM – Per interview with E2 (HWD), E2 confirmed the resident’s pre-admission tuberculosis testing results were not in evidence. The facility provided evidence</p>	<p>A. All residents are at risk of this deficient practice. R7 will have a 2 step PPD or x-ray completed to confirm no active TB disease.</p> <p>B. No residents were harmed due to this deficient practice. An audit will be completed by the Health & Wellness Director and/or designee no later than 3/15/2026 to confirm no other residents are missing their initial PPD paperwork. If missing, the Health & Wellness Director will obtain the original 2-step PPD, x-ray or bloodwork. If unable to obtain 2 step PPD or x-ray will be completed.</p> <p>The ED re-educated the HWD and sales manager on state regulation for admission criteria in regards to TB testing on 3/10/2026.</p> <p>C. RCA – R7 did not have evidence of a 2-step PPD, chest x-ray nor bloodwork confirming R7 was free of Tuberculosis. R7’s admission was not conducted properly and per state regulations. The Health & Wellness Director along with the Executive Director are no longer employed by Brookdale.</p> <p>D. Residents will have their charts audited by the Executive Director and/or designee daily for five (5) days or until 100% compliance is achieved, weekly for one (1) month until 100% compliance is achieved and, then monthly for (2) months until 100% compliance is achieved. The audits will be incorporated into our quarterly QAPI meetings.</p>	

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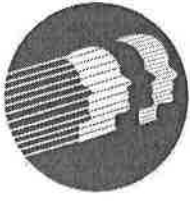
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<p>3225.9.0</p> <p>3225.9.7</p> <p>S/S - D</p>	<p>of a tuberculin surveillance questionnaire dated 2/5/26.</p> <p>2/25/26 - Findings were reviewed with E1 (ED) and E2, at the exit conference, beginning at approximately 2:30 PM.</p> <p>Infection Control</p> <p>The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.</p> <p>Based on record review and interview, it was determined that for two (R1 and R10) out of 10 residents reviewed for pneumococcal vaccines, the facility failed to provide evidence of the residents' pneumococcal vaccine. Findings include:</p> <p>1. 11/11/25 - R1 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined.</p>	<p>A. All residents are at risk of this deficient practice.</p> <p>B. No residents were harmed due to this deficient practice. All resident charts will be audited by the Health & Wellness Director and/or designee to confirm that the pneumococcal vaccine was offered and they either accepted or declined the vaccine.</p> <p>C. RCA - R1 was admitted along with the spouse. In reviewing the admission, we believe we verified the presence of the pneumococcal form for R1's spouse but not for R1. R1's family will be contacted by the Health & Wellness Director and/or designee to obtain a completed pneumococcal vaccine form.</p> <p>The Executive Director re-educated the Health & Wellness Director on the state regulation to verify all residents must have pneumonia vaccine information confirmed on admission on 3/10/2026.</p> <p>D. All residents will have their charts audited by the Executive Director and/or their designee daily for five (5) days or until 100% compliance is achieved, then weekly for four (4) weeks until 100% compliance is achieved, and then monthly for two (2) months until 100% compliance is achieved. The audits will be incorporated into our quarterly QAPI meetings.</p>	

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<p>3225.11.0 3225.11.3 S/S – D</p>	<p>2. 4/9/25 – R10 was admitted to the facility. The facility lacked evidence of the pneumonia vaccine record or that the pneumococcal pneumonia vaccine was offered or declined.</p> <p>2/25/26 2:00 PM – Per interview with E2 (HWD), E2 confirmed the medical records did not contain the residents' pneumonia vaccine information. E2 stated she does not have access to DelVax but will request it.</p> <p>2/25/26 - Findings were reviewed with E1 (ED) and E2, at the exit conference, beginning at approximately 2:30 PM.</p> <p>Resident Assessment</p> <p>Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.</p> <p>Based on record review and interview, it was determined that for one (R7) out of 10 residents reviewed for pre-admission medical evaluations, the facility failed to provide evidence of the Physician's pre-admission evaluation. Findings include:</p> <p>2/5/26 – R7 was admitted to the facility.</p> <p>2/5/26 – The Physician evaluation visit was completed on the day of admission, not within the regulation of 30 days prior to admission.</p> <p>2/25/26 2:00 PM – Per interview with E2 (HWD), E2 confirmed the Physician's medical evaluation was completed the same day as R7's admission.</p>	<p>A. All residents are at risk of this deficient practice.</p> <p>B. No residents were harmed due to this deficient practice.</p> <p>C. The Executive Director re-educated the Health & Wellness Director on the state regulation in regards to resident medical assessment being completed 30 days prior to admission on 3/10/2026.</p> <p>D. The Executive Director will audit new resident admission paperwork to verify medical assessment are completed within twenty (20) days prior to admission, before resident physically moves into community. The results will be reviewed at quarterly QAPI meetings.</p>	

