



**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: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: March 24, 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>3225.9.0</p>	<p>An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from March 19, 2026, through March 24, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred and seven (107). The survey sample totaled eighteen (18) residents.</p> <p>Abbreviations/definitions used in this state report are as follows:</p> <p>CM – Care Manager; ED – Executive Director; LPN – Licensed Practical Nurse; RN – Registered Nurse;</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. 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>1. E3 was corrected in the moment via surveyor. R18 medication re-administered appropriately. E3 received further education immediately from DON.</p> <p>2. Any residents receiving medication, has the potential to be affected by the deficient practice.</p> <p>3. Root cause analysis was determined to be that staff member E3 did not follow infection control policies as outlined by policy and procedure. All staff that administer medications to receive re-education on the appropriate infection control procedures while administering medication by the Regional Float RN. This information is provided in orientation for new staff.</p> <p>4. Observation of medication pass to be observed daily x 5, then weekly times 4 until 100% compliance is met. Executive Director will be responsible for audit completion.</p>	<p>05/08/2026</p>

Provider's Signature

Michael...

Title

Executive Director

Date

4/21/26



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<p>3225.12.0</p> <p>3225.12.1</p> <p>3225.12.1.3</p> <p>S/S - F</p>	<p>3/24/26 10:30 AM – During an interview, E3 stated that he always opened medications with bare hands to mix with pudding and then administers medication to resident. E3 stated “I did not touch the medication inside the capsule.” E3 confirmed he did open the capsule ungloved and poured it into the medication cup.</p> <p>3/23/26 11:00 AM – During an interview, E2 (DON) stated that all staff are trained upon hire and annually regarding infection control. E2 further stated the expectation during medication administration is to open medications using a gloved hand and the nurse should follow stand precautions.</p> <p>3/24/26 3:00 PM – Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.</p> <p>Services</p> <p>The assisted living facility shall ensure that:</p> <p>Food service complies with the Delaware Food Code</p> <p>Delaware Food Code</p> <p>Based on observations, interviews, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include:</p> <p>2-103.11 Person in Charge.</p> <p>The PERSON IN CHARGE shall ensure that</p>	<p>1. No immediate corrective action available.</p> <p>2. All residents that receive meals at the facility have the potential to be impacted by the deficient practice.</p> <p>3. Root cause analysis was determined to be that reports of temperature checks were not retained in a specific location for the ability to keep. Education to be provided to all culinary staff responsible for food temperature monitoring that all records are to be kept for 1 year to ensure compliance, training will be provided by the Acting Culinary Director. Records are to be kept in a binder in the Dining Director’s office.</p> <p>4. Temperature logs will be produced during daily manager meeting x 5 days and then weekly x 4 until 100% compliance is achieved. Executive Director will be responsible for auditing.</p>	<p>05/08/2026</p>

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<p>3225.16.0 3225.16.2 S/S – D</p>	<p>(G) EMPLOYEES are properly cooking TIME/TEMPERATURE CONTROL FOR SAFETY FOOD, being particularly careful in cooking those FOODS known to cause severe foodborne illness and death, such as EGGS and COMMINUTED MEATS, through daily oversight of the EMPLOYEES' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated as specified under § 4- 203.11 and ¶ 4-502.11(B);</p> <p>3/19/26 - During the survey of the facility at approximately 3:30 PM, temperature monitoring were not consistently maintained to verify that safe food temperatures were being maintained to prevent food borne illness of highly susceptible residents. It was discovered that the facility was missing 276 mealtime temperature logs out of 234 reviewed. The facility failed to provide records for the months of October, November, and December 2025.</p> <p>3/20/26 4:00 PM - Discussed findings with E1 (ED) and E4 (Director of Culinary).</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>1. No immediate resolution available. 2. All residents that have falls have the potential to be impacted by this deficient practice. 3. Root cause analysis was determined to be that there was not an existing knowledge of the change in Delaware State Board of Nursing determination of LPN scope of practice. All LPN staff to be educated that they are not</p>	<p>05/08/2026</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 evi- denced by:</p> <p>Based on record review, interviews and other facility documentation, it was deter- mined that three (R7, R10 and R11) out of five residents reviewed for falls, the facility failed to ensure that nursing services met professional standards as evidenced by having LPNs complete the post fall assess- ment and documentation for residents' post fall which violates the Delaware State Board of Nursing Scope of Practice. Findings include:</p> <p>1. Review of R7's clinical record revealed:</p> <p>12/5/24 – R7 was admitted to the facility.</p> <p>11/17/25 8:00 AM – A facility reported inci- dent documented that R7 was found lying on the floor in her room and stated R7 fell while walking to the bathroom. The report documented that R7 was assessed for pain and injury by the E3 (LPN) and R7 was com- plaining of lower back pain post fall.</p> <p>11/17/25 – An incident report on the EHR (electronic health record) documented res- ident assisted to seated position, vital signs obtained, and assessment completed. The EHR documented an electronic signature noted by E3 (LPN).</p> <p>3/20/26 12:24 PM – During an interview, E3 confirmed that he completed the post fall assessment on 11/17/25 for R7.</p>	<p>authorized to assess a resident post fall. Post fall assessments are to be completed by an RN. Training to be provided by Regional Float RN An RN is available to the facility at all times to include an on call RN for assess- ment.</p> <p>4. Audit of falls will be completed weekly x 4 and then x2 months until compliance achieved.</p>	

