

#### STATE SURVEY REPORT

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NAME OF FACILITY: Brookdale Dover

DATE SURVEY COMPLETED: February 10, 2025

	STATEMENT OF DEFICIENCIES	
SECTION	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 com-

plete the notification of

the incident, reports etc

another incident occurred

less than an hour later.

4111125

The LPN sent both residents to the hospital for evaluation for injuries

Provider's Signature Transport

Title Gundie Dilector

Date 3/17/25



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STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES

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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

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.

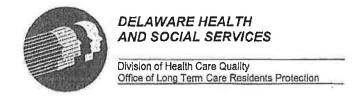
The policy: Neglect Exploitation Prohibition Policy was re-reviewed with this LPN on February 4, 2025. The review emphasized, protection of all residents from the aggressor, timely notification of all appropriate parties, and documentation of all incidents. Both R1 and R2 were evaluated by the psychiatric nurse practitioner pre and post the incidents. R2's medications were adjusted (see page 8 of deficiency report 1/27/25).

was in-serviced 2/4/25, once Community realized the first incident was not reported, during investigative process.

Provider's Signature

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Title Executive Arechy



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	OF DEFICIENCIES C DEFICIENCIES	CORRECT	TION OF	TOR'S PLAN FOR DEFICIENCIES WITH ES TO BE CORRECTED	Completion Date
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) — baurine; WNL — Within normal limits; XR — X-ray.  Assisted Living Facilities Resident Rights, Assisted living facilities are requirements are requirements which are requirements were not make a determined that for one (R1) three residents reviewed for abusing with other residents are requirements were not make a determined that for one (R1) three residents reviewed for abusing with other residents on the care unit, from abuse.  Findings include: The facility policy entitled, "Abuse Exploitation Prohibition Policy 5/21), states the following: "Brookdale is committed to mais safe environment for each residents and employee. Instances or allegabuse, neglect or exploitation of the care unit, and employee. Instances or allegabuse, neglect or exploitation of the care unit, and employee. Instances or allegabuse, neglect or exploitation of the care unit, and employee. Instances or allegabuse, neglect or exploitation of the care unit, and employee. Instances or allegabuse, neglect or exploitation of the care unit, and employee. Instances or allegabuse, neglect or exploitation of the care unit, and employee. Instances or allegabuse, neglect or exploitation of the care unit.	dired by 16 comply s of Pa- from ver- ruel and ry seclu- allowance, vation of  et as evi- ew and re- ation, it 1) out of use, the fa- (R1), ee memory  se, Neglect " (revised  intaining a ent, visitor gations of	В.	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 falled 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	

Provider's Signature

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treated seriously and must be reported to

Title Execution Dilector

Date 3/37/95



Office of Long Term Care Residents Protection

DHSS - DHCQ 263 Chapman Road, Sulte 200, Cambridge Bldg. Newark, Delaware 19702 (302) 421-7400

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	CORRECTIO	TRATOR'S PLAN FOR N OF DEFICIENCIES WITH DATES TO BE CORRECTED	Completion Date
	the Executive Director or to	he supervisor on	sent out to the hospital to	

- 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 lim-Ited 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

injuries. Both residents returned to the Community and no injuries nor changes in medical condi-C. tion 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.

Post survey there was an D. 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. HWD/designee will monitor all incidents of resident abuse to ensure 100% compliance of the

Provider's Signature

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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 identifled 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."

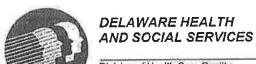
Abuse, Neglect & Exploitation Prohibition Policy, taking corrective actions as indicated.

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.

Provider's Signature

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Title Executor Dicetr Date 3/27/25



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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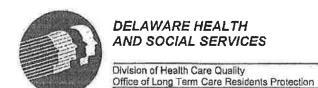
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	1/24/25 6:05 PM — In a writte E6 stated that E7 left the roo were giving resident care and E7 yell for R2 to stop. E6 there on her back in the doorway or room. R1 "was crying and up went to get the med tech and 1/24/25 6:05 PM — In a writte E5 stated she heard E7 yell R saw R1 on the floor in the doresident's room. R1 was crying that staff tried several times the common area.	om where they of then heard in saw R1 lying of a resident's set." E6 then d nurse.  en statement, 12's name. E5 porway of a ng. E5 stated		
	1/24/25 6:30 PM — A note in vealed the following: "Reside served at approx. 6:10 PM be other resident and falling to ting her head on the floor. V and WNL, resident checked injury found, no bruising four sent to the ER for evaluation HWD all made aware."	ent was ob- eing hit by an- the floor hit- itals obtained for injury, no ind. Resident		3
ř	1/24/25 6:45 PM - A note in vealed the following: "Trans pital. Resident observed hitt punching in the abdomen of dent. When asked what hap to this writer as resident wa calm and did not speak. Vita and WNL. Resident sent to tuation and check for possible MD and HWD made aware."	fer out to hos- ing and fanother resi- pened unclear s lying in bed als obtained he ER for eval- e UTI. POA,		
÷	This was the second allegati to resident abuse involving f			

Provider's Signature \_

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Title Executive Director



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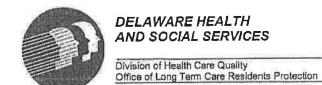
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	1/24/25 Untimed – A hospital reported that R1's CT scan of the vealed the following: "No determined and the following: "No determined and the spine revermence of acute intracranial parts." CT scan of the spine revermence of the spine revermence of the spine revermence of the spinal join 1/25/25 1:25 AM – A note in Five aled the following: "Resider back on stretcher, sleeping, the back to her bed via 2 parameter mail CT cervical and CT head, Is mal. BP: 103/55, P 65, O2 95% 1/25/25 Arrival time 10:22 AM R2's medical record revealed thing: "Resident returned back for stretcher accompany with 2 Elbut confused. BP: 141/60, P: 697% R: 20. Had normal CT head chest. No UTI found. Had IM Head and IM Head IM III."	the head re- ected evi- thology." aled there ctures and ints.  R1's chart re- int returned ansferred dics. Had nor- ab work nor- is, T 97.7."  M — A note in the follow- from ED via MS. Pleasant io, T 97.7, O2 id, EKG, XR Haldol at	
	Upon return from the hospital no 1:1 supervision or every 30 checks for R2. These intervent place for R1 for an unspecified offered no protection to the odents in the memory care unit	D-minute tions were in d time, which other resi-	
	1/25/25 2:31 PM — A note in Find vealed that at approximately 2 was notified that R1 was hit be resident. R1 was assessed and ries. R1 was to be on 30-minutes.	10:35 AM, E4 y another I had no inju-	
	1/25/25 7:21 PM — A note in F vealed that at approximately 3		

Provider's Signature

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Title Executor Arch



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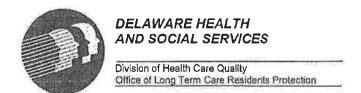
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STA	ATEMENT OF DEFICIENCIES		NISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES		TION OF DEFICIENCIES WITH ED DATES TO BE CORRECTED	Date
	was notified that R2 had hit ardent. R2 was found walking baroom and laying down in his bassessed and had no injuries.  1/27/25 5:19 PM – A note in Five aled the following: "Spoke was NP regarding resident behaviors."	ack to his bed. R2 was R2's chart re- with Psych		
	traline has been increased on increased Lorazepam to BID @ (8:00 AM) and 1400 (2:00 PM creased Depakote to 250 mg and 125 mg in the PM. Will m fectiveness. No aggressiveness shift."	1/5/25. She (at) 0800 and in- in the AM conitor for ef-		
	1/28/25 9:22 AM — A note in vealed the following: "After [I both parties kept apart and N 1:1 by staffs to ensure her sat day then enforce 30-minute of R1."	R2] hit [R1], Ars. [R1] kept fety for all		
	1/29/25 2:55 PM — In an inter (ADON) stated on 1/25/25 at AM a med tech (unnamed) to R1 came up from the hall hol stomach and crying. E3 made there was no injury to R1. E3 (HWD), who directed staff to pervision of R1. E3 reiterated was witnessed.	around 10:50 old them that ding their e sure that called E2 have 1:1 su-		
	1/30/25 9:57 AM — In an inte (Med Tech) stated that on 1/ timed), during med pass, E11 "scream" in the hallway. E11 ing her side and R2 enter his stated that no one saw R2 hi "we just heard R1 scream." that it is possible that R1 cou	'25/25 (un- L heard a saw R1 hold- room. E11 t R1 and that E11 stated		

Provider's Signature

how hike

Title Excelleni Durch



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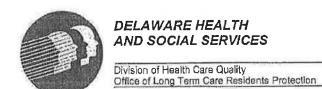
Provider's Signature

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riio <del>-iio-iio-iii</del>	her side as she was holding th	ne rail F11	T
	was not aware of any injury to		
	was not aware or any injury to	o na.	
	1/30/25 1:55 PM – In an inter	rview regard-	
	ing the second incident on 1/	24/25, E7	
	stated that on 1/24/25 R1's fe	eet were	4
	sticking out of the door. E7 st	ated at the	
	time of the incident she asked	d R2, "What	
	are you doing?" and that R2 r	an into his	1
	room. R1 was on the floor and	d crying. R2	
	told E7, "I'll do it 10 more tim	I I	
	"he" (sic) keeps coming in my		
	it again if he (sic) comes in my		
	stated that R2's room used to	-	
	one of R1's friends, who is no	-	
	facility, and R1 used to go to		
	visit. E7 stated that staff can		1
	R1 from walking but also ackr	_	4
	that staff have to "watch resi		
	med room and give care." E7		
	R2 will occasionally swat at st		
	they attempt to give care. The		
	mention made of the first inc	ident on	1
	1/24/25 at 4:50 PM.		
	1/30/25 2:48 PM – In an inter	rujow F3	1
	stated that staff saw R2 going		
	At no point did anyone witne		
	R1.	33 AZ Metrig	
	112.		
	1/31/25 7:40 AM – A note in	R1 and R2's	
	chart revealed that on 1/25/2		
	mately 10:35 AM, no associa	, ,	
	tually witnessed R2 hit or tou	uch R1.	
	1/31/25 12:16 PM – In an int	erview F8	4
	(LPN) stated on 1/24/25 after		
	incident that she called EMS		1
	sent out. E8 stated R2 was hi		
	resident. E8 stated that white	-	

Title Excusor

the assisted living section of the facility



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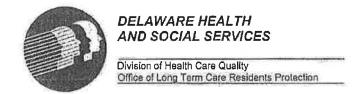
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	there were no Issues and that	he was	
	pleasant and "a gentleman." E	The state of the s	
	was not in the memory care un		
	although she worked. E8 state		1
	went to the unit, R2 was lying		į.
	R1 was in the common area. E.	II	
	note any injury or bruising to F		
	served her abdomen and face	· · · · · · · · · · · · · · · · · · ·	
	note any injury. E8 stated that		¥.
	dents were calm and R1 was n		
	There was no mention made o	of the first in-	
	cident on 1/24/25 at 4:50 PM.		
	2/3/25 10:30 AM – In an inter	view 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 the	ey heard E6	
	call out R2's name. E5 stated t	hat R1 was	1
	standing against the wall cryin	g. E5 stated,	
	"I guess [E6] saw [R2] hitting [	R1]." E5	1
	then stated that she again hea	ard a staff	1
	member call out R2's name. E	5 later ob-	1
	served R1 laying in the room a	ecross from	
	R2's room. R1 was holding her	r face and	
	crying. E5 stated that after the	e first inci-	
	dent, she saw a bruise on R1's	left cheek.	1
	After the second incident, R1	was "very	1
	upset" and crying. E5 stated t	hat one Inci-	
	dent happened before dinner	and the	
	other happened after dinner,	but she was	
	not certain of specific times. E	5 acknowl-	
	edged that before and after m	neals is a very	1
	busy time. R1 was not on 1:1:	supervision =	
	between 4:50 PM and 6:05 PM	и.	
	2/3/25 10:15 AM — In an inter		
	(family member) stated, "I ha	IV	1
	and that R1 has been "beaten	up five or six	
	times." F1 stated she was not		
	the same person as before. Fi	l stated that	

