



**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

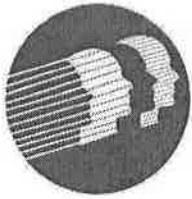
Page 1 of 16

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: September 3, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from September 1, 2026, to September 3, 2026. The facility census on the first day of the survey was 38 (thirty-eight). The survey sample totaled seven (7) residents and a subsample survey of an additional five (5) residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures, and complaint and incident documentation from the State Agency. Abbreviations/definitions used in this state report are as follows: BOM/HR – Business Office Manager/Human Resources; CERTIPHI - Background screening services that cover both fundamental research components and specialized searches for healthcare organizations; DELPROS - Delaware's Professional Regulation Online Services portal. D/KM - Dining/Kitchen Manager; ED - Executive Director; EMR – Electronic Medical Record; HWD - Health Wellness Director; LPN – Licensed Practical Nurse; MM – Maintenance Manager; PSP (Personal Service Plan) – Facility form utilized as the Service Agreement: RN – Registered Nurse;	The following is the Plan Of Correction for Brookdale Hockessin for the statement of deficiencies from the survey completed on September 3, 2026. This plane of corrections is being submitted as conformation of our continued efforts to comply with state regulatory requirements. In this document we have outlined our specific actions we will take in response to the identified issues. We remain committed to delivering top quality healthcare services.	

Provider's Signature _____ Regina Romano _____ Title __Executive Director____ Date ____9/24/2026_____



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STATE SURVEY REPORT

Page 2 of 16

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3225.0	SA (Service Agreement) - 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.		
3225.1.0	Assisted Living Facilities Purpose 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.		
3225.12.0	Assisted Living Facilities		
3225.12.1	The assisted living facility shall ensure that:	3225.12.0	
3225.12.1.3	Food service complies with the Delaware Food Code	3225.12.1	
S/S – F	4458 State of Delaware Food Code Regulations	3225.12.1.3	
	2.0 Adoption of United States Public Health Service 2022 Food Code	S/S – F	
	2.1 The State of Delaware Food Code adopts, as if fully set forth in this regulation,	Food service	
		A. There were no residents negatively impacted by this deficient practice. A new cook was hired who is a Certified Food	

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STATE SURVEY REPORT

Page 3 of 16

NAME OF FACILITY: Brookdale Hockessin

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	the United States Public Health Service 2022 Food Code 2022 Food Code U.S Food and Drug Administration Chapter 2. Management and Personnel 2-1 Supervision 2-101 Responsibility 2-101.11 Assignment. (A) Except as specified in ¶¶ (B) and (C) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation. 2-102.11 Demonstration. Based on the RISKS inherent to the FOOD operation, during inspections and upon request the PERSON IN CHARGE shall demonstrate to the REGULATORY AUTHORITY knowledge of foodborne disease prevention, application of the HAZARD Analysis and CRITICAL CONTROL POINT principles, and the requirements of this Code. The PERSON IN CHARGE shall demonstrate this knowledge by: (B) Being a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. Chapter 3. Food 3-401 Cooking 3-401.11 Raw Animal Foods. (A) Except as specified under ¶ (B) and in ¶¶ (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts	Protection Manager (CFPM). The Executive Director (ED) or designee is assisting other cooks obtain their CFPM certifications. E4 (KM) or designee will verify that all temperature logs were completed for the previous six (6) months and are placed in a binder and housed in the kitchen. B. All residents have the potential to be affected by this deficient practice. E4 or designee will verify that there is at least one dining staff member that is CFPM certified scheduled when the kitchen is in operation. C. All food service/dietary staff will be re-trained by the Kitchen manager or designee on verification of all temperature checks documentation during the meal times per the Delaware food code 3-401.11 This will be by 9/25/2026. All new kitchen staff will be in-serviced by the ED or designee during orientation. D. To assist with ongoing compliance, the ED, Kitchen Manager or designee will perform audits of temperature logs weekly for four (4) weeks, then biweekly for four (4) weeks and then monthly until 100% compliance is achieved.	10/18/2026

