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 10, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint survey was conducted at this facility beginning January 29, 2025, and ending February 10, 2025. The facility census on the entrance day of the survey was sixty (60) residents. The survey sample size totaled thirteen (13) residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. Abbreviations/definitions used in this state report are as follows: ED – Executive Director; HWD – Health & Wellness Director; LPN – Licensed Practical Nurse; NP – Nurse Practitioner; 1:1 Supervision – one staff person assigned direct supervision of one resident; Abatement – The ending, reduction, or lessening of something; Abdomen – The part of the body between the chest and the hips; Anxiety – General term for several disorders that cause nervousness, fear, apprehension and worrying; BID – Twice daily; BP – Blood pressure; CT scan – Imaging test that takes detailed pictures of the inside of the body; Depakote – Medication that can be used to treat certain behavioral symptoms in patients with dementia; Dementia – A severe state of cognitive impairment characterized loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;	A. Brookdale Dover Assisted Living and Memory Care continues to be committed to maintaining a safe environment for each resident, visitor and employee. R2 was moved to the memory care unit on 12/18/24 due to his decline in mobility related to his decline with his dementia, both his physical and mental decline, with an increase of falls. R2 had NO prior history of aggression towards other residents prior to this move to the Memory Care. After the initial physical interaction between R2 and R1 the nurse was notified and did assess both residents immediately and found no visible injuries and both residents appeared their usual selves. The nurse was in the process of providing care to other residents that only a nurse can provide, insulin etc., before she could complete the notification of the incident, reports etc another incident occurred less than an hour later. The LPN sent both residents to the hospital for evaluation for injuries	4/11/25

Provider's Signature [signature] Title Executive Director Date 3/27/25

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	ED – Emergency Department; EKG – An electrocardiogram (EKG) is a medical test that records the electrical activity of the heart; EMR – Electronic medical record; EMS (Emergency Medical Services) – a system that provides emergency medical care; ER – Emergency room; Haldol – Medication that can be used to treat severe agitation; IM – Intramuscular; Immediate Jeopardy (IJ) – Crisis situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident; Lorazepam – Medication that can be used for agitation and anxiety; Major Depressive Disorder – Also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause; Med Tech (Medication Technician) – A staff member who prepares and gives medications to patients. They work under the supervision of a licensed nurse or other qualified caregiver; O2 – Oxygen; P – Pulse; POA – Power of Attorney; R – Respirations;	and or change of condition causes. UTI etc. She reported the 2nd event to the HWD and appropriate parties. Both R1 and R2 were evaluated and no medical causes nor injuries were found by the hospital, all appropriate parties were notified and supervision of both was initiated. During our investigation the LPN realized that had she put increased supervision in place after the first incident the second incident may never have occurred. The policy: Neglect Exploitation Prohibition Policy was re-reviewed with this LPN on February 4, 2025. The review emphasized, protection of all residents from the aggressor, timely notification of all appropriate parties, and documentation of all incidents. Both R1 and R2 were evaluated by the psychiatric nurse practitioner pre and post the incidents. R2's medications were adjusted (see page 8 of deficiency report 1/27/25). LPN was in-serviced 2/4/25, once Community realized the first incident was not reported, during investigative process.	4/11/25

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3225 **3225.14.0** **3225.14.1** **16 Del. Code Part II Ch. 11, Subchapter II Rights of Residents** **§ 1121. Resident rights.** **S/S – K**	UTI (Urinary Tract Infection) – bacteria in urine; WNL – Within normal limits; XR – X-ray. **Assisted Living Facilities** **Resident Rights** **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.** **(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.** These requirements were not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (R1) out of three residents reviewed for abuse, the facility failed to protect a resident (R1), along with other residents on the memory care unit, from abuse. Findings include: The facility policy entitled, "Abuse, Neglect & Exploitation Prohibition Policy" (revised 5/21), states the following: "Brookdale is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to	B. All Associates had the Brookdale Policy, "Abuse, Neglect & Exploitation Prohibition Policy" emphasizing what to do when there is resident to resident abuse, taking immediate actions to prevent injury to them and or others, immediately doing 1:1 with the aggressor, reporting to the nurse and the nurse, nurse completes assessment and then determining plan of action which includes, level of supervision, change of condition concerns, notification of appropriate parties including MD, HWD, ED and POA. And completing all required documentation related to the incident. The Lpn on duty was notified by the Memory Care Unit of the incident between R2 and R1, the LPN assessed both residents and saw no injury nor changes regarding each resident. The LPN failed to change the level of supervision for R2 and In less than an hour another physical altercation occurred between R1 and R2. Both R1 and R2 were	4/11/25