Provider's Signature Men he

Title Execution Allector



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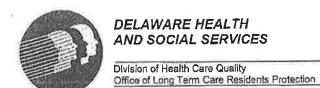
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	she was told that "[R1] got hokay."  2/3/25 12:13 PM — In an intestated that on 1/24/25 at 4:5 were going down the hall an punch R1 in the face. E6 callostop and R2 proceeded to pumore times. R1 "was bawling out." Later E7 heard a sound calling R2's name. E7 went to R2's room. E6 stated that ing hysterically." E6 stated signeenish, yellowish spot and puffy." E6 stated they had be keep R1 up front and have a person with eyes on her. E6 wanders and if staff don't selikely in someone else's room she witnessed the first even nessed the second event on 2/3/25 12:30 PM — In an integen (EMS) stated that he was no had assaulted a female residuations but was only told	erview, E6 50 PM they id saw R2 ed to R2 to unch R1 two g her eyes I and ran out o R1 and then R1 was "cry- he noted "a I it was a little een trying to t least one stated that R1 ee her, she is m. E6 stated t and E7 wit- 1/24/25. erview, E8 etified that R2 dent. E8 was more anger ask additional	
<del></del>	more aggression."  2/3/25 12:44 PM – In an interstated that on 1/24/25 they the memory care unit a "counce E4 stated that staff told her hitting a resident. E4 stated certain if there was one or ton 1/24/25 and didn't reme time the staff came to her. there was an initial event, si	were called to uple of times." that R2 was she was not wo incidents imber what E4 thought if	

any sort of notification before the second

Title Excustor Dilzak-



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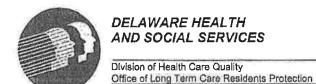
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	one occurred, stating that the dent happened so fast. E4 apo not remembering so well and succession of the second	logized for said she o good."  Interview and on and other dy was ED).	
	2/4/25 4:34 PM — The accepta ment plan included the facility Neglect & Exploitation Prohibit with an emphasis on what act and when to do a 1 on 1, alon in sheet wherein staff acknow ceiving education of this policion was to be completed by all on 2/7/25 prior to the start of the they had not already completication on 2/4/25.	o's Abuse, ition Policy ions to do g with a sign riedged re- y. Education i site staff by eir shift, if	
	Findings reviewed on 2/5/25 conference at 2:40 PM with E (ADON).		
	2/10/25 3:10 PM - The facility was reviewed with E2. It was through observation, intervie review that the facility met al ments for the Immediate Jeonment on 2/7/25.	determined w and record   require-	
3225.19.6	Reportable incidents shall be immediately, which shall be hours of the occurrence of the to the Division. The method shall be as directed by the Division in the method of the directed by the Division.	within 8 ne incident, of reporting	

Title Exceptor DIRECT



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ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED Completion Date

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 dementla. 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 em-

> R2 was moved to the memory care unit on 12/18/24 due to his decline in mobility related to his decline with his de-

mentia, both his physical

physical interaction be-

tween R2 and R1 the

ployee.

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 After the initial Care.

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 com-

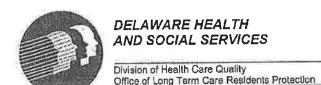
plete the notification of the incident, reports etc another incident occurred less than an hour later.

hospital for evaluation for injuries

The LPN sent both residents to the

men Fin Provider's Signature\_

Exemple Direct Date 3/07/25 Title



### STATE SURVEY REPORT

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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

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 FMR.

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 2<sup>nd</sup> 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.

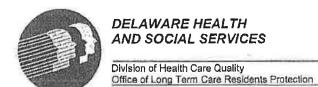
The policy: Neglect Exploitation Prohibition Policy was re-reviewed with this LPN on February 4, 2025. The review emphasized, protection of all residents from the aggressor, timely notification of all appropriate parties, and documentation of all incidents, Both R1 and R2 were evaluated by the psychiatric 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

Provider's Signature \_

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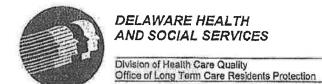
## STATE SURVEY REPORT

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NAME OF FACILITY: Brookdale Dover

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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
	Findings reviewed on 2/5/25 a conference at 2:40 PM with E1 (HWD).	Hrookdale volidy "Antise 1	4/11/25
rovider's Sig	nature Jacu Fila	curred between R1 and R2. Both R1 and R2 were sent out to the hospital to rule out change of condition causes (uti,etc) and injurles. Both residents returned to the Community and no injuries nor changes in medical condi-	3/27/25



### **STATE SURVEY REPORT**

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NAME OF FACILITY: Brookdale Dover

DATE SURVEY COMPLETED: February 10, 2025

	OF DEFICIENCIES IC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Findings reviewed on 2/5/25 at conference at 2:40 PM with E1 (HWD).	the exit	use, tion re- 4/25 had el of first there sec- nder- port- and quire- two same all as- cy ad- o resi- tly, in- one on diately All pro- yed, in- nd doc- The Il moni- of resi- ensure
· · · · · · · · · · · · · · · · · · ·	Audits will be conducted b	v the FD 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.

Provider's Signature,

\_\_ Title ED