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: Dover Place

DATE SURVEY COMPLETED: December 3, 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 November 25, 2025, through December 3, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records, and review of other facility documents as indicated. The facility census on the first day of the survey was (84) forty-eight. The survey sample totaled (11) eleven residents. Abbreviations/definitions used in this report are as follows: AWD - Assistant Wellness Director; CSM - Care Services Manager; CT scan - computerized tomography scan; ED - Executive Director; FM - Family Member; LPN - Licensed Practical Nurse; MT - Medication Technician; PO - Medications given by mouth; RN - Registered Nurse; RCP - Resident Care Partner; UAI - Uniform Assessment Instrument, an assessment completed by the facility.		
3225	**Assisted Living Facilities**		
3225.16.0	**Staffing**		
3225.16.2 **S/S – D**	**A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents**		

Provider's Signature _____ Title __Executive Director_____ Date _12/31/2025____

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	shall be employed and shall comply with applicable state laws and regulations. **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for two (R4 and R10) out of eleven total sampled residents the facility failed to provide enough staff to meet the supervisory needs of the residents. For R10 the facility failed to provide adequate supervision to prevent the residents from entering another resident's room without permission. Findings include: 1. Review of R10's clinical record revealed: 10/1/25 - An initial UAI assessment documented that R10 had dementia and a history of wandering. 11/5/25 - A change of condition service plan completed for R10 documented "Neurocognitive Orientation: Severe Impairment Resident is frequently disoriented and requires frequent supervision and oversight. Resident will maintain and/or maximize current level of functioning with wandering. Resident has current or history of wandering that does not jeopardize safety. Current or history of wandering within the residence or facility and may wander outside but does not jeopardize health or safety (of self or others). 12/1/25 10:04 AM - During an interview FM1 stated, "On 11/2/25 [R10] wandered into [R11's] room. I saw it on the camera we have in there. [R10] was near the door	A. Residents R10, & R11 affected. Community Staffing reviewed by Executive Director. Memory Care associates will be retrained by Executive Director or designee regarding the redirection of residents who try to enter other residents' rooms without permission. B. Current Residents residing in memory care potentially affected. Executive Director or designee will offer each resident/responsible party in memory care unit a Velcro stop sign for door to divert any resident from entering another resident's room without permission C. Residents of memory care who have a documented history of wandering will be placed on q1 hour checks for 14 days; then q2 hour checks for 14 days; and then daily monitoring for 8 weeks by direct care staff members to ensure staff are providing adequate supervision to prevent the residents from entering another resident's room without permission. D. Executive Director or designee will review the results of the audits daily for 7 days until consistently reach 100% success over 3 consecutive evaluations. Then the Executive Director will review the audits two times a week until consistently	1/16/2026

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	about five minutes, and I realized he urinated in the room that night. He started to cough, and [E13 RCP] must have heard it and came and got [R10] out. FM1 reported that R11 remained asleep during the encounter and that housekeeping cleaned the room after the facility's initial cleaning." 12/1/25 11:45 AM - During an interview E2 (CSM) confirmed that R10 entered R11's room and urinated on the floor. E2 stated "When we were told I physically went in and cleaned the carpet." 12/2/25 6:05 AM - During an interview E13 (RCP) stated, "I went in to check on [R11] like we do every two hours. [R10] was in the hall, he wanders. I went to check on other patients and didn't see him, so I went looking for him and found him in [R11's] room. I wasn't more than five minutes. I didn't know he peed in there." 2. Review of R4's clinical record revealed: 8/7/25 - An initial UAI assessment documented that R4 had dementia, and a history of wandering. 8/8/25 - A service plan completed for R4 documented, "Psychosocial: extensive wandering issues. Requires supervision." 11/16/25 - Review of the facility schedule revealed there were three RCPs scheduled to provide care on the memory care unit E12, E14, and E15.	reaching 100% success at 3 consecutive evaluations. Then the Executive Director will review the audits once a week until consistently reaching 100% success at 3 consecutive evaluations. Then the Executive Director will monitor the audits one month later at QAPI to ensure plan is 100% successfully implemented. Documentation: Training Agenda ; Audit Form A. Resident s effected R4, R5, R7. Staff immediately separate the residents after incident occurred between R4 & R5. R7 did not have a fall. B. Residents in memory care unit potentially affected. Memory care staff will be re-trained on de-escalation techniques when dealing with residents with dementia and cognitive impairments. Executive director reviewed community staffing plan in memory care. C. Executive director or designee will complete audits daily x30 days and then weekly x8 weeks of memory care resident notes regarding behaviors and compare to staffing patterns to see if staffing adjustments are needed in memory care. D. Executive Director will review audits weekly for 12 weeks to identify if staffing patterns in Memory Care need to be adjusted and ensure 100% success rate. Documentation: Training agenda	1/16/2026