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STATE SURVEY REPORT

Page 4 of 16

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	of the FOOD to a temperature and for a time that complies. 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified 75 FDA Food Code 2022 Chapter 3. Food under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130°F) or above; P or (2) At 5°C (41°F) or less. Based on interview and document review it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 9/1/26 12.30 PM – During the survey of the facility and review of Certified Food Protection Manager (CFPM) certifications revealed E4 (D/KM) was the only CFPM. Through interview with E4, it was determined that E4 works six days a week. This schedule does not meet the requirement to always have a Certified Food Protection Manager on site when the kitchen is in operation. 9/1/26 2:45 PM – During the survey of the facility and a review of food temperature documentation provided by E4 (D/KM), it was revealed that there were missing food temperature logs in the months of June, July, and August. The month of June revealed 38 meals out of 60 reviewed did not have food		

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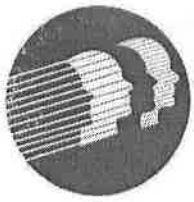
Page 5 of 16

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: September 3, 2026

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3225.13.0 3225.13.3 S/S – E	temperature documentation. The month of July did not have logs available for review. Additionally, the month of August had 48 meals out of 60 meals reviewed that did not have food temperature documentation. 9/3/26 – Findings were reviewed per telephone with E1 (ED) at the environmental exit conference at approximately 4:00 PM. Service Agreements The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number. This requirement was not met as evidenced by: Based on record review, it was determined that for six (R1, R2, R3, R5, R6 and R7) out of seven sampled residents, the service agreements did not contain the Physician information. Findings include: 1. 10/31/22 - R1 was admitted to the facility. The facility lacked evidence that the SA dated 4/3/26 contained the Physician's name, address and telephone number. 2. 10/5/24 – R2 was admitted to the facility. The facility lacked evidence that the SA dated 5/28/26 contained the Physician's name, address and telephone number. 3. 3/9/26 – R3 was admitted to the facility. The facility lacked evidence that the SA dated 3/9/26 contained the Physician's name, address and telephone number. 4. 8/14/26 - R5 was admitted to the facility. The facility lacked evidence that the SA	3225.13.3 Service Agreements A. There were no residents negatively impacted by this deficient practice. Each resident Service Agreement (SA) will reflect the physician's name, address and phone number. B. All residents have the potential to be affected by this deficient practice. Health and Wellness Director (HWD) or designee will verify that the SA has the correct personal attending physician name, address, and phone number is identified in the SA. C. Upon admission, all resident medical records will include the residents attending physician name, address, and phone number. All nursing staff will be retrained by the HWD on the importance of making sure that the resident personal physician's name, address, and phone number is added to the service agreement. D. To assist with ongoing compliance, the ED, HWD, or designee will perform audits of a	10/18/2026

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STATE SURVEY REPORT

Page 6 of 16

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	dated 8/14/26 contained the Physician's name, address and telephone number. 5. 3/16/20 – R6 was admitted to the facility. The facility lacked evidence that the SA dated 3/8/26 contained the Physician's name, address and telephone number. 6. 1/31/03 – R7 was admitted to the facility. The facility lacked evidence that the SA dated 7/2/26 contained the Physician's name, address and telephone number. 9/3/26 2:30 PM – During an interview, E2 (HWD) confirmed that the SAs did not contain the Physician's information. E2 stated the PSP form used by the facility for the SA has no place to add the physician information. 9/3/26 - Findings were reviewed per telephone with E1 (ED), E2 (DHW) and E3 (BOPM/HR) at the exit conference, beginning at approximately 2:30 PM. This requirement was not met as evidenced by: Based on record review, it was determined that for six (R1, R2, R3, R5, R6 and R7) out of seven sampled residents, the service agreements did not contain the Physician information. Findings include: 1. 10/31/22 - R1 was admitted to the facility. The facility lacked evidence that the SA dated 4/3/26 contained the Physician's name, address and telephone number. 2. 10/5/24 – R2 was admitted to the facility. The facility lacked evidence that the SA	sample of resident medical records weekly for four (4) weeks, biweekly for four (4) weeks, and monthly until all files have been updated and 100% compliance is achieved.	

