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: AL - Brookdale Dover

DATE SURVEY COMPLETED: June 12, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Revisit and Complaint Survey to the Complaint Survey that ended March 24, 2025, was conducted by the State of Delaware Division of Health Care Quality, office of Long-Term Care Residents protection from June 10, 2025, thru June 12, 2025. The facility census on the first day of the survey was forty-four (44). The sample size was nine (9) residents. The facility was found not to be in substantial compliance. Abbreviations/definitions used in this state report are as follows: CP – Care Partner; HHAED – Home Health Agency Executive director; DHW – Director of Health and Wellness; DDCS – District Director of Clinical Services; ED – Executive Director; LPN – Licensed Practical Nurse; MT – Medication Tech; ROS – Regional Operations Specialist; Uniform Assessment Instrument (UAI) assessment tool used to evaluate resident function.	4/15/2025-- Previous Health & Wellness Director (HWD) vacated her position. 5/7/2025 & 5/8/2025- Upon review of the UAI's, after the previous Health and Wellness Director (HWD) vacated her position, certain UAI's were noted to be out of compliance. The root cause analysis was determined to be the prior HWD's non-compliance with maintaining UAI's. District Director of Clinical	
3225.0 **3225.11.0** **3225.11.5** **S/S – E**	**Assisted Living Facilities** **Resident Assessment** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and**		

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	when there is a significant change in the resident's condition. Based on record review and interview it was determined that for four (R2, R3, R6 and R8) out of nine residents reviewed the facility failed to ensure that UAI assessments were completed annually. Findings include: 1/11/24 – An initial/admission UAI assessment was completed for R2. 1/16/24 – An initial/admission UAI assessment was completed for R3. 3/12/24 – An initial/admission UAI assessment was completed for R8. 4/30/24 – An initial/admission UAI assessment was completed for R6. Review of R2, R3, R6 and R8's resident's clinical records lacked evidence of any additional UAI assessments. 6/11/25 10:48 AM – During an interview E3 (DDCS) confirmed the facility failed to ensure that UAI assessments completed annually. E3 stated, "We did identify that and are in the process of reviewing them". 6/12/25 3:18 PM – The Findings were reviewed during the exit conference with E3 (DDCS) and E6 (ROS).	Services and Clinical Services Specialist completed an audit and implemented a tracking tool. A. The UAI for R2, R3, R6 and R8 were completed. B. A full house audit was completed to verify compliance with UAI, resident assessments. C. Individuals responsible for completion of UAI will be re-educated on requirements of completion by 7/25/2025. D. A new tracking tool has been implemented to assist in maintaining compliance with resident UAI's. The Health and Wellness Director (HWD) and/or designee will review current UAIs, using the tracking tool, to verify UAI completion by 7/14/2025. E. The new tracking tool will be reviewed monthly by the Health & Wellness Director (HWD) and/or designee to verify UAI's are completed upon move in, annually, and with any change in condition. F. The UAI tracking tool audits completed will be submitted to the QAPI committee.	
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.1.3	**Food service complies with the Delaware Food Code**		
S/S – D	**Delaware Food Code**		

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	3-305.11 Food Storage. (A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (2) Where it is not exposed to splash, dust, or other contamination. **3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTAB-LISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.** Based on observation and interview it was determined that the facility failed to ensure food was stored properly to prevent possible contamination and that stored food was clearly marked to indicate date by which food should be consumed. Findings include: 6/12/25 10:02 AM - During a kitchen observation the following occurred: Four trays of pureed food were located on a shelf in the walk-in refrigerator uncovered and undated.	No residents were negatively affected by this alleged deficient practice. A. The unlabeled and undated trays of pureed food were removed from the walk-in refrigerator at the time of the Survey on 6/12/2025. Each resident who receives a pureed diet will be reviewed by the Health and Wellness Director (HWD) and/or designee, for any negative outcomes related to their meals. If any negative outcomes are present, the resident's physician and legal representative will be notified, and resident will be monitored pursuant to any physician's orders. All pureed food will be labeled and dated by the Dining Services Director and/or designee. B. Dining Staff will be re-trained by the Executive Director and/or designee on the Delaware Food Code specific to 3-501.17 by 7/14/2025. This training will include proper food storage, proper labeling and dating of food, verifying food is free from contamination per community policy. Documentation of re-training will be available for review. C. Upon review it was determined the Dining Staff required additional training. To assist with ongoing compliance, the Executive Director and/or designee will audit the pureed items that are placed in the walk-in refrigerator three (3) times a week for four (4) weeks until 100% success and then weekly for four (4) weeks until 100% success to verify completion. Results will be documented on	

