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: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225	An unannounced Complaint survey was conducted at this facility from November 20, 2025, through November 24, 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 forty (40). The survey sample totaled three (3) residents. **Assisted Living Facilities** Abbreviations/definitions used in this state report are as follows: BIMS (Brief Interview for Mental Status) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15; 0-7: Severe impairment (decisions rarely/never made); 8-12: Moderately impaired; 13-15: Cognitively intact; CNA- Certified Nursing Assistant; DAL – Director of Assisted Living; DPM - Director of Property Management; Elopement – an unauthorized and unsupervised departure of a patient from a care setting; ED – Executive Director; LPN – Licensed Practical Nurse; NHA - Nursing Home Administrator;	R1 POC 1. R1 no longer resides in the unsecured area of AL. R1 was sent to the hospital for evaluation on 9/13/25 when the event occurred with no injury. Resident was discharged to her daughter's home on 9/14/25. R1 was admitted to SNF on 9/25/25 from daughter's home. R1 was admitted to the secured memory AL area on 10/31/025 from the SNF. A root cause analysis was conducted and involved a review of the cognitive assessment process. 2. New admissions from 11/10/25 to present were reviewed on 11/23/25 for cognitive status. The results of the BIMS score were intact cognition. 3. A BIMS will be completed for new admissions on the day of admission by the admitting RN. Results will be reviewed with the interdisciplinary team. Determination will be made by the interdisciplinary team if their cognition is appropriate to reside in general AL. Education was provided by NHA to RNs performing UAIs to assess cognition and complete a BIMS. Education was completed on 11/22/25. 4. Admission records will be audited by the DAL withing 48 hours after admission to ensure completion of BIMS and appropriate cognitive status to reside in general AL. ~~All~~ audit results will be brought to quarterly QAPI meeting. Threshold for compliance is 100 %. If 100% compliance is reached for a 60-day period, the	Completed 11/23/25

Provider's Signature K Perrone Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Perineal – referring to the area between the thighs, the external genitals and the anus; Service Agreement – allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services; UAI (Uniform Assessment Instrument) – a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both initial and ongoing basis; UTI (Urinary Tract Infection) – bacteria in the urine; Wander guard – a system designed to prevent wandering in elderly people or those with dementia. It relies on bracelets worn by residents, sensors on doors and a technology platform. When a resident approaches a monitored door, the systems alert caregivers in real time for them to respond to the wandering resident. Wandering Risk - 0 - 5 Low Risk to Wander, 6 - 10 At Risk to Wander, 11 – above, High Risk to Wander; This requirement was not met as evidenced by:	QAPI committee will direct if the audits are to continue or not. If 100% compliance is not reached, the audits will be ongoing and continue to be reported to QAPI until 100% compliance for a 60-day period is reached. R2 POC 1. R2 has not had an elopement since 11/9/25. Door was monitored by a staff member at all times from 11/9/25 until door locking mechanism was repaired on 11/14/25 by security vendor, new pagers deployed on 11/19/25 and a new alarm box installed on 11/14/25. ~~2.~~ Door lock audits were initiated along with pager function audits and routine elopement drills conducted. There have been no other elopements. A root cause analysis was conducted and involved multiple parts/devices of the system. 3. AL staff were educated by DAL regarding door alarms and pager alerts for the secured area. They were also educated on what to do and who to report issues to. This was completed on 11/25/25. DAL has successfully completed elopement drills on 11/21/25, 11/24/25, 11/26/25 with good outcomes. Elopement drills will continue monthly ongoing, unless deemed otherwise by the QAPI committee. Drill results will be presented at each quarterly QAPI meeting. 4. Audits will be conducted as follows: Secured memory unit door lock audit every hour by nurse or designee	Completed 11/25/25

