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 - Oakbridge Terrace at Manor House **DATE SURVEY COMPLETED:** October 15, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from October 13, 2025, through October 15, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-eight (38). The survey sample totaled five (5) residents. Abbreviations/definitions used in this state report are as follows: DON – Director of Nursing; NHA – Nursing Home Administrator; Hematoma – collection of blood as a result of trauma, such as a black eye; a bruise, a black and blue mark.		
3225.0	**Assisted Living Facilities**		
3225.19.0	**Records and Reports**	1. Resident R4 was clinically assessed by an RN immediately following the fall on 10/13/25. No adverse outcomes occurred due to the delayed reporting outside the 8-hour window. The resident remained stable with continued monitoring per protocol. A 30-day retrospective audit of all incidents and falls from 09/13/25 to 2. 10/13/25 was conducted to identify any other reportable incidents that may not have been submitted within the 8-hour timeframe. No additional incidents requiring reporting were identified as overdue. All residents who experienced falls during this time were reviewed to ensure appropriate clinical assessments and monitoring occurred.	10/31/2025
3225.19.3	**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.**		
3225.19.7	**Reportable incidents include:**		
3225.19.7.7	**Significant Injuries**		
3225.19.7.7.2 S/S – D	**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 up to 48 hours.**		

Provider's Signature ______ Title NHA Date 10/24/25

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	This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R4) out of one resident reviewed for falls, the facility failed to report R4's fall that required periodic monitoring to the State agency within the appropriate timeframe. Findings include: 2/14/24 - R4 was admitted to the facility. 10/13/25 8:19 PM - A facility incident report documented that R4 had an unwitnessed fall and found lying on the bedroom floor. 10/13/25 8:19 PM - A nursing progress note documented that R4 was found lying on the apartment floor, with head resting on the edge of the sewing machine table. The progress note further documented that R4 had two hematomas noted to the back of head with no active bleeding. Additionally, the on-call provider was notified, and the ongoing neurological assessment was initiated for R4. 10/14/25 10:22 AM – An incident report was submitted to the State Agency documenting R4 had an unwitnessed fall on 10/13/25 at 8:19 PM. 10/14/25 9:46 AM - During an interview, E2 (DON) confirmed the incident was submitted to the State Agency on 10/14/25 at 10:22 AM. The facility failed to submit the incident report to the State Agency within eight hours. 10/15/25 - Findings were discussed with E1 (NHA) and E2 during the exit conference.	3. Education will be provided to the management team, and nursing staff by the nursing home administrator or designee on reportable events per the state guidelines, including any incident that requires 24-hour neuro checks. Upon root cause analysis, it was identified that the incident was not reported initially due to no hospital transfer of the resident within the 8 hours. The incident report was submitted when the decision was made to send the resident out for further evaluation of a CT scan to the head the next day. 4. The Director of Assisted Living or designee will review the facility's 24-hour report daily to ensure all potentially reportable incidents are identified and reported within the required timeframe. An audit will be conducted of 100% of the incident reports weekly x 4 weeks, then monthly x 3 months or until 100% compliance is achieved to confirm timely submission. In the event where compliance is consistently below the goal, the interdisciplinary team (IDT) will review the process, and revision will be made to maintain and sustain compliance. Results will be reviewed in Quality Assurance and Performance Improvement meetings.	

Provider's Signature [signature] Title NHA Date 10/24/25