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	Three trays of pureed food were located on a shelf in the walk-in refrigerator covered in plastic and undated. E5 (cook) immediately confirmed the finding. 6/12/25 3:18 PM – The Findings were reviewed during the exit conference with E3 (DDCS) and E6 (ROS).	a tracking sheet by the Executive Director and/or designee.	
3225.12.0 **3225.12.3**	**Services** **The assisted living facility shall ensure that the resident's service agreement is being properly implemented.** Based on record review and interview it was determined that for one (R7) out of nine residents reviewed the facility failed to ensure that services documented in the service agreement were implemented. Findings include: The facility policy on service plans last updated, 3/2020 indicated service plans are implemented and maintained for each resident to address needs. The facility policy on skin integrity last updated, 5/2023 indicated, "As indicated, refer to wound care needs to home health/hospice for treatment after obtaining physician approval and or order. Review of R7's clinical record revealed: 10/1/24 – A service plan (agreement) documented that R7 received contracted "Home Health services for wound care."	Unable to determine Root Cause of Service Agreement not being implemented for R7. Previous clinical leadership and Executive Director no longer works in the community. A. R7 on 3/26/2025 returned home with her husband. The identified concerns cannot be corrected. B. An audit of all current resident service agreements was completed by the Health and Wellness Director (HWD) and/or designee to verify resident service agreements are current based on the services being provided. C. Direct care associates responsible for completion of service plans will be re-educated by the Health and Wellness Director (HWD) and/or designee on the process and policy for updating documentation and implementing service agreements by 7/25/2025. D. The Health & Wellness Director (HWD) and/or designee will monitor service plans weekly for four (4) weeks until 100% success, and then monthly for (2) months until 100%	

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	1/23/25 - A physician's order was written for R7 to receive a liquid protein twice a day for wound healing and prevention. 1/31/25 – A physician's order was written for R7 to have a wound care consult. 2/25/25 – A progress note in R7's clinical record written by E7 (NP) documented, "patient with stage 2 sacral wound, no signs or symptoms of infection remains afebrile consult home health for wound care." It is unclear when the area initially opened. 2/27/25 - A referral form was completed by E7 (NP) for R7 to receive wound care for a Stage II wound to the sacrum. 3/7/25 – The contracted home health agency made the first visit to perform wound care for R7. 6/12/25 1:36 PM – During an interview with C1(HHAED) it was confirmed that the facility's contract home health agency that provides wound care began service for R7 on 3/7/25. 6/12/25 2:51 PM – During an interview E3 (DDCS) stated, "Best I can tell it [the wound] started late November... I don't see that the home health started at that time. 6/12/25 3:18 PM – The Findings were reviewed during the exit conference with E3 (DDCS) and E6 (ROS).	success, to verify any change in condition and/or additional interventions that have been completed. All findings will be submitted to the QAPI committee.	
3225.13.0 **3225.13.4** **S/S – D**	**Service Agreements** **The facility shall be responsible for appropriate documentation in the service agreement for services provided or arranged by the facility.**	4/25/25- Previous Executive Director and Clinical Nurse Specialist had a conversation with R6 CG1 and daughter and indicated visitation would be supervised moving forward.	