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	the Executive Director or the supervisor on duty immediately. 1.Definitions: Abuse as defined in 16 Del. Code, 1131 a. "Physical Abuse" is defined in Delaware as unnecessary inflicting of pain or injury to a resident, which includes, but not limited to: hitting, kicking, pinching, slapping, pulling hair or any sexual molestation." Review of clinical records revealed the following: 2/19/19 – R2 was admitted to the assisted living facility with diagnoses including, but not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, along with major depressive disorder, single episode, unspecified. On 12/18/24, R2 was moved to the memory care unit due to safety concerns as a result of falls while residing in the assisted living section of the facility. 11/2/22 – R1 was admitted to the memory care unit in the facility with diagnoses including, but not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, along with major depressive disorder, recurrent, moderate and anxiety disorder. 1/24/25 4:50 PM – In a written statement, E6 (care partner) stated that when she came out of a resident's room, she saw R2 punch R1 on the left side of her face under her eye. As E6 ran down the hall, staff called out R2's name. R2 proceeded to	C. sent out to the hospital to rule out change of condition causes (uti,etc) and injuries. Both residents returned to the Community and no injuries nor changes in medical condition were found. The LPN involved had the Abuse, Neglect & Exploitation prohibition policy reviewed with her 2/4/25 and understands that had she changed R2 level of supervision when the first incident occurred there may not have been a second incident. Also understood the timely reporting, communication and documentation requirements. There have been no further incidents between R1 and R2. D. Post survey there was an incident between two males in AL and the same LPN implemented all aspects of the policy addressing resident to resident abuse correctly, including having a one on one placed immediately on the aggressor. All protocols were followed, including reporting and documentation. The HWD/designee will monitor all incidents of resident abuse to ensure 100% compliance of the	4/11/25

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	punch R1 two more times in the same spot. R1 was holding her face crying. There was no documentation of this incident in either resident's EMR. 1/24/25 4:50 PM – In a written statement, E7 (care partner) stated as she was setting the dining room for dinner, one coworker ran down the hall to R2 "pounding" on R1. There was a small bruise forming under her left eye. R1 was crying and holding her face...". There was no documentation of this incident in either resident's EMR. 1/24/25 4:50 PM – In a written statement, E5 (med tech) stated they were in the med room and heard E6 yell R2's name. E5 stated she saw R2 walking away from R1, who was crying. There was no documentation of this incident in either resident's EMR. The above statements were the first identified resident to resident altercation involving R2. There was no evidence this allegation of abuse was documented, reported, or that R1 and other residents were protected from further abuse. 1/24/25 6:05 PM – In a written statement, E7 stated she came out of a resident room because she heard "squealing." E7 looked down the hall and saw R2 standing over R1 and was punching her in the chest with a closed fist. E7 yelled to R2 to stop and R2 ran to his room. E7 stated she noted 2 scratches on R1's neck and redness, but no bleeding. E7 went to R2's room and asked why he did what he did and R2 stated, "He (sic) was in my room 10 times."	Abuse, Neglect & Exploitation Prohibition Policy, taking corrective actions as indicated. Audits will be conducted by the ED or HWD daily x 2 weeks then weekly x 2 weeks and then monthly x 2 months until 100% compliance. Audits will be conducted to determine if anabuse incident occurred and if so was there compliance with timeliness of reporting, appropriate documentation in the EMR and appropriate supervision at the time of the incident. Findings to be reported to the QAPI Committee.	4/11/25