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	<p>2. Review of R10's clinical record revealed:</p> <p>10/28/21 – R10 was admitted to the facility.</p> <p>10/23/25 4:00 PM – A facility report incident documented that R10 was found on the floor of her room next to the bed, lying in the left lateral position. The report documented that R10 was assessed by E5 (LPN).</p> <p>10/23/25 – An incident report on the EHR documented resident assessed at bedside, able to move all extremities, and hematoma (bruise/swelling) to left side of forehead. The EHR documented an electronic signature noted by E5 (LPN).</p> <p>3/24/26 12:50 PM – During an interview, E2 (DON) confirmed that E5 (LPN) completed the post fall assessment on 10/23/25 on R10.</p> <p>3. Review of R11's clinical record revealed:</p> <p>7/11/19 – R11 was admitted to the facility.</p> <p>10/24/25 3:00 PM – A facility reported incident documented that R11 had a witnessed fall.</p> <p>10/24/25 – A post fall assessment documented that R11 had no injuries and able to ambulate with no concerns. The post fall assessment was signed off by E5 (LPN).</p> <p>10/29/25 3:19 PM – An x-ray report documented that R11 had a fracture at the neck of the left femur bone.</p> <p>11/1/25 2:15 PM – A facility reported incident was submitted to the state agency.</p>		

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<p>3225.19.0 3225.19.6</p>	<p>3/24/26 12:50 PM – During an interview, E2 (DON) confirmed the post fall assessment was completed by E5 (LPN).</p> <p>3/24/26 3:00 PM – Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.</p> <p>Records and Reports</p> <p>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.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review and review of other facility documentation for one (R10) out of five residents review for falls, the facility failed to conclude the investigation and submit follow up report to the division in the five-day timeframe. Findings include:</p> <p>Review of R10's clinical record revealed:</p> <p>10/28/21 – R10 was submitted to the facility.</p> <p>10/23/25 4:00 PM – A facility report incident documented that R10 was found on the floor of her room next to the bed, lying in the left lateral position.</p> <p>11/13/25 11:55 PM – A facility reported 5 day follow up report was submitted to the State Agency.</p>	<p>1. No immediate remedy available. Executive Director did verify system access for reporting.</p> <p>2. Any resident that is involved in a reportable incident has the potential to be impacted by the deficient practice.</p> <p>3. Root Cause Analysis was determined to be access to the reporting system for 5 day follow ups. Executive Director and Wellness Director will maintain access to reporting system and any access issues will be immediately addressed with Wellsky and DHSS to ensure ability to report timely.</p> <p>4. An audit will be completed daily x 5 and then weekly x 4 of all reportables to ensure all 5 day follow ups are completed according to regulatory guidelines until 100% compliance achieved. Executive Director will be responsible for completion of audit.</p> <p>1. No immediate remedy available.</p>	<p>05/08/2026</p> <p>05/08/2026</p>

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<p>3225.19.7 3225.19.7.1 3225.19.7.1.3 3225.19.7.1.3.1 3225.19.7.7 3225.19.7.2 S/S - E</p>	<p>3/24/26 12:50 PM -- During an interview, E2 (DON) confirmed the 5 day follow up report was not submitted to the state agency within the 5 days.</p> <p>3/24/26 3:00 PM -- Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.</p> <p>Reportable incidents include:</p> <p>Abuse as defined in 16 Del.C. §1131.</p> <p>Emotional abuse.</p> <p>Staff to resident.</p> <p>Significant injuries.</p> <p>Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review and review of other facility documentation, it was determined for five (R15, R, R, R, and R) out of five residents sampled for reportable incidents, the facility failed to report to the Division within the required 8 hours. Findings include:</p> <p>1. Review of R15's clinical record revealed:</p> <p>1/3/26 - R15 was admitted to the facility.</p>	<p>2. Any resident that experiences a reportable event has the potential to be affected by the deficient practice.</p> <p>3. Root cause analysis determined that the Executive Director and Wellness Director investigated the incidents prior to reporting to ensure they were truly reportable events. Further x-ray reports were not addressed in a timely manner to ensure correct reporting times. Executive Director educated on reporting first and then investigating. Nursing staff were educated that any x-rays or lab reports that determine an injury occurred, are to be immediately called to the Executive Director or Wellness Director for reporting. During orientation incoming Wellness Director will be educated as to appropriate reporting. Education Provided by Executive Director and Regional Float RN.</p> <p>4. An audit of progress notes, labs, and radiology reports will be completed daily x 5 and then weekly x 2 by the Executive Director until substantial compliance is achieved.</p>	