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	Based on record review and interview it was determined that for one (R6) out of nine residents reviewed the facility failed to ensure that documentation in the service agreement reflected services provided by the community. Findings include: The facility policy on service plans last updated, 3/2020 indicated "The service plan should be specific and individualized to the needs of the resident; specific and individualized approaches for the care of the resident based on their needs. Review of R6's clinical record revealed: 5/6/24 – R6 was admitted to the facility, CG1 was documented as R6's responsible party. 1/15/25 – A service plan/agreement was completed for R6. 4/25/24 4:26 PM – The facility submitted an incident report to the State Agency that alleged physical abuse of R6 by CG1. 5/1/25 – A five day follow up to the 4/25/25 incident regarding R6 and CG1 was submitted to the State Agency. In the submission the facility documented that R6's care plan would be revised to reflect supervised visits with CG1. 6/10/25 12:33 PM – During an interview CG1 denied any physical abuse towards R6 and stated, "We been married 70+ plus years, all our life. They think I'm gonna do something to him. So now they watch us. I just stay where they can see me."	CG1 and daughter agreeable to supervised visitation. An updated care plan to reflect conversation and intervention was not completed at the time. Staff were updated and implemented supervised visitation on 4/25/25. A. R6 care plan was updated and documented supervised visit with R6's significant other. B. Care profile books (Care Plans) have been updated and are available to care staff for review of resident current interventions. C. An audit was completed on current residents to verify care profiles/ plans are current based on interventions. D. Direct care associates responsible for documenting and implementing interventions in the care profiles/plans will be re-educated by the Health and Wellness Director (HWD) and/or designee on the community policy by 7/25/2025. E. The Health & Wellness Director (HWD) and/or designee will monitor care profiles/plans weekly for four (4) weeks until 100% success and then monthly for (2) months until 100% success, to verify completed documentation of interventions. Findings will be reported at the QAPI Committee meetings.	

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	6/10/25 -6/12/25 – CG1 was observed visiting R6 with staff supervision. 6/11/25 – Review of R6's care profile/plan and service plan/agreement lacked evidence that they were updated to include documentation regarding supervised visits with CG1. 6/12/25 3:18 PM – The Findings were reviewed during the exit conference with E3 (DDCS) E6 (ROS).	Health and Wellness Coordinator (HWC) did not identify incident as sexual abuse and did not report to the Executive Director or Health and Wellness Director (HWD). Documentation found during report audit of incident and investigation completed. State reportable submitted, and re-education completed with Health and Wellness Coordinator (HWC) by the Clinical Services Specialist on 5/29/2025.	
3225.19.0 **3225.19.6** **S/S- D**	**Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** Based on record review and interview it was determined that for one (R2) out of three residents reviewed for allegations of abuse the facility failed to ensure that an allegation of abuse was reported to the State agency within eight hours. Findings include: The facility policy on abuse, neglect and exploitation, last updated 5/2021, indicated "The Executive Director should notify the DHCQ within eight hours of the occurrence." 5/28/25 4:11 PM – The facility submitted an allegation of sexual abuse to the State Agency that allegedly occurred on 5/26/25 at 5:40 PM. The report submission was greater than eight hours past the alleged occurrence.	A. Report was submitted upon the community's identification of the incident. B. An audit of progress notes have been completed for the last 30 days to verify no additional incidents were not identified and/or reported. C. Community re-education for all associates will be completed by the Health and Wellness Director (HWD) and/or designee on reporting requirements, identification of a reportable incident and community policy of notification by 7/25/2025. D. To assist with ongoing compliance, the Health and Wellness Director (HWD) and/or designee will review the 24-hour summary report and progress notes daily for two (2) weeks until 100% success and then weekly for four (4) weeks until 100% success to verify completion. E. Findings will be reported at the QAPI Committee meetings.	

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	6/11/25 2:30 PM – During an interview E1 (ED) confirmed the delay in reporting. E1 stated, "The nurse was told right away but he thought because it was just a 'pat' that he didn't need to report it. He was educated." 6/12/25 3:18 PM – The Findings were reviewed during the exit conference with E3 (DDCS) and E6 (ROS).		

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