Provider's Signature J Rennone Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.19.7.5.2 **Title 16 Health and Safety Chapter 11 Long Term Care Facilities and services Sub-chapter III.** **S/S – J**	**Any circumstance in which a cognitively impaired resident, whose whereabouts are unknown to staff, exits the facility.** **Abuse, Neglect, Mistreatment, financial Exploitation, or Medication Diversion of Patients or Residents.** **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.** Based on observation, interview, record review and other facility documentation it was determined that for two (R1 and R2) out of three (3) residents reviewed for neglect, the facility failed to ensure that R1 and R2 did not leave the building unsupervised. This failure put the residents at immediate jeopardy and risk of a serious adverse outcome. R1, a severely cognitively impaired resident, was able to elope from the Assisted Living section of the facility on to the parking lot on 9/13/25 at 7:50 PM. R2, a severely cognitive impaired resident, was able to elope from the locked Memory Care section of the facility on to the parking lot on11/7/25 at 12:48 PM and again on 11/9/25 at 7:45 AM. An immediate jeopardy (IJ) was identified starting on 11/21/25 at 11:00 AM, with an abatement date of 11/21/25 at 5:00 PM. Findings include:	11/21/25-11/24/25 at 10:00 am. If 100% compliant with locking, decrease audit to every 4 hours until 11/27/25. If 100% compliant then audit locks every shift going forward. Audit cycle will not progress until 100% compliance has been reached at each level. Pager function will be audited by nurse or designee every shift ongoing. Any issues will be reported immediately to the nurse supervisor and addressed. Threshold for compliance is 100%. The QAPI committee will review ~~all~~ audits for compliance. If a threshold of 100% is not achieved, a QAPI plan will be required to be submitted to the QAPI committee by the DAL. The QAPI committee will monitor compliance and make recommendations based upon outcomes.	

Provider's Signature K Perrone Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An undated facility document entitled "Elopement Policy" included, "The community will respond to any unauthorized, unescorted, or unsafe exit of a cognitively impaired resident. This includes failure of a cognitively impaired resident to follow sign out procedures when leaving the premises. Elopement is considered a potentially life-threatening event...." 1. R2's clinical record revealed: 9/2/25 – R2 was admitted to the facility's memory care unit with diagnoses including but not limited to Alzheimer's disease and anxiety disorder. R2's cognitive assessment in the UAI (Uniform Assessment Instrument) documented that she was oriented to person and place. The UAI also documented that R2 had short term memory problems. 9/15/25 – R2's elopement assessment entitled, "Wandering Risk Scale", documented a score of 29, indicating a high [elopement] risk. R2's clinical documentation included orders to check the wander guard placement every shift and function every week. 10/23/25 to 11/6/25 – R2's clinical document revealed a total of 14 episodes of wandering behaviors out of 45 opportunities. 11/7/25 1:03 PM – A facility investigative document included, "...Security [name of security guard] called that [R2] was at the welcome house near [name of the road.]"		

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	The welcome house is the located near the road where vehicles enter and exit the property. 11/7/25 2:15 PM – A facility document entitled "Elopement Drill", included, "Maintenance notified to ensure door to [name of unit] is operational." Corrective action, "Placed resident [R2] on hourly rounds." The facility failed to identify that the malfunctioning lock/alarm on the door placed all the residents who resided on the memory care unit at risk for elopement. 11/7/25 2:55 PM - R2's clinical record included, "Resident had gotten out of the dementia unit around 1248 [12:48 PM.] Resident had walked out of the [name of entrance/exit door] and proceeded toward the [name of building] before resident was able to walk further, security radioed [name of the unit] to notify staff that she [was] outside. Security was able to stay with her until staff was able to return her to the [name of unit]." 11/7/25 7:02 PM - R2's post elopement assessment entitled, "Wandering Risk Scale", documented a score of 24, indicating a high elopement risk. R2 was placed on hourly rounds and observations by the staff and maintenance ensured that door locks operational on [name of unit.] The facility failed to investigate how R2 exited the second alarmed exit/entrance door that opened to the sidewalk.		