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	<p>1/19/26 – A review of a facility statement authored by E2 (DON) documented “I received a phone call from [R15’s] [FM1] stating at 7:30 AM [R15] called and was upset that E10 (CM) called [R15] an “idiot” and didn’t help with getting [R15] ready. Further review of the statement documented R15 reported being called an “idiot” by E__ to E2.</p> <p>1/19/26 3:05 PM – A review of a facility reported incident to the Division for R15 documented a report of abuse.</p> <p>1/20/26 3:19 PM – A review of a facility reported incident to the Division for R15 documented the incident of verbal abuse was reported by the facility more than twenty-four hours later.</p> <p>3/23/26 1:55 PM – An interview with E2 confirmed the facility did not report the allegation of abuse within the Division’s required time frame. E2 stated, “Oh, ok yes it was reported late.”</p> <p>2. Review of R7’s clinical record revealed:</p> <p>12/5/24 – R7 was admitted to the facility.</p> <p>11/17/25 8:00 AM – A facility reported incident documented that R7 had an unwitnessed fall and found lying on the floor.</p> <p>11/18/25 12:21 PM – A facility reported incident was submitted to the state agency.</p>		

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	<p>3/20/26 11:52 AM – During an interview, E2 (DON) confirmed the report was not submitted to the state agency within the appropriate timeframe.</p> <p>3. Review of R8’s clinical record revealed:</p> <p>3/25/20 – R8 was admitted to the facility.</p> <p>1/30/26 11:40 AM – A facility reported incident documented resident had a witnessed fall and lowered herself to the floor.</p> <p>2/2/26 – A progress note documented that R8 presented with discoloration to hand and x-ray to be completed. Xray was positive for fracture.</p> <p>2/4/26 00:37 AM – A facility reported incident was submitted to the state agency.</p> <p>3/20/26 3:01 PM – During an interview, E2 (DON) confirmed that the report was not submitted to the state agency within the appropriate timeframe.</p> <p>4. Review of R11’s clinical record revealed:</p> <p>7/11/19 – R11 was admitted to the facility.</p> <p>10/24/25 3:00 PM – A facility reported incident documented that R11 had a witnessed fall.</p> <p>10/29/25 3:19 PM – An x-ray report documented that R11 had a fracture at the neck of the left femur bone.</p> <p>11/1/25 2:15 PM – A facility reported incident was submitted to the state agency.</p>		05/08/2026

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<p>Title 16 – Healthy and Safety Sub- chapter II § 1121. Resi- dent's rights.</p> <p>S/S – D</p>	<p>3/24/26 12:50 PM – During an interview, E2 (DON) confirmed that the staff notified her of the positive fracture and realized on 11/1/25 that the report was not submitted to the state agency.</p> <p>3/24/26 3:00 PM – Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.</p> <p>(30) Each resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review, and review of other facility documentation for one (R13) out of ten residents reviewed for abuse the facility failed to prevent a staff to resident abuse. Findings include:</p> <p>Review of R13's clinical record revealed:</p> <p>9/15/22 – R13 was admitted to the facility.</p> <p>2/6/25 – A UAI (Uniform Assessment Instrument) documented that R13 had dementia, had a history of assaultive behaviors, resistive to care, and community is required to arrange Behavior Management Program.</p> <p>4/25/25 7:45 AM – A facility reported incident documented that a staff member reported another staff member [R6] had</p>	<ol style="list-style-type: none"> 1. No remedy available for R13 as they no longer reside at the facility. 2. Any resident displaying memory impairment and combative behaviors has the potential to be impacted. 3. Root Cause Analysis determined that E6 did not utilize their training in abuse prevention appropriately. All direct care on memory care units will complete Relias training course "Dementia Care: Challenging Behaviors and Direct Care Staff" which includes appropriate handling of combative behaviors. 4. An audit of careplans will be completed of any residents that have displayed combative or aggressive behaviors to ensure effective interventions are provided. 	

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	<p>placed their hand on a [R13] resident's mouth. The report documented the staff member [E6] was removed from duties pending investigation.</p> <p>4/25/25 8:00 AM – A witness statement documented that [E8] was assisting E6 to provide care to R13 and during care R13 became combative, trying to bite, and spit on E6. After R13 spit on E6, E6 hit R13 on the mouth twice and stated "You [R13] aren't going to spit on me." E8 documented that the incident was reported to E7 (LPN) immediately.</p> <p>5/25/25 – A service agreement documented that R13 requires physical assistance x1 for ADL's, requires behavior management, and frequent redirection related to neurocognitive deficit.</p> <p>3/24/26 10:54 AM – During an interview, E7 (LPN) stated that E8 (CM) reported on 4/25/25 that she witnessed E6 (CM) hit R13 in the mouth during care. E7 stated an assessment was completed to R13 post incident and no evidence of any injury was noted at that time. E7 also stated that on 4/26/25 R13 had a bruise and swelling noted to the left side of the lip.</p> <p>The facility failed to protect R13 from physical abuse from staff.</p> <p>3/24/26 3:00 PM – Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.</p>	<p>1.No remedy available for Resident R13 at this time. A review of all resident records that have been to external appointments reviewed to ensure consult or follow up obtained from said appointment.</p> <p>2. Any resident that attends an outside medical appointment has the potential to be affected by this deficient practice.</p> <p>3. Root cause analysis indicates that the deficient practice derived from the facility not receiving follow up instructions nor obtaining them on their own. All nursing staff will be educated that anyone that attends an outside appointment is to have follow up documentation. If said documentation is not automatically provided by resident/family or outside medical practice, nursing staff will contact the medical practice for follow up.</p>	<p>05/08/2026</p>

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S/S - D	<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 following:</p> <p>c. Failure to carry out a prescribed treatment plan for a patient or resident.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review and review of other facility documentation for one (R1) out of five reviewed for neglect, the facility failed to provide a prescribed treatment resulting in infection. Findings include:</p> <p>Review of R1's clinical record revealed:</p> <p>7/23/24 – R1 was admitted to the facility.</p> <p>8/6/25 – A pre-operative instruction sheet documented that R1 was to have a procedure on 9/9/25 and 10/24/25 with an outside provider.</p> <p>9/9/25 – A post-operative instruction sheet documented that R1 had the following dressing change order: Bandage to remain in place for 24 hours, Clean affected area, apply ointment, and bandage every day, twice a day. R1 will follow up for suture removal in 21 days or 3 weeks from current date.</p> <p>10/24/25 – A provider procedure note documented that R1 had a Mohs procedure completed to right posterior shoulder for</p>	<p>Training will be provided by Regional Float RN.</p> <p>4. The Executive Director will audit 3 x per week x 4 weeks to ensure that all appointments have substantial compliance in obtaining follow up.</p>	

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	<p>removal of basal cell carcinoma. "The patient understands they will receive post-surgical care and follow up from the referring physician's office. Antibiotic ointment and dry sterile dressing applied." Follow up in three weeks for suture removal.</p> <p>10/24/25 1:23 PM – A nursing progress note documented that "[R1] returned from outside appointment and no new orders regarding wound care. Sister dropped off prescription order of Keflex and sent to pharmacy."</p> <p>11/14/25 – A provider follow up progress note documented that R1 was present for suture removal and provider ordered labs for culture related to infection on skin. The progress note documented expectations for skin care was surgical sites to be cleansed with sterile saline, topical antibiotics and non-adhesive dressing to be applied. The provider ordered doxycycline 100 mg one tablet by mouth twice a day for seven days related to infection.</p> <p>11/14/25 – A physician's order documented doxycycline 100 mg by mouth twice a day for 7 days related to infection and mupirocin (antibiotic ointment) apply twice a day to surgical site for two weeks.</p> <p>3/23/25 1:34 PM – During an interview, E9 (RN) confirmed that R1 went to an outside provider appointment on 10/24/25 and 11/14/25. E9 stated the expectation is when a resident returns from an outside</p>		

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NAME OF FACILITY: Brandywine Assisted Living Seaside Pointe

DATE SURVEY COMPLETED: March 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	<p>provider appointment, the nurse would re-view the consultation notes documented on the facility provided document that the resident takes. E9 stated that provider's do not always complete the consult form and the resident's do not always return the forms to the facility for the nurse to review. E9 stated she was not aware that R1 had a procedure completed on 10/24/25 and does not recall receiving outside provider consult notes or orders. E9 stated she did receive the antibiotic order from outside provider and submitted it to pharmacy for R1. E9 confirmed she did not call the provider to determine if any wound care orders were ordered post procedure.</p> <p>The facility failed to initiate prescribed treatment for R1 that resulted in an infection requiring antibiotics.</p> <p>3/24/26 3:00 PM – Findings were discussed with E1 (ED) and E2 (DON) during the exit conference.</p>		

Provider's Signature _____ Title _____ Date _____



**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

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