DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: AL - Oakbridge Terrace at Country House **DATE SURVEY COMPLETED:** July 1, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual Survey was conducted at this facility from June 30, 2025, through July 1, 2025. The deficiencies contained in this report are based on observations, interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was twenty-seven (27). The survey sample totaled seven (7) residents. Abbreviations/definitions used in this state report are as follows: AL – Assisted Living; CNA – Certified Nursing Assistant; C/O – Complaints of; DAL - Director of Assisted Living; DCS – Director of Culinary Services; LPN – Licensed Practice Nurse; MT – Med Tech; NA – Nursing Aide; NHA – Nursing Home Administrator; NP - Nurse Practitioner; RA – Room air; RCD – Regional Clinical Director; V/S – Vital signs; WBC – Willowbrook Court (secured unit).		
3225.0	**Assisted Living Facilities**		
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.1.3 **S/S – F**	**Food service complies with the Delaware Food Code** **Delaware Food Code**	A. The flying insects have been addressed by pest control services in the identified areas and through cleaning. B. The Director of Culinary and Nutrition services will inspect all areas of kitchen to ensure there are no other areas of concern with flying insects.	08/27/2025

Provider's Signature Jennifer Greenwald Title NHA Date 7/24/2025

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	6-2 DESIGN, CONSTRUCTION, AND INSTALLATION **6-202 Functionality** **6-202.15 Outer Openings, Protected.** **(A) Except as specified in (B), (C), and (E) and under (D) of this section, outer openings of a FOOD ESTABLISHMENT shall be protected against the entry of insects and rodents by:** **(1) Filling or closing holes and other gaps along floors, walls, and ceilings;** **(2) Closed, tight-fitting windows; and** **(3) Solid, self-closing, tight-fitting doors.** **B) Paragraph (A) of this section does not apply if a FOOD ESTABLISHMENT opens into a larger structure, such as a mall, airport, or office building, or into an attached structure, such as a porch, and the outer openings from the larger or attached structure are protected against the entry of insects and rodents.** This requirement is not met as evidenced by: Based on the observation, interview and record review, it was determined that the facility failed to comply with the Delaware Food Code and ensure the premises remained free from insects and other pests. Findings include: 6/30/25, 10:53 AM – During the kitchen tour with E18 (DCS), the surveyor found some small flying insects under the dish washing machine and in the dry storage area. E18 confirmed the findings during the kitchen tour.	C. The Director of Culinary and Nutrition services will provide training to culinary management team regarding proper cleaning standards and weekly drain cleaning. D. The Director of Culinary and Nutrition services/Designee will complete inspections under the dish washing machine and the dry storage area to ensure the areas are free of flying insects. Audits will occur daily for two weeks until 100% compliance is achieved, then weekly for two weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is achieved. Outcomes of these audits will be submitted to quarterly QAPI Committee for review and recommendations as indicated.	

Provider's Signature Jennifer Greenwaet Title NHA Date 7/24/2025

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	6/30/25 at 3:03 PM - Findings were reviewed with E1 (NHA). **6-5 MAINTENANCE AND OPERATION** **6-501 Premises, Structures, Attachments, and Fixtures - Methods** **6-501.111 Controlling Pests.** **The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by:** **(A) Routinely inspecting incoming shipments of FOOD and supplies;** **(B) Routinely inspecting the PREMISES for evidence of pests;** **(C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under §§ 7- 202.12, 7-206.12, and 7-206.13; Pf and** **(D) Eliminating harborage conditions.** **This requirement is not met as evidenced by:** Based on the observation, interview and record review, it was determined that the facility failed to comply with the Delaware Food Code and ensure the outer openings of the building is secure to prevent the entry of rodents and other pests. Findings include: 6/30/25, 11:07 AM – During the kitchen tour with E18 (DCS) and E19 (DPM), the surveyor found gaps under two (2) back doors of the kitchen, which lead to the outside trash docking platform. The door gaps were large	A. The gaps under the exit doors in the kitchen have been repaired with installation of new door sweeps. B. All other doors leading to exterior will be inspected to ensure proper door sweeps. C. The Director of Property Management/Designee will create a new preventative maintenance order for team members to inspect and ensure that door sweeps remain functional. Preventative maintenance orders will be completed weekly. D. The Director of Property Management/Designee will monitor/audit completion of weekly PMs weekly for four weeks until 100% compliance is achieved and then monthly for 3 months until 100% compliance is achieved. Outcomes of these audits will be submitted to quarterly QAPI Committee for review and recommendations as indicated.	08/27/2025

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	enough such that cockroaches or other insects could crawl through. Due to the nature of kitchen waste transport through the doors, the kitchen and food storage room are susceptible to vermin encroachment. The finding was confirmed with E18 during the kitchen tour. 6/30/25 at 3:03 PM - Findings were reviewed with E1 (NHA).		
3225.16.0 3225.16.2 S/S-E	**Staffing** **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.** **State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties 2024...Post Fall Assessment & Documentation- RN..." Updated 4/10/24.** This requirement was not met as evidenced by: Based on record review, interviews and review of other facility documentation including incident reports, it was determined that four (R1, R2, R5 and R6) out of seven residents reviewed for Accidents, the facility failed to ensure that nursing services met professional standards as evidenced by having LPNs complete the post fall assessment and documentation for residents' post fall which violates the Delaware State Board of Nursing Scope of Practice.	A. Initial post-fall assessments will be conducted by an RN, in accordance with the DE Nurse Practice Act. B. Residents residing in OakBridge Terrace at Country House could be impacted. C. Educations will be provided to all licensed nurses and CNAs by the DAL no later than 07/30/2025, that the AL team member will contact the RN on-site in AL for the initial post-fall assessment. When there is not an RN on-site in AL, the team member will contact the skilled nursing neighborhood to request RN to perform the initial post-fall assessment either in person or via telehealth. The RN completing the assessment will document assessment findings in the resident record. D. The DAL/Designee will provide education to all licensed nurses and CNAs no later than 7/30/2025, that the AL team member will contact the RN on-site in AL for the initial post fall assessment. When there is not an RN onsite in AL, the AL team member will contact the skilled nursing neighborhood to request that the RN present complete the initial post fall assess-	8/27/2025

Provider's Signature Jenny Greenwood Title NHA Date 7/24/2025

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	1. 11/8/24 – R1 was admitted to the facility. 3/1/25 - Per EMR documentation at 4:50 PM, E16 (LPN) noted "Alerted by staff that resident on the floor. Resident unable to explain what occurred secondary to dementia dx. Resident non-compliant with assessment. Able to get himself from floor without assistance. No s/s pain, distress or discomfort noted. Gait slow and unsteady without assistive device. MAEE. Skin intact. No open areas noted. Attempted to obtain VS x's 3 without success. Resident becoming combative. Requires constant redirection to use his walker. Resident has very poor safety awareness. PCP and resident's spouse notified of incident. Will continue to monitor". The post fall assessment was completed by E16, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3/2/25 – Per EMR documentation at 9:07 PM, E12 (LPN) noted "Around 1856 (6:56 PM) this evening staff notified writer that the resident was on the floor in the living room. Staff report that she was trying to redirect the resident and he resisted which caused him to fall backwards hitting his head on the door way opening. His skin was intact and no noted injury. He offers no c/o pain or discomfort @ this time. Staff assisted the resident from the floor and he has very unsteady gait, and noncompliant with staff. Staff will cont. to monitor him. V/S 138/67, 65, 18, 98.0, 97% RA. His spouse and PCP was made aware". The post fall assessment was completed by E12, not an RN as required by the Delaware	ment either in person or via telehealth. The RN completing the assessment will document the assessment findings in the resident record. The audit will be conducted once a week x4 weeks until 100% compliance is achieved, then one a month for 3 months until 100% compliance is achieved. Outcomes of these audits will be reported at the Quarterly QAPI Committee Meeting for review and recommendations as indicated.	

Provider's Signature Jennifer Quennoz Title NHA Date 7/24/2025

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	State regulation of the Board of Nursing Scope of Practice. 2. 9/1/22 - R2 was admitted to the facility. 2/10/25 - Per EMR documentation at 10:42 PM, E12 (LPN) noted "at 2118 (9:18 PM) this evening the resident was found laying on his back in his bedroom area with his walker nearby. He was unable to explain what happened. He was alert with slurred speech and noted was a bottle of whiskey on his side table. He denies hitting his head. -SOB (shortness of breath). -chest pain,+ Neuro check, FULL ROM (range of motion), PERLA (pupils equal and reactive to light). The resident was assisted from the floor and HS (hour of sleep) care was given. He offers no c/o (complaint) @ this time. V/S 111/70, 88, 20, 97.0. His Spouse and NP was made aware". The post fall assessment was completed by E12, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 3. 3/10/25 – R5 was admitted to the facility. 3/30/25 - Per EMR documentation at 9:30 AM, E14 (LPN) noted "Resident found on floor in shower. When asked he stated that he slipped reaching back to grab his towel prior to getting out of the shower. Assessed and VS: 98.3F, 88, R 26, 169/101 via machine, 95% room air, with no c/o pain but skin tear noted to resident's R forearm. 2X assisted to standing and then supervised to sitting on the edge of his bed with a towel under him and assisted with dressing. Resident is AAOX3 (alert and oriented times three) and able to state what happened and is aware of		

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	his underlying medical conditions stating that he has had Cardiac Bypass and has a Pacemaker, ABD (abdominal) hernia, Diabetes and has a CGM (continuous glucose monitor) on the back of his R (right) arm Cleaned with NS (Normal Saline) and first aide applied. Current Tx (treatment). Orders preformed to his foot and face. Maintenance contacted and installed grip strips in his shower and a hook for him to hang his pendent on when he is bathing himself. POA contacted to notify of his fall as well as the Provider". The post fall assessment was completed by E14, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 4. 12/4/19 – R6 was admitted to the facility. 5/31/25 - Per EMR documentation at 10:25 AM, E16 (LPN) noted "Alerted by staff - resident found on floor. Received resident sitting on floor in hallway. NAD (no apparent distress) noted. Resident unable to articulate what occurred. No visible injuries or deformities noted. Scalp intact. No contusions, hematomas or open areas noted. Skin intact. No open areas or sites of discoloration noted. No s/s (signs/symptoms) pain, distress or discomfort noted. Gait slow and moderately steady with rollator. VS (vital signs) 91/46- 89- 16- 97.2- 92%RA (room air). Provider on call notified. Resident's son informed. Per staff, resident has been coughing since yesterday. Resident observed with a dry, infrequent, non-productive cough. Will		

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	continue to monitor. Staff instructed to increase resident's fluid intake and to assist her when changing position". The post fall assessment was completed by E16, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. 6/30/25 – Per interview with E2 (DAL) at approximately 11:30 AM, E2 confirmed the LPN staff are performing post-fall resident assessments. E2 stated the organization was working on a plan to address this. 7/1/25 – Findings were reviewed with E1 (NHA), E2, E3 (ED) and E20 (RCD) at the exit conference beginning at approximately 2:30 PM.		
16 Delaware Code, Chapter 11, Sub-chapter III	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)** **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, interview and review of other facility documentation, it was determined that for one (R2) out of seven	A. Past Non-Compliance: Deficient practice previously identified and corrected as noted in PIP. PNC compliance date 06/16/2025.	06/16/2025

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	sampled residents, the facility failed to provide appropriate interventions to maintain the safety of a resident. Findings include: 9/1/22 – R2 was admitted to the Assisted Living Facility with diagnoses including gait and mobility abnormality and bladder cancer. The ninth diagnosis entry on those listed was mild cognitive impairment. 10/22/25 – Per EMR entry at 1:24 PM, H1 (Hospice RN) noted R2 exhibited SOB (shortness of breath) with exertional activity and he prefers to stay in his room. H1 noted R2 continues to be alert and oriented x 4. 12/6/24 – Per EMR entry at 9:33 AM, E4 (LPN) noted R2 seemed to be having more increased confusion and was coming out of his room less than in the past. 12/16/24 – Per EMR entry at 9:07 AM, E2 (DAL) noted that R2 was screened for wandering risk and there was no history of wandering, was not displaying verbal cues for elopement or behaviors that could lead to elopement. It was determined that R2 was a Low Risk for wandering. 1/4/25 – Per EMR entry at 9:02 AM, E2 noted: "reported that resident was outside at 0600 (6:00 AM) this morning entering the building. He was ok and returned to his room no signs of trauma or injury. Spoke to resident at 0800 (8:00 AM) he was still in bed he could recall my name, year, month, and where he is. He could recall the events he stated he thought he had to put gas in his truck. He stated when he got outside he realized that he doesn't have a truck and that he had gotten confused and he realizes that		

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	was wrong. Will have a CNA (certified nurse assistant) to sit outside his apartment overnight tonight and tomorrow night to ensure safety". 1/6/25 - Per EMR entry at 9:02 AM, E2 noted: "Had staff sit outside resident's room X 2 nights since episode on Saturday morning. No reports of confusion or disorientation from the weekend". 1/30/25 - Per EMR documentation, an Interdisciplinary Group Plan of Care meeting which included nursing, social work, spiritual care and Hospice input was completed. The plan identified changed medications and cardiovascular status with ongoing issues including safety and facility coordination of care. Nursing report by H2 (Hospice RN) included increased forgetfulness and fatigue. 2/10/25 – Per EMR entry at 10:42 PM, E12 (LPN) noted R2 was found lying on his back in his bedroom area with his walker nearby and unable to explain what happened. E12 noted R2 was alert with slurred speech and noted was a bottle of whiskey on his side table. 2/11/25 – Per EMR entry at 1:41 PM, E2 (DAL) noted R2 was screened for wandering risk and there was a history of wandering and displaying behaviors that could lead to elopement. E2 noted R2 had a diagnosis of dementia or cognitive development but had not wandered in the last three months. It was determined that R2 was a High Risk for wandering. 2/13/25 - Per EMR documentation, an Interdisciplinary Group Plan of Care meeting which included nursing, social work, spiritual		