Provider's Signature Tracie Fick Title Executive Director Date 3/27/25

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	1/24/25 6:05 PM – In a written statement, E6 stated that E7 left the room where they were giving resident care and then heard E7 yell for R2 to stop. E6 then saw R1 lying on her back in the doorway of a resident's room. R1 "was crying and upset." E6 then went to get the med tech and nurse. 1/24/25 6:05 PM – In a written statement, E5 stated she heard E7 yell R2's name. E5 saw R1 on the floor in the doorway of a resident's room. R1 was crying. E5 stated that staff tried several times to keep R1 in the common area. 1/24/25 6:30 PM – A note in R1's chart revealed the following: "Resident was observed at approx. 6:10 PM being hit by another resident and falling to the floor hitting her head on the floor. Vitals obtained and WNL, resident checked for injury, no injury found, no bruising found. Resident sent to the ER for evaluation. POA, MD, HWD all made aware." 1/24/25 6:45 PM – A note in R2's chart revealed the following: "Transfer out to hospital. Resident observed hitting and punching in the abdomen of another resident. When asked what happened unclear to this writer as resident was lying in bed calm and did not speak. Vitals obtained and WNL. Resident sent to the ER for evaluation and check for possible UTI. POA, MD and HWD made aware." This was the second allegation of resident to resident abuse involving R2 hitting R1.		

Provider's Signature Jaden Fick Title Executive Director Date 3/27/25

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	1/24/25 Untimed – A hospital document reported that R1's CT scan of the head revealed the following: "No detected evidence of acute intracranial pathology." R1's CT scan of the spine revealed there were no injuries found, no fractures and osteoarthritis of the spinal joints. 1/25/25 1:25 AM – A note in R1's chart revealed the following: "Resident returned back on stretcher, sleeping, transferred back to her bed via 2 paramedics. Had normal CT cervical and CT head, lab work normal. BP: 103/55, P 65, O2 95%, T 97.7." 1/25/25 Arrival time 10:22 AM – A note in R2's medical record revealed the following: "Resident returned back from ED via stretcher accompany with 2 EMS. Pleasant but confused. BP: 141/60, P: 60, T 97.7, O2 97% R: 20. Had normal CT head, EKG, XR chest. No UTI found. Had IM Haldol at 2213 on 1/24/25. Notified POA upon his return." Upon return from the hospital, there was no 1:1 supervision or every 30-minute checks for R2. These interventions were in place for R1 for an unspecified time, which offered no protection to the other residents in the memory care unit from R2. 1/25/25 2:31 PM – A note in R1's chart revealed that at approximately 10:35 AM, E4 was notified that R1 was hit by another resident. R1 was assessed and had no injuries. R1 was to be on 30-minute checks. 1/25/25 7:21 PM – A note in R2's chart revealed that at approximately 10:35 AM, E4		

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	was notified that R2 had hit another resident. R2 was found walking back to his room and laying down in his bed. R2 was assessed and had no injuries. 1/27/25 5:19 PM – A note in R2's chart revealed the following: "Spoke with Psych NP regarding resident behaviors. His Sertraline has been increased on 1/5/25. She increased Lorazepam to BID @ [at] 0800 (8:00 AM) and 1400 (2:00 PM) and increased Depakote to 250 mg in the AM and 125 mg in the PM. Will monitor for effectiveness. No aggressiveness noted this shift." 1/28/25 9:22 AM – A note in R2's chart revealed the following: "After [R2] hit [R1], both parties kept apart and Mrs. [R1] kept 1:1 by staffs to ensure her safety for all day then enforce 30-minute checks for R1." 1/29/25 2:55 PM – In an interview, E3 (ADON) stated on 1/25/25 at around 10:50 AM a med tech (unnamed) told them that R1 came up from the hall holding their stomach and crying. E3 made sure that there was no injury to R1. E3 called E2 (HWD), who directed staff to have 1:1 supervision of R1. E3 reiterated that nothing was witnessed. 1/30/25 9:57 AM – In an interview, E11 (Med Tech) stated that on 1/25/25 (untimed), during med pass, E11 heard a "scream" in the hallway. E11 saw R1 holding her side and R2 enter his room. E11 stated that no one saw R2 hit R1 and that "we just heard R1 scream." E11 stated that it is possible that R1 could have hit		