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	11/16/25 - An incident report submitted to the state agency alleged a resident-to-resident physical altercation occurred between R4 and R5. 11/16/24 4:30 PM - A statement written by E12 (RCP) documented that during the above incident E12 was, "... in the kitchen getting a drink for another resident." 11/16/25 4:30 PM - A statement written by E15 (RCP) documented that during the above incident E15 "Was in the room with another resident." 12/1/25 12:57 PM - During an interview E14 (RCP) stated, "I was trying to tell [R5] to stay away because I was handling it. [R4] was trying to get out of the door. At the same time [R7] was trying to stand up [unassisted]. I was by myself. I was standing in the middle between them [R4 and R5] but I am so short that [R4] was able to go over my head." E14 reported the other scheduled RCPs were with other residents at the time. 12/3/25 2:30 PM - Findings were reviewed with E1 (ED) and E2 (CSM) at the exit conference.		
3225.19.0 **3225.19.6** **S/S – D**	**Records and reports** **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.** **This requirement was not met as evidenced by:**		

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	Based on record review and interview it was determined that for four (R1, R8, R10, and R11) out of eleven residents reviewed for reportable incidents the facility failed to ensure the incidents were reported as required. Findings include: The facility policy on Abuse Prohibition last updated 2018 indicated, "Report any incident to the Administrator or designee immediately. Report the incident to the State Regulatory Agency within three days of the occurrence." 11/30/25 untimed - R12 (RCP) completed written statements that detailed resident-to-resident altercations involving R1, R8, R10 and R11. 12/1/25 8:17 AM - The facility reported resident-to-resident altercations between R1, R8, R10 and R11 to the state agency. 12/1/25 1:51 PM - During an interview E2 (CSM) confirmed that incident reports regarding resident-to-resident altercations between R1, R8, R10 and R11 were not reported within the required timeframes. E2 stated, "we are working with the staff on that". 12/3/25 2:30 PM - Findings were reviewed with E1 (ED) and E2 (CSM) at the exit conference.	A. Residents affected R1, R8, R10, & R11. Reportable incident reported to the department on 12/1/2025 for altercation involving R1, R8, R10, & R11. B. Current community residents potentially affected. Executive Director or designee will review last 30 days of resident notes and employee statements to ensure that any incidents involving reportable events have been reported to the department within the designated timeframe. Community staff to be re-educated on reportable incidences and process of reporting any incidents to management at the time the incident occurs by Executive Director or designee. C. Resident Wellness Director or Designee will complete audits of resident notes and community incidents daily x4 weeks and then weekly x 8 weeks to ensure that the facility reports reportable incidents to the department within the designated timeframe. D. Results of these audits will be reviewed by Executive Director weekly for 4 weeks until 100% success for 3 consecutive evaluations; then reviewed monthly by the Executive Director for 3 months at QAPI until consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate.	1/16/2026
3225.19.7 **3225.19.7.7.5** **S/S – D**	**Reportable incidents include:** **Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and**		

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	safety or requires extensive monitoring for up to 48 hours. **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for one (R3) out of four residents reviewed for medication administration the facility failed to ensure a significant medication error was reported within the required timeframe. Findings include: 11/12/25 - A statement written by E11 (LPN) documented, "Med error on record...I flagged the narcotic page in question and let [E9 (AWD)] know about the discrepancy." 11/14/25 - The facility submitted an incident report to the state agency regarding a medication error involving R3 receiving the wrong dose of anti-anxiety medication, two days after the medication error was discovered. 12/3/25 11:47 AM - During an interview E9 (AWD) stated, "I came in on the 13th, [E11 (LPN)] worked the 12th. I don't remember when I let [E2 (CSM)] know because I did investigate some." 12/3/25 11:49 AM - During an interview E2 (CSM) confirmed that the medication error involving R3 was not reported within required timeframe. 12/3/25 2:30 PM - Findings were reviewed with E1 (ED) and E2 (CSM) at the exit conference.	A. Resident R3 affected. Reportable incident involving medication error for R3 was reported on 11/14/2025. B. Current community residents potentially affected. Executive Director or designee will review last 30 days of employee statements to ensure that any Medication Errors have been reported to the department within the designated timeframe. Executive Director or designee will review last 30 days of employee statements to ensure that any Medication Errors have been reported to the department within the designated timeframe. C. AWD & CSM will be re-trained on reportable incidents and the designated timeframe of which the reportable incidents need to be reported to the department. Resident Wellness Director or Designee will complete audits of employee statements daily x4 weeks and then weekly x 8 weeks to ensure that the facility reports any Medication Errors to the department within the designated timeframe. D. Results of these audits will be reviewed by Executive Director weekly for 4 weeks until 100% success for 3 consecutive evaluations; then reviewed monthly by the Executive Director for 3 months at QAPI until	1/16/2026

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16 Del. Code §1131 **Chapter 11, Subchapter III.3** **S/S – D**	**Abuse, Neglect, Mistreatment, Financial Exploitation, of Residents or Patients** **§ 1131. Definitions.** **(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 the interview and record review, it was determined that for one (R6) out of eight residents reviewed for neglect, the facility failed to provide adequate supervision to ensure safety while providing care for R6 while the resident was in bed. Additionally, the facility failed to ensure that each resident received their medication as ordered. R1 received an additional dose of insulin resulting in a significant medication error that placed R1 at risk for hypoglycemia. Findings include: 1. The facility fall risk management policy last updated 2018 indicated, "It is up to all of us to make sure that the residents' living area is safe and that individual precautions are taken to prevent falls." Review of R6's clinical record revealed: 6/17/25 - A service plan revealed R6 was dependent on staff for all mobility, ambulation, and ADLs.	consistently reaching 100% success over 3 consecutive evaluations. Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Documentation: Training agenda A. Residents affected R6. Employee E6 received corrective action and one on one verbal coaching by Resident Wellness Director regarding providing adequate supervision to ensure safety of residents while providing care by Resident Wellness Director following incident that occurred involving R6. B. Residents' dependent on staff for all ADLs potentially affected. Community clinical staff to be retrained on providing adequate supervision to ensure safety of residents while providing care. C. Resident Wellness Director or designee will complete audits of resident falls daily for 30 days then weekly for 8 weeks to ensure that staff are providing adequate supervision to ensure safety of residents while providing care.	1/16/2026

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	6/30/25 - R6 was admitted to the memory care unit at the facility with a diagnosis of dementia 11/15/25 4:01 PM - A progress note revealed R6 fell from the bed to the floor and was sent to the hospital for evaluation. 11/15/25 1:30 PM - A facility incident report revealed that R6 was on the floor between the bed and the nightstand on his back. 11/15/25 2:29 PM - An emergency room report revealed CT scan of the head negative and no evidence of fracture. Patient is stable and discharged back to the facility. 11/24/25 - A Uniform Assessment Instrument revealed R6 was cognitively impaired. 12/1/25 8:45 AM - 12/1/25 8:45 AM – During an interview E6 (MT) reported that R6 was transferred to the bed for incontinence care. E6 then stated, "I left R6 on the bed and walked to the closet to get incontinence supplies, R6 fell out of the bed on to the floor." E6 confirmed R6 was left unsecured in the bed. 12/1/25 9:45 AM – In an interview, E7 (MT) stated that R6's bed is up against the wall. E6 explained if she had to walk away from a resident to get supplies, she would make sure the bed is in a low position and make sure the resident is up against the wall. 12/02/25 9:55 AM - During an interview, E8 (MT) stated that if she had to step away	D. Executive Director or designee will review the audits 3 times a week until consistently reach 100% success over 3 consecutive evaluations. Then the Executive Director or designee will review the audits weekly until consistently reaching 100% success at 3 consecutive evaluations. Then the Executive Director will monitor the audit a month later at QAPI to ensure plan is 100% successfully implemented. Documentation: Training agenda	