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<p>3225.14.0</p> <p>3225.14.1</p> <p>Del.C. Ch 11, Subchapter II - § 1121. Resident's rights. § 1123. Notice to patient.</p> <p>S/S- C</p>	<p>2/25/26 - Findings were reviewed with E1 (ED) and E2, at the exit conference, beginning at approximately 2:30 PM.</p> <p>Resident Rights</p> <p>Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein.</p> <p>(b) Copies of § 1121 of this title shall be furnished to the resident upon admittance to the facility; all residents currently residing in the facility; and the authorized representative under § 1122 of this title. The long-term care facility shall retain in its files a statement signed by each person listed in this subsection that the person has received a copy of § 1122 of this title.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and interview, it was determined for ten (R1, R2, R3, R4, R5, R6, R7, R8, R9 and R10) out of 10 residents reviewed for the updated resident rights notification, the facility failed to ensure that the resident or resident representative was notified and signed off on the updated resident rights form. Findings include:</p> <p>1. 11/1/25 – R1 was admitted to the facility. The resident rights that R1 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>2. 7/10/23 – R2 was admitted to the facility. The resident rights that R2 received was the</p>	<p>A. All residents are at risk of this deficient practice.</p> <p>B. No residents were harmed by this deficient practice. The ED or designee will provide all residents and/or their family member with the new resident right form and a signed copy will go into their file by 3/25/2026. Residents who were admitted after survey received the correct resident rights.</p> <p>C. Residents will have their charts audited by the Executive Director and/or their designee daily for five (5) days or until 100% compliance is achieved, weekly for one (1) month until 100% compliance is achieved, and then monthly for two (2) months until 100% compliance is achieved. The audits will be incorporated into our quarterly QAPI meetings.</p>	

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	<p>2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>3. 2/26/24 – R3 was admitted to the facility. The resident rights that R3 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>4. 12/30/21 – R4 was admitted to the facility. The resident rights that R4 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>5. 12/24/21 – R5 was admitted to the facility. The resident rights that R5 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>6. 2/17/25 – R6 was admitted to the facility. The resident rights that R6 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>7. 2/5/25 – R7 was admitted to the facility. The resident rights that R7 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p>		

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<p>3225.16.0</p> <p>3225.16.2</p> <p>S/S – D</p>	<p>8. 9/2/22 – R8 was admitted to the facility. The resident rights that R8 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>9. 6/12/08 – R9 was admitted to the facility. The resident rights that R9 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>10. 4/9/25 – R10 was admitted to the facility. The resident rights that R10 received was the 2006 version. The facility failed to provide evidence that the updated version distributed by the State in September 2023 was provided to the resident or resident representative.</p> <p>2/25/26 2:00 PM – Per interview with E1 (ED), E1 confirmed the resident rights version being utilized by the facility was the 2006 version, not the updated 2023 version.</p> <p>2/25/26 - Findings were reviewed with E1 and E2 (HWD), at the exit conference, beginning at approximately 2:30 PM.</p> <p>Staffing</p> <p>A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.</p> <p>State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties</p>	<p>A. All residents are at risk of this deficient practice.</p> <p>B. No residents were harmed by this deficient practice.</p> <p>C. RCA – the community has one RN that works a typical weekday schedule. During the off shifts, if a resident fell, they would notify the RN and the LPN on site completed the evaluation tool. Effective immediately, the community engaged with our physician practice, Seniority, who has agreed to be available for all fall related incidents via telehealth. In addition, the Health & Wellness Director will also assist in this process.</p> <p>D. Residents who experience a fall will have their charts audited by the Executive Director and/or their designee daily for five (5) days or until 100% compliance is achieved, then weekly for one (1) month until 100% compliance is achieved, and then monthly for two (2) months until 100% compliance is achieved. The audits will be incorporated into our quarterly QAPI meetings.</p>	

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	<p>2024...Post Fall Assessment & Documenta- tion- RN..." Updated 4/10/24.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interviews and other facility documentation including incident re- ports, it was determined that three (R2, R8 and R10) out of 10 residents reviewed for Ac- cidents, the facility failed to ensure that nurs- ing services met professional standards as ev- idenced by having LPNs complete the post fall assessment and documentation for resi- dents' post fall which violates the Delaware State Board of Nursing Scope of Practice. Findings include:</p> <p>1. 7/10/23 - R2 was admitted to the facility.</p> <p>12/29/25 5:43 PM – Per EMR entry by E18 (LPN), E18 noted R2 was found lying on his left side on the patio floor next to the rabbit hutch at 4:40 PM. E18 noted R2's "Assess- ment completed. No apparent injury." There was no evidence that R2 was evaluated by an RN after this fall.</p> <p>The post fall assessment was completed by E18, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p> <p>2. 9/2/22 - R8 was admitted to the facility.</p> <p>10/25/25 4:29 AM – Per the EMR entry by E19 (LPN), R8 was found on the floor by the bathroom door in his room at 3:56 AM. E19 noted "no injury noted post assessment". There was no evidence that R8 was evaluated by an RN after this fall.</p>		

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	<p>The post fall assessment was completed by E19, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p> <p>3. 4/9/25 – R10 was admitted to the facility.</p> <p>12/7/25 4:40 PM - Per the EMR entry by E20 (LPN), E20 noted that R10 was found on the floor near the recliner. E20 noted "no injuries noted". There was no evidence that R10 was evaluated by an RN after this fall.</p> <p>The post fall assessment was completed by E20, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p> <p>1/21/26 9:20 PM- Per the EMR entry by E19 (LPN), E19 noted that R10 was found at on the floor next to her bed at 8:50 PM. E19 noted "no injuries noted". There was no evidence that R10 was evaluated by an RN after this fall.</p> <p>The post fall assessment was completed by E19, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p>		

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