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	her side as she was holding the rail. E11 was not aware of any injury to R1. 1/30/25 1:55 PM – In an interview regarding the second incident on 1/24/25, E7 stated that on 1/24/25 R1's feet were sticking out of the door. E7 stated at the time of the incident she asked R2, "What are you doing?" and that R2 ran into his room. R1 was on the floor and crying. R2 told E7, "I'll do it 10 more times because "he" (sic) keeps coming in my room. I'll do it again if he (sic) comes in my room." E7 stated that R2's room used to belong to one of R1's friends, who is no longer in the facility, and R1 used to go to that room to visit. E7 stated that staff cannot prevent R1 from walking but also acknowledged that staff have to "watch residents and the med room and give care." E7 stated that R2 will occasionally swat at staff when they attempt to give care. There was no mention made of the first incident on 1/24/25 at 4:50 PM. 1/30/25 2:48 PM – In an interview, E2 stated that staff saw R2 going to his room. At no point did anyone witness R2 hitting R1. 1/31/25 7:40 AM – A note in R1 and R2's chart revealed that on 1/25/25 at approximately 10:35 AM, no associate on duty actually witnessed R2 hit or touch R1. 1/31/25 12:16 PM – In an interview, E8 (LPN) stated on 1/24/25 after the second incident that she called EMS and had both sent out. E8 stated R2 was hitting another resident. E8 stated that while R2 was in the assisted living section of the facility		

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	there were no issues and that he was pleasant and "a gentleman." E8 stated she was not in the memory care unit that day although she worked. E8 stated when she went to the unit, R2 was lying in bed and R1 was in the common area. E8 did not note any injury or bruising to R1. E8 observed her abdomen and face and did not note any injury. E8 stated that both residents were calm and R1 was not crying. There was no mention made of the first incident on 1/24/25 at 4:50 PM. 2/3/25 10:30 AM – In an interview E5 stated that on 1/24/25 at the time of the first incident, they were in the med room doing meds. E5 stated that they heard E6 call out R2's name. E5 stated that R1 was standing against the wall crying. E5 stated, "I guess [E6] saw [R2] hitting [R1]." E5 then stated that she again heard a staff member call out R2's name. E5 later observed R1 laying in the room across from R2's room. R1 was holding her face and crying. E5 stated that after the first incident, she saw a bruise on R1's left cheek. After the second incident, R1 was "very upset" and crying. E5 stated that one incident happened before dinner and the other happened after dinner, but she was not certain of specific times. E5 acknowledged that before and after meals is a very busy time. R1 was not on 1:1 supervision between 4:50 PM and 6:05 PM. 2/3/25 10:15 AM – In an interview, F1 (family member) stated, "I have concerns" and that R1 has been "beaten up five or six times." F1 stated she was not sure if it was the same person as before. F1 stated that		

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	she was told that "[R1] got hit, but she was okay." 2/3/25 12:13 PM – In an interview, E6 stated that on 1/24/25 at 4:50 PM they were going down the hall and saw R2 punch R1 in the face. E6 called to R2 to stop and R2 proceeded to punch R1 two more times. R1 "was bawling her eyes out." Later E7 heard a sound and ran out calling R2's name. E7 went to R1 and then to R2's room. E6 stated that R1 was "crying hysterically." E6 stated she noted "a greenish, yellowish spot and it was a little puffy." E6 stated they had been trying to keep R1 up front and have at least one person with eyes on her. E6 stated that R1 wanders and if staff don't see her, she is likely in someone else's room. E6 stated she witnessed the first event and E7 witnessed the second event on 1/24/25. 2/3/25 12:30 PM – In an interview, E8 (EMS) stated that he was notified that R2 had assaulted a female resident. E8 was advised by staff that R2 had more anger outbursts. E8 attempted to ask additional questions but was only told R2 has "had more aggression." 2/3/25 12:44 PM – In an interview, E4 stated that on 1/24/25 they were called to the memory care unit a "couple of times." E4 stated that staff told her that R2 was hitting a resident. E4 stated she was not certain if there was one or two incidents on 1/24/25 and didn't remember what time the staff came to her. E4 thought if there was an initial event, she didn't make any sort of notification before the second		