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Page 7 of 16

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	dated 5/28/26 contained the Physician's name, address and telephone number. 3. 3/9/26 – R3 was admitted to the facility. The facility lacked evidence that the SA dated 3/9/26 contained the Physician's name, address and telephone number. 4. 8/14/26 - R5 was admitted to the facility. The facility lacked evidence that the SA dated 8/14/26 contained the Physician's name, address and telephone number. 5. 3/16/20 – R6 was admitted to the facility. The facility lacked evidence that the SA dated 3/8/26 contained the Physician's name, address and telephone number. 6. 1/31/03 – R7 was admitted to the facility. The facility lacked evidence that the SA dated 7/2/26 contained the Physician's name, address and telephone number. 9/3/26 2:30 PM – During an interview, E2 (HWD) confirmed that the SAs did not contain the Physician's information. E2 stated the PSP form used by the facility for the SA has no place to add the physician information. 9/3/26 - Findings were reviewed per telephone with E1 (ED), E2 (DHW) and E3 (BOPM/HR) at the exit conference, beginning at approximately 2:30 PM.		
3225.14.0	Resident Rights		
3225.14.1	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.		
S/S – E			

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STATE SURVEY REPORT

Page 8 of 16

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Del.C. Ch 11, Sub- chapter II - § 1121. Resident's rights.	§ 1121. Resident's rights. (21) Each resident has the right, personally, through other persons, or in combination with others to do any the following d. Present complaints or petitions to the facility's staff or administrator, the Department of Health and Social Services, the protection and advocacy agency, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination. This requirement was not met as evidenced by: Based on observation and interview, it was determined that grievance forms were not readily available to residents. Findings include: 9/1/26 - During the survey of the facility, at approximately 12:00 PM, the surveyor inquired from E3 (BOM/HR) where the grievance forms were located. It was discovered that they were behind the desk at the front entrance and a resident would need to request a form from a staff member. These forms were not easily accessible and do not allow for residents to file a grievance anonymously. 9/3/26 – Findings were reviewed per telephone with E1 (ED) at the environmental exit conference at approximately 4:00 PM.		
3225.14.0	Resident Rights		
3225.14.1	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.		
S/S -E		3225.14.0 3225.14.1	

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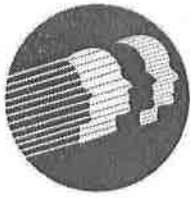
Page 9 of 16

NAME OF FACILITY: Brookdale Hockessin

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Del.C. Ch 11, Subchapter II - § 1121. Resident's rights. § 1123. Notice to patient.	(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. This requirement was not met as evidenced by: Based on record review and interview, it was determined for seven (R1, R2, R3, R4, R5, R6 and R7) out of seven residents reviewed for 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: The Resident Rights form (updated September 2023) required each resident or resident representative to sign and date acknowledging the receipt of a copy of the Resident Rights. 1. 10/31/22 - R1 was admitted to the facility. The facility was unable to provide any documentation of R1 or R1's resident representative being notified and signing off on the updated Resident Rights form. 2. 10/5/24 - R2 was admitted to the facility. The facility was unable to provide any documentation of R2 or R2's resident representative being notified and signing off on the updated Resident Rights form.	S/S – E Resident Rights A. There were no residents negatively impacted by this deficient practice. Grievance forms have been placed in a binder and placed on the table upstairs, in a common area, where they are accessible to residents if they choose to file a grievance anonymously. All residents or resident representatives were immediately notified and have either signed off on or were given the updated resident rights form to sign and return to the community. B. All residents have the potential to be affected by this deficient practice. ED, HWD or designee will verify that the grievance binder is on the table upstairs where they are readily available to the residents to file a grievance anonymously. Previous copies of the resident rights forms have been removed and replaced by the updated forms to verify compliance with the provisions of the Rights of Patients. C. HWD, Sales Manager (SM), BOM or designee will be retrained by the ED or designee on the importance of resident rights forms, including obtaining signed acknowledgements and obtaining a copy of the resident's rights form at the time of admission. A copy of the signed resident right's statement, will be kept in the files.	10/18/2026

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STATE SURVEY REPORT

Page 10 of 16

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DATE SURVEY COMPLETED: September 3, 2026