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	care and Hospice input was completed. The plan identified changed problems in pain/discomfort, safety and neurological. The plan noted recent medication changes and that due to the resident's cognitive impairment, resident was not to consume alcohol. 2/15/25 – Per EMR entry at 9:02 AM, E14 (LPN) noted that per report from the night shift R2 tried to leave out the front doors to Assisted Living around 5:30 AM and when redirected and asked what he was doing stated, R2 replied "I am trying to go home". 2/18/25 – Per EMR entry at 1:49 PM, E4 (LPN) noted: "Overnight shift will check to ensure that (R2) is in bed every hour for 5 days". 2/25/25 – Per EMR entry at 1:13 PM, E4 noted: "At approximately 05:00 (5:00 AM) Resident was in the foyer of the OBT entrance in his under ware knocking on the door to get in. Staff assisted him back to his room. He could not say why he was out there. NP, Administrator, wife and Hospice made aware. Hourly checks will be done on the night shift". 3/3/25 – Per EMR entry at 1:00 AM, E21 (RN) noted: (sic) "At approximately 12:45P M-1:00 AM this nurse was notified by security that a resident was on the ground in the parking lot. When I arrived, I found the resident lying on his back with only a T-Shirt, underwear and house slippers on. He was very confused, very cold and extremely anxious. Resident had no abrasions or contusions around the face or head. Resident had ROM		

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	in all 4 extremities. Resident knees were very red but had no broken skin on either knee. Resident had abrasions on left upper thigh and on his left lower forearm. I cleansed the area with NSS patted dry and applied band aides to the areas. Resident also had small contusions on left great toe and the toe next to it. Cleansed area with NSS (Normal Saline Solution), padded dry and left areas open to air. Residents vital signs were within the residents normal baseline. Resident had ROM in all 4 extremities. Initial neuro checks was within the residents normal baseline. Obtaining VS were very difficult due to residents anxiety. Resident was C/O severe back pain and at 200AM I gave him a dose of PRN Morphine and a PRN dose of Ativan due to his extreme anxiety. Resident continues to want to get up. Placed a wander guard on his right wrist. At around 4:00 AM resident finally began to settle and dose off to sleep. Attempted to call residents wife and got no answer. Will continue to monitor resident closely. Call bell is within reach/safety measures being maintained". 3/3/25 – Per EMR entry at 10:30 AM, E4 (LPN) noted that R2 was moved to WBC (Willowbrook Court) due to increased level of care need for placement in a secure location after R2 was found outside in the middle of the night. 7/1/25 – Per interview with E2 (DAL) at approximately 8:50 AM, E2 stated resident had a dream and left to the parking lot to put gas in his truck on 1/4/25. E2 stated resident realized he was dreaming and did return inside from the parking area. E2 stated the resident		

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	was placed on every hour checks to ensure safety after this incident. 7/1/25 – Per interview with E1 (NHA) at approximately 9:15 AM, E1 stated the wife purchased a door alarm for resident's apartment door. E1 stated the alarm was installed around 2/27/25 and emitted a chirping sound when the door was open. Once the door closed, the alarm made no sound. E1 stated the alarm was not a continuous sound and staff may not have heard the chirp on 3/3/25 as the resident closed his door on exit. E1 stated the resident was still cognitive but staff were starting to see some issues and spoke with wife regarding a move into a secured unit. E1 stated the residents' key fobs in the Assisted Living area only work on certain areas pertaining to the memory care unit. The key fob is not used when entering or exiting the building. The key fob is used at the front entrance gate to gain entrance to the campus only. E1 shared the facility PIP (Performance Improvement Plan) completed on 3/12/25 after the incident. All existing residents with a diagnosis of cognitive impairment were evaluated for wander risk and elopement behaviors. System revisions were put in place that the DAL will review any changes in resident behaviors and communicate these changes to the resident's practitioner to determine if there is a need for further diagnostic testing. If no clinical factors are identified, the interdisciplinary team and resident's family will discuss the need for a higher level of care.		

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	The facility failed to provide appropriate timely interventions to maintain the safety of a resident which resulted in an elopement and potential injury. 7/1/25 – Findings were reviewed with E1, E2, E3 (ED) and E20 (RCD) at the exit conference beginning at approximately 2:30 PM. 7/1/25 - After interview, review of the facility records and documentation and the facility abatement plan (PIP), it was determined that the facility identified their deficient practice and corrected it. This correction was verified through record review, facility tracking logs, facility audits and interviews with both E1 and E2, the alleged compliance was met as of June 16, 2025, and verified by the Surveyor on July 1, 2025.		

Provider's Signature Jenny Grennan Title NHA Date 7/24/2025

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