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	one occurred, stating that the second incident happened so fast. E4 apologized for not remembering so well and said she "cannot remember that day so good." 2/4/25 11:22 AM – Based on interview and review of facility documentation and other sources, an Immediate Jeopardy was called and reviewed with E1 (ED). 2/4/25 4:21 PM – E1 (ED) provided an abatement plan. 2/4/25 4:34 PM – The acceptable abatement plan included the facility's Abuse, Neglect & Exploitation Prohibition Policy with an emphasis on what actions to do and when to do a 1 on 1, along with a sign in sheet wherein staff acknowledged receiving education of this policy. Education was to be completed by all on site staff by 2/7/25 prior to the start of their shift, if they had not already completed the education on 2/4/25. Findings reviewed on 2/5/25 at the exit conference at 2:40 PM with E1, E2 and E3 (ADON). 2/10/25 3:10 PM - The facility's abatement was reviewed with E2. It was determined through observation, interview and record review that the facility met all requirements for the Immediate Jeopardy abatement on 2/7/25.		
3225.19.6	**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.**		

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3225.19.7 3225.19.7.1 3225.19.7.1.1 3225.19.7.1.1.2 S/S – D	**Reportable incidents include:** **Abuse as defined in 16 Del.C. §1131.** **Physical abuse.** **Resident to resident with or without injury.** Based on interview and a review of other facility documentation, it was determined that for one (R1) out of three sampled residents reviewed abuse, the facility failed to report an allegation of abuse. Findings include: The facility policy titled "Abuse, Neglect, Exploitation Prohibition Policy" last revised, May 2021 indicated, " ...The Executive Director should notify the Division of Long Term Care Residents Protection within 8 hours of the occurrence followed by a written report within 48 hours ...". A review of clinical records revealed: 2/19/19 – R2 was admitted to the assisted living facility with diagnoses including, but not limited to, unspecified dementia. On 12/18/24, R2 was moved to the memory care unit. 11/2/22 – R1 was admitted to the memory care unit in the facility with diagnoses including, but not limited to, unspecified dementia. 1/24/25 4:50 PM – In a written statement, E6 (care partner) stated that when she came out of a resident's room, she saw R2 punch R1 on the left side of her face under her eye. As E6 ran down the hall, staff called out R2's name. R2 proceeded to punch R1 two more times in	A. Brookdale Dover Assisted Living and Memory Care continues to be committed to maintaining a safe environment for each resident, visitor and employee. R2 was moved to the memory care unit on 12/18/24 due to his decline in mobility related to his decline with his dementia, both his physical and mental decline, with an increase of falls. R2 had NO prior history of aggression towards other residents prior to this move to the Memory Care. After the initial physical interaction between R2 and R1 the nurse was notified and did assess both residents immediately and found no visible injuries and both residents appeared their usual selves. The nurse was in the process of providing care to other residents that only a nurse can provide, insulin etc., before she could complete the notification of the incident, reports etc another incident occurred less than an hour later. The LPN sent both residents to the hospital for evaluation for injuries	4/11/25