Provider's Signature B Mella Title Executive Director Date 12/31/2025

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	from a resident who is in bed to get supplies, she would make sure the bed is in a low position and place a pillow under the resident's side that is not against the wall. 12/1/25 12:45 PM - During an interview, E5 (LPN) stated that E6 rolled out of bed when she stepped away to get supplies. 12/1/25 1:00 PM – During an interview, E2 (CSM) reported receiving a call from E5 (LPN), and she was unaware if R6 hit her head. E2 contacted the physician, who directed that R6 be sent to the emergency room for evaluation. E2 confirmed that E6 walked away from the resident to retrieve supplies, did not secure the resident's safety, and the resident's bed was in a high position. 12/3/25 2:30 PM - Findings were reviewed with E1 (ED) and E2 (CSM) at the exit conference. 2. The facility policy on medication management last updated December 2023 indicated, "Concurrent with the UAI based assessments there shall be an on-site medication review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication to ensure that: Each resident receives the medications that have been specifically prescribed in the manner that has been ordered." Review of R1's clinical record revealed: 4/21/25 – An initial UAI assessment documented that R1 had diabetes and required medication administration from staff.		

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	4/21/25 – A service agreement documented that R1 was to receive medication administration services. 4/23/25 – R1 was admitted to the facility on the memory care unit with multiple diagnoses including dementia and diabetes. 10/5/25 – A physician's order was written for R1 to receive 30 units of long-acting insulin daily for diabetes at 8:00 AM. 11/23/25 8:00 AM – R1's MAR documented that E5 (LPN) administered the ordered dose of 30 units of insulin to the resident. 11/23/25 10:16 AM – The facility submitted an incident report to the State Agency that alleged a medication error occurred when R1 received a second dose of insulin that was not ordered. R1 was provided orange juice and blood sugars were checked. R1 was not symptomatic. 11/24/25 – A progress note in R1's clinical record written by E17 (NP) documented that R1 was seen for hypoglycemia. R1 was seen sitting up, alert, pleasant and cooperative. 11/25/25 3:50 PM – During an interview E5 (LPN) stated, "I was assigned to memory care that day. I went over and gave [R1] her insulin after checking her blood sugars and documented as ordered. Then I went to do a treatment on another resident. When I came back [E16 (LPN)] said 'I gave [R1] her insulin for you'. I immediately checked out [R1] called the doctor, family etc. We	A. Resident affected R1. Resident was monitored by community staff per physician instruction after medication error occurred. B. Residents ordered insulin potentially affected. Community nurses re-trained on 11/28/2025 regarding following prescribers orders in relation to administering insulin. C. Resident Wellness Director or designee will complete daily audits x30 days to ensure all residents prescribed insulin received their insulin as ordered. To ensure ongoing compliance Resident Wellness Director will complete Weekly audits X 8 weeks to ensure that all residents prescribed insulin receive their insulin as ordered. D. Results of these audits will be reviewed by Executive Director 3 times weekly until 100% success for 3 consecutive evaluations, then weekly for 4 weeks until 100% success for 3 consecutive evaluations; Then reviewed one more time a month later at QAPI by Executive Director to ensure 100% success rate. Documentation: Training and sign off	1/16/2026

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	checked her blood sugars throughout the shift and monitored her." 11/26/25 10:10 AM – During an interview E16 (LPN) stated, "We give insulin before R1 eats. The aide usually calls us on walkie to come. I didn't have R1 that morning. Another nurse [E5(LPN)] did, and they called on the walkie three times and so I said let me help her out and I checked [R1's] blood sugar and she was like 123 and I gave her insulin and when she [E5 (LPN)] came back I told her and she said she already gave and I said I didn't know and so we quickly assess give her juice." 11/26/26 10:45 AM – An email statement from E16 (LPN) was provided that documented an account consistent with the prior interview. 12/3/25 2:30 PM - Findings were reviewed with E1 (ED) and E2 (CSM) at the exit conference.		