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	3. 3/9/26 - R3 was admitted to the facility. The facility was unable to provide any documentation of R3 or R3's resident representative being notified and signing off on the updated Resident Rights form. 4. 5/8/25 - R4 was admitted to the facility. The facility was unable to provide any documentation of R4 or R4's resident representative being notified and signing off on the updated Resident Rights form. 5. 8/14/26 - R5 was admitted to the facility. The facility was unable to provide any documentation of R5 or R5's resident representative being notified and signing off on the updated Resident Rights form. 6. 3/16/20 - R6 was admitted to the facility. The facility was unable to provide any documentation of R6 or R6's resident representative being notified and signing off on the updated Resident Rights form. 7. 1/31/03 - R7 was admitted to the facility. The facility was unable to provide any documentation of R7 or R7's resident representative being notified and signing off on the updated Resident Rights form. 9/3/26 9:15 AM – During an interview, E3 (BOM/HR) confirmed the resident agreement/contract does not include the updated resident's rights form, nor does the resident handbook provided at admission. E3 confirmed the form in the handbook was not the updated version. 9/3/26 - Findings were reviewed with E1 (ED), E2 (DHW) and E3 at the exit conference, beginning at approximately 2:30 PM.	D. To assist with ongoing compliance, the HWD, HWC, SM, BOM, or designee will perform audits of random resident medical records weekly for four (4) weeks, biweekly for four (4) weeks, and monthly until all files have been updated and 100% compliance is achieved.	

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STATE SURVEY REPORT

Page 11 of 16

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3225.16.0	Staffing		
3225.16.2	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.	3225.16.2	
S/S- D	This requirement was not met as evidenced by: Based on record review, interview and State Agency Incident reporting, it was determined that one E10 (LPN) was hired in the LPN position but was not licensed in the State of Delaware to practice. Findings include: 12/2/25 – E10 (LPN) was hired in a part-time position. 9/2/26 11:30 AM – During an interview, E3 (BOM/HR Manager) stated she was newly hired at the time and was not aware to check the DELPROS site for license eligibility. E3 stated the background system (Certiphi) she checks applicants at pre-hire, listed E10's license as active LPN. E3 stated she was auditing the licenses of staff on 3/31/26 and it was discovered that E10's LPN license was for Pennsylvania, not Delaware. E3 stated she notified the ED and HWD as soon as discovered and E10 was suspended immediately pending investigation. E10's employment was terminated on 4/6/26 and the licensing incident was reported to the Delaware Board of Nursing. 9/3/26 11:45 AM – Surveyor reviewed the hiring process in place since this incident. E3	Staffing Past Non-Compliance Completed - 4/6/26	

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STATE SURVEY REPORT

Page 12 of 16

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Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.) § 1131. Definitions. S/S – D	was educated on the hiring process 3/31/26. Subsequent applicants' licenses were verified through the DELPROS site prior to hire. Compliance was as of met 4/6/26. 9/3/26 - Findings were reviewed with E1 (ED), E2 (DHW) and E3 at the exit conference, beginning at approximately 2:30 PM. Title 16 DE CODE; Chapter 11; Subchapter III (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: a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety. This requirement was not met as evidenced by: Based on record review and interview, it was determined that one (R6) out of twelve residents reviewed for medication orders, the facility failed to follow up regarding a medication that was prescribed and subsequently administered when it was listed as an allergy in the resident's record. 3/16/20 – R6 was admitted to the facility. The hybrid record listed numerous antibiotic allergies which included Macrobid. 8/25/26 – An order for Macrobid 100 MG two times a day for UTI (urinary tract infection) until 8/31/26 was in evidence and administration began on 8/26/26. 8/26/26 10:41 AM – The medication was identified as a possible drug allergy, was	Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.) A. There were no residents negatively impacted by this deficient practice. All nursing staff will be re-educated by the HWD on providing timely notification after a resident incident. B. All residents have the potential to be affected by this deficient practice. The HWD or designee will verify that medication orders are reviewed to verify the resident does not have allergies to the prescribed medication. C. Upon admission, HWD or designee will verify any prescribed medications listed are not a known allergy in the resident's record. D. To assist with ongoing compliance, the HWD or designee will perform audits of resident medication order records weekly for four (4) weeks, biweekly for four (4) weeks and	10/18/2026

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STATE SURVEY REPORT

Page 13 of 16

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	noted by E6 (LPN) in the EMR labeled as "Physicians Order Note" noting the possible allergy. There was no indication that the physician was verbally notified and that the medication was approved to be administered as ordered. The EMR entries on 8/29/26, 8/30/26 and 8/31/26 all noted "continues on antibiotic with no adverse reactions noted." 9/3/26 11:35 AM – During an interview, E2 (HWD) confirmed the allergy was listed in R6's record and the staff should have notified the physician and the pharmacist regarding the order prior to administration. E2 stated that E6 was unable to recall if the physician was notified. E2 noted R6 had her own physician who was sometimes delayed in responding when contacted. 9/3/26 – Surveyor performed additional focused reviews of five additional residents' records for medication allergies and orders. No other incidents were identified. 9/3/26 – While the resident did not seem to exhibit adverse reactions, there was potential for harm in administering a medication listed as an allergy. 9/3/26 - Findings were reviewed with E1 (ED), E2 and E3 (BOM/HR) at the exit conference, beginning at approximately 2:30 PM.	monthly until all files have been checked and 100% compliance is achieved.	
3225.18.0	Emergency Preparedness		
3225.18.1	Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.		
S/S – F		3225.18.0 3225.18.1	

Provider's Signature _____ Regina Romano _____ Title __Executive Director____ Date ____9/24/2026_____



**DELAWARE HEALTH
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Office of Long-Term Care Residents Protection

DHSS - DHCQ
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Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

Page 14 of 16

NAME OF FACILITY: Brookdale Hockessin

DATE SURVEY COMPLETED: September 3, 2026

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	700 Delaware State Fire Prevention Regulations 703 Installation, Operation, Maintenance, Testing and Sales of Signaling Systems, Fire Protection Systems and Fire Extinguishers Chapter 1 Operation, Maintenance, and Testing of Fire Protection Systems 4.0 Periodic Inspections, Testing, And Maintenance Service. 4.1 General. 4.1.1 Periodic inspections, testing, and maintenance of fire alarm signaling, fire suppression, and any other fire protection systems, devices, and equipment shall be conducted in accordance with the National Fire Protection Association's National Fire Codes and Standards, as adopted and/or modified by these Regulations. The required inspection, testing, and maintenance service shall be conducted by a licensed company or by an owners representative at the intervals established by the National Fire Protection Association's National Fire Codes and Standards, as adopted and/or modified by these Regulations. Based on interviews and observation it was determined that the facility failed to comply with the Delaware State Fire Prevention Regulations. Findings include: 9/1/26 12:00 PM - During the survey of the facility, the surveyor requested from E5 (MM) the most recent fire system inspection reports. A review of the annual fire alarm inspection report dated February 16, 2026, indicated the first-floor room sounders were	S/S -- F Emergency Preparedness A. There were no residents negatively impacted by the deficient practice. Fire Training was performed to all staff and a Fire Watch was implemented immediately. The Fire watch will continue until all deficiencies are corrected. B. All residents have the potential to be affected by this deficient practice. ED and MM or designee will verify that the Fire Watch is being conducted every 60 minutes, per requirements, and recorded on the Fire Watch log. C. All Staff will be rein-serviced by the Maintenance Manager or designee on the verification that the Fire Watch is being performed and documented in accordance with the Local Fire Code and the National Fire Protection Association's National Fire Codes and Standards. D. To assist with ongoing compliance, the ED, Maintenance Manager or designee will perform an audit of the Fire Watch logs daily and continue until all deficiencies are corrected. and 100% compliance is achieved.	10/18/2026

Provider's Signature _____ Regina Romano _____ Title ___Executive Director_____ Date _____9/24/2026_____



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Page 15 of 16

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	not functioning, and they were placed on a fire watch. This surveyor requested additional documentation regarding an implemented fire watch from February 16, 2026, and repair of the identified deficiencies. A review of fire watch documentation revealed inconsistent practices when February, March, May, and June documentation were unavailable and hourly watches were not implemented. As of 9/3/2026, additional documents had not been received to support the deficiencies had been addressed. 9/3/26 – Findings were reviewed per telephone with E1 (ED) at the environmental exit conference at approximately 4:00 PM.		

Provider's Signature Regina Romano Title Executive Director Date 9/24/2026



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