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	the same spot. R1 was holding her face crying. There was no documentation of this incident in either resident's EMR. 1/24/25 4:50 PM – In a written statement, E7 (care partner) stated as she was setting the dining room for dinner, one coworker ran down the hall to R2 "pounding" on R1. There was a small bruise forming under her left eye. R1 was crying and holding her face ...". There was no documentation of this incident in either resident's EMR. 1/24/25 4:50 PM – In a written statement, E5 (med tech) stated they were in the med room and heard E6 yell R2's name. E5 stated she saw R2 walking away from R1, who was crying. There was no documentation of this incident in either resident's EMR. 2/3/25 at 12:13 PM – During an interview, E6 (care partner) confirmed that they witnessed R2 had punched R1 in the face multiple times. E6 stated they stayed with R1 while E5 (med tech) got the nurse who came to the unit and assessed the residents. 2/3/25 at 12:44 PM – During an interview, E4 (LPN) stated they were called to the memory care unit where staff told them that R2 had hit R1. E4 became very vague during the interview and could not recall what they did after assessing R1 and R2. 2/5/25 at 9:35 AM – An interview with E1 (ED) confirmed that they did not know about the first incident on 1/24/25 at 4:50 PM and would have reported it if they had known.	and or change of condition causes UTI etc. She reported the 2nd event to the HWD and appropriate parties. Both R1 and R2 were evaluated and no medical causes nor injuries were found by the hospital, all appropriate parties were notified and supervision of both was initiated. During our investigation the LPN realized that had she put increased supervision in place after the first incident the second incident may never have occurred. The policy: Neglect Exploitation Prohibition Policy was re-reviewed with this LPN on February 4, 2025. The review emphasized, protection of all residents from the aggressor, timely notification of all appropriate parties, and documentation of all incidents. Both R1 and R2 were evaluated by the psychiatric nurse practitioner pre and post the incidents. R2's medications were adjusted (see page 8 of deficiency report 1/27/25). LPN was In-serviced 2/4/25, once Community realized the first incident was not reported, during investigative process.	4/11/25

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	Findings reviewed on 2/5/25 at the exit conference at 2:40 PM with E1 and E2 (HWD).	B. All Associates had the Brookdale Policy , "Abuse, Neglect & Exploitation Prohibition Policy" emphasizing what to do when there is resident to resident abuse, taking immediate actions to prevent injury to them and or others, immediately doing 1:1 with the aggressor, reporting to the nurse and the nurse, nurse completes assessment and then determining plan of action which includes, level of supervision, change of condition concerns, notification of appropriate parties including MD, HWD, ED and POA. And completing all required documentation related to the Incident. The Lpn on duty was notified by the Memory Care Unit of the incident between R2 and R1, the LPN assessed both residents and saw no injury nor changes regarding each resident. The LPN failed to change the level of supervision for R2 and in less than an hour another physical altercation occurred between R1 and R2. Both R1 and R2 were sent out to the hospital to rule out change of condition causes (uti,etc) and injuries. Both residents returned to the Community and no injuries nor changes in medical condi-	4/11/25

Provider's Signature Tami Fox Title ED 3/27/25

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 10, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Findings reviewed on 2/5/25 at the exit conference at 2:40 PM with E1 and E2 (HWD).	C. The LPN involved had the Abuse, Neglect & Exploitation prohibition policy reviewed with her 2/4/25 and understands that had she changed R2 level of supervision when the first incident occurred there may not have been a second incident. Also understood the timely reporting, communication and documentation requirements. There have been no further incidents between R1 and R2. D. Post survey there was an incident between two males in AL and the same LPN implemented all aspects of the policy addressing resident to resident abuse correctly, including having a one on one placed immediately on the aggressor. All protocols were followed, including reporting and documentation. The HWD/designee will monitor all incidents of resident abuse to ensure 100% compliance of the Audits will be conducted by the ED or HWD daily x 2 weeks then weekly x 2 weeks and then monthly x 2 months until 100% compliance. Audits will be conducted to determine if an abuse incident occurred and if so was there compliance with timeliness of reporting, appropriate documentation in the EMR and appropriate supervision at the time of the incident. Findings to be reported to the QAPI Committee.	4/11/25

Provider's Signature Marie Fica Title ED Date 3/27/25