DELAWARE HEALTH
AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: AL - Arden Courts of Wilmington

DATE SURVEY COMPLETED: June 5, 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 from June 3, 2025, through June 5, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-four (24). The survey sample totaled seven (7) residents. Abbreviations/definitions used in this state report are as follows: ADNS – Assistant Director of Nursing Services; Divalproex Sodium – A medication used to treat seizures, bipolar disorder, and migraine headaches; DON – Director of Nursing; ED – Executive Director; EMR – Electronic Medical Record; LPN – Licensed Practical Nurse; MAR – Medication Administration Record; RC – Resident Caregiver; RSD – Resident Services Director; RSS – Resident Service Supervisor Trazadone – A medication used to treat major depressive disorder; TVO – Telephone Verbal Order.		
3225.0	**Assisted Living Facilities**		
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.**		
16 Del. Code,	**Resident Rights**		

Provider's Signature Jack Rice Title Executive Director Date 7/1/2025

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Chapter 11, Subchapter II § 1121 S/S – G	**(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.** This requirement was not met as evidenced by: Based on investigative documents, review of medical records, interviews and other facility documentation, it was determined that the facility failed to prevent resident to resident abuse when R2 pushed R1, resulting in harm when R1 sustained a fractured hip. Findings include: 12/20/23 – R2 was admitted to the facility with diagnoses including dementia with behavior concerns. R2's medical record documented numerous recent episodes (detailed below) of aggressive behaviors. 4/3/25 - Per EMR documentation at 4:26 PM, E7 (RC) documented: R2 "was seen walking in the hallway in Boathouse (Facility Unit) before physically assaulting another resident. Caregiver stated she was walking to assist another resident when she heard yelling. As she turned around she saw [R2] strike another resident. Both residents evaluated for injuries. No visible injuries. Emergency services was notified. [R2] transferred to the ER to be evaluated. MD and DON made aware". 4/4/25 - Per EMR documentation at 10:58 AM, E6 (LPN) documented "Per TVO from [Psychiatrist] N/O: Depakote Sprinkle 250mg q HS. Faxed order to pharmacy. TVO form placed in MD book. Called Wife and left a message at 1030 [AM]."	1. R2 was discharged to the hospital on 5/22 and it was determined following a reassessment that R2 required a higher level of care after his hospitalization. Resident has been discharged from the community and will not be returning. 2. Executive Director completed a 30 day review to determine any other residents within the community with aggressive behaviors towards other residents by reviewing incident reports and progress notes. 3. Executive Director has conducted re education with all staff regarding the recognition, identification, and response to behaviors towards other residents and the process of notification of any changes. 4. The executive director/designee will audit incident reports and progress notes weekly x 4 weeks and monthly x 3 months for any reports of resident to resident aggression. The executive director will also audit 5 staff members weekly x4 weeks and monthly x3 months to ensure no staff members have witnessed any resident to resident abuse. The findings will then be reviewed by the facility QAPI committee for further recommendations as needed. Date of compliance: July 11, 2025	

Provider's Signature _____ Title Executive Director Date 7/11/2025

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	4/8/25 - Per EMR documentation at 10:58 PM, E6 (LPN) documented R2 "is calm during the shift, no aggressive behaviors noted. Resident had follow up telehealth appointment with House psychiatrist today. Resident appeared calm during the appointment, able to answer simple questions. No new orders received. [Psychiatrist]] stated he will visit the facility in person tomorrow and have another follow-up in person visit with the resident". R2 was maintained on every 15-minute checks. 4/23/25 – Per EMR documentation at 1:26 PM, Physician Psychiatrist documented per "late entry": Patient seen for follow up for mood and medications. Patient is alert and oriented to self but confused about place and time. Patient's recent and remote memory is impaired. Patient is not suicidal or homicidal. Denied delusion or paranoia. Sleep and appetite are good. Patient is compliant with Care and medications. A/P Dementia Alzheimer's Type Late Onset. Major Depression, Generalized Anxiety Disorder. Patient is stable on current medications. No recommendations at this time. Will follow for mood and medications". 5/17/25 – Per EMR documentation at 10:58 PM, E6 (LPN) documented R2 "reportedly had aggressive episode towards another resident. [R2] denied event initially but told police officer that other resident attempted to hit him and he blocked her punches and she fell. Unable to verify. [R2] was seen walking away from resident who was on the floor and pointed "He hit me." Called RN DON. Instructed to send to ER for evaluation s/p aggressive and harmful episode. Called the [health provider] and left message with answering service in 1914 (7:14 PM). Called wife		

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	at 1951 (7:51 PM) to notify of pending ER transfer. 2 EMTS arrived at 2000 (8:00 PM) but declined transport due to [R2] refusing to be evaluated and refusing to be transported to ER. Notified RN DON and wife. [R2's] wife arrived at 2130 (9:30 PM) and was unsuccessful attempting to take to ER. After the incident R2 was immediately placed on 1:1 direct visualization. Appears calm and is currently in bed". The facility notified the police department after the incident and attempted to send R2 to the ER for evaluation. R2 refused transport even after his wife came to the facility and attempted to have him go to the ER. 5/19/25 – Per EMR documentation by E14 (LPN) at 3:16 PM. E14 documents: "Resident continues on monitoring s/p (after) aggressive behaviors. Alert and responsive. Resident had 1:1 Direct Visualization this shift with no issues noted. 1:1 has been D/C'd (discontinued) per [Psychiatrist] . New Order for Depakote 125MG, 2 CAPS, PO, BID and Trazodone 50MG, PO, QHS per [Psychiatrist]. Orders updated in MAR and faxed to [Pharmacy]. Resident enjoyed visit from his wife this afternoon. Will continue with current plan of care". 5/19/25 – Per review of R2's MAR, medication changes were ordered. R2's Divalproex Sodium was increased from daily to twice per day for mood disorder and Trazadone 50 mg was ordered daily at bedtime for aggression. 5/19/25 – Per review of the facility's "Resident 1:1 Check" logs, R2 remained on 1:1 checks by a staff member. 5/20/25 – Per medical record documentation from E1 (ED), E1 indicated the Psychiatrist		

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	Physician evaluated R2 on 5/19/25, adjusted R2's medications, found R2 not a danger to himself or others and was cleared from 1:1 supervision as the 1:1 was contributing to R2's aggressive behaviors. Documentation indicated the facility's IDT (Interdisciplinary Team) met and discussed the findings and since the 1:1 triggers R2's agitation. The IDT followed the Psychiatrist recommendation and discontinued the 1:1 supervision, and to "balance direct visualization without escalating [R2's] behavior which requires some distance between [R2] and the staff monitoring him." 5/20/25-5/22/25 – Per review of the facility's "Resident 15-minute Check" logs, R2 remained on every 15-minute checks by a staff member between. 5/22/25 – Per EMR documentation at 8:49 PM, E5 (LPN) documented R2 "was involved in a resident-to-resident incident. [R2] entered another resident's room and physically pushed him onto the floor, resulting in the need for medical evaluation. When questioned about the incident, [R2] stated that he pushed the resident because he was tired of him slamming doors throughout the facility. [R2] was immediately placed on direct visualization for safety and behavior monitoring. [R2] was then transported via emergency services to be evaluated. A small cut and some bleeding were noted to the R (right) hand. No other visible injuries were noted. All parties have been notified. [R2] will remain on direct visualization upon return from hospital". 6/3/25 – Per telephone interview with E5 (LPN) at approximately 11:50 AM regarding the 5/22/25 incident, E5 stated that R1 had been agitated and accusing a female resident		

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	of being in his room "stealing his shoes". E5 stated as she was walking towards R1's room, she noted R2 was coming out of the room. E5 stated she found R1 on the floor complaining of right sided pain. 911 was called and R1 was transported to the hospital. E5 stated that R2's response when asked why he pushed R1, R2 responded that he was tired of R1 slamming doors. E5 stated she did not believe any staff witnessed the actual event. E5 stated R2 usually sleeps at night, and she was unaware of any previous altercations or increased behaviors between R1 and R2 before this. 6/3/25 – Per telephone interview with E12 (RC) at approximately 12:15 PM regarding the 5/22/25 incident, E12 stated she did not witness as she was coming into the hallway near dining area. E11 stated she saw R2 standing by the medicine cart then disappeared. E11 stated she heard a door slam and then a scream. Two RC responded and found R2 standing over R1 who was on the floor. E11 stated that R2 responded "he shouldn't be slamming doors." E11 stated she was unsure if R2 hit or pushed R1. E11 stated the incident happened within seconds. E11 stated she had not witnessed any other behavior altercations between these two. E11 stated R2 was on every 15-minute checks alternating with 1:1 care as he was exit seeking. 6/3/25 – Per interview with E12 (RC) at approximately 12:50 PM regarding the 5/22/25 incident, E12 stated that R1 was agitated that evening and was cursing and slamming doors. E12 stated she was standing near R2 when he walked off, heard a thud and then a scream. E12 found R1 on the floor and R2 was in R1's room. E12 stated it happened "super quick"		

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	and had not witnessed any previous behavior issues between these two residents. E12 stated R2 had been on 1:1 care but was recently changed to every 15-minute checks. 6/3/25 – Per interview with E1 (ED) at approximately 3:00 PM regarding the 5/22/25 incident, E1 stated the ER had informed them that R1 suffered a fractured hip and was admitted to the hospital. E1 stated R2 was also admitted to the hospital and was re-evaluated by the RSD yesterday. E1 stated that there is no indication at this time that R2 will return to the Assisted Living facility due a potential higher level of care need. A resident-to-resident altercation occurred on 5/22/25 around 7:00 PM. It was determined that the facility failed to ensure R1 was free from abuse by R2. This resulted in harm to R1 who suffered a fractured hip. 6/5/25 - Findings were reviewed with E1 (ED) at the exit conference beginning approximately 4:30 PM.		

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