Provider's Signature _____ Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	11/7/25 to 11/8/25 – R2's clinical document revealed a total of 3 episodes of wandering behaviors out of 9 opportunities. 11/9/25 7:45 AM – A facility document entitled "Incident Report Residents & Visitors" documented that R2 was alert and confused prior to the incident. The description of the incident included, "[R2] was observed by a staff member walking outside heading towards the parking lot. Staff member pulled off to the side to park, approached resident and safely escorted her back to the memory care unit. The corrective actions included every 30 minutes monitoring." 11/9/25 11:07 AM – R2's post elopement assessment documented an elopement score of 24, indicating a high [elopement] risk. 11/9/25 11:14 AM - R2's clinical record included, "[R2] was found outside the building at 0745 [7:45 AM] by a home health aide. Not sure what exit she went out after getting off the dementia unit. Resident was escorted back to the unit..." The facility failed to ensure that R2 did not exit the building two days after the first elopement. 11/20/25 12:00 PM – During an interview, E7 (CNA) stated, "I reported that the pagers were not alarming when the residents were near or try to open the door. After the first elopement, we were told to check the resident [R2] every hour to make sure that she did not leave the unit. I checked on her, but		

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	I have other residents to take care of as well so I could not keep my eye on her all the time." The Surveyor asked E7 whether there was a staff member stationed at the exit door of the unit. E7 stated, "I did not see anyone monitoring the door." 11/20/25 12:30 PM – During an interview, E10 (LPN) stated, "[R2] has been trying to leave since the day she got here. She keeps asking to go home. We try to keep her busy, but she can walk fast so it can be hard to constantly watch her." The Surveyor asked E10 whether she received a notification to her pager when a resident was near or tried to open the exit door. E10 stated, "We used to get an alert on the pagers with the old doors but not with the new door." The Surveyor also asked E10 whether the exit door was monitored by staff after R2's first elopement incident. E10 stated, "We were told to watch the door, but I did not see someone there all the time." 11/20/25 2:20 AM – During an interview, E2 DAL (Director of Assisted Living) stated, "On 11/6/25, the door to [name of the unit] was changed to make it look more home like. The new door had a 15 second delay and then it would open. I also observed that the alarm was not loud enough to hear at a distance, so I alerted maintenance [E5 DPM]. The door was assessed, and he stated it was working. I was told that the door had to have a delayed opening because it was considered an egress door. I was off the next day. I was informed that [R2] had eloped on 11/7/25, and I told the staff to check on her and door frequently. The Surveyor asked E2		

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	if there was a staff member stationed at the door to ensure that the residents did not exit the door. E1 stated, "I told the staff to check on the resident so they can know where she was. I was told that [R2] had exited the building on 11/9/25. I told the staff to check on her every 30 minutes and monitor the door. I even monitored the door myself. Stop signs were placed on the inside of the door. I called E1 (NHA) and updated her on the situation." 11/20/25 3:00 PM – During an interview, E1 stated, "I called [E3 ED] and notified him about the concerns about the door and maintenance not being able to fix them. E3 spoke with E5 and was told that it was the fire code and could not be bypassed. On 11/10/25, I identified issues with the 15 second egress bypass not functioning properly and the door box alarm sounding too softly. I also tested the pagers and found that the door alarm was not alarming [communicating] with them consistently. The alarm box outside of the main exit door was tested with the wander guard and it was alarming properly. The issues were reported to E3 and E5. E5 reached out to [name of the door installation company] and they were not available to come out right away. The lock was adjusted a little further to see if it would help per the door company recommendations. New pagers were ordered, and the door was continuously monitored by the staff. On 11/14/25, the 15 seconds egress was turned off, and a new box/alarm was installed on the door. The new alarm now sounds loudly when it is triggered. There have not been any other		

Provider's Signature K DeRone Title NHA Date 12/29/25 Revised

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village DATE SURVEY COMPLETED: November 24, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	issues with the door since the egress feature has been disabled. We did not have any further issues with the alarm boxes either." 11/21/25 5:00 PM - The facility's abatement plan for the immediate jeopardy included: a. Staff education for all [name of unit] staff regarding door alarms and pager alerts for exit door to be completed 11/25/25. b. Responding to alarm at secured door. c. Ensuring that when the door alarm sounds, the pagers activate. d. Wearing pagers at all times. e. Pager code descriptions of areas. f. Quickly responding to pager alerts. g. If pagers do not activate with door alarm, report immediately to the nurse supervisor. h. If door alarm malfunctions at any time, a staff member is to be staffed to guard the door until it is assessed by nurse supervisor or maintenance worker. 11//21/25 5:00 PM - Staff interviews conducted, and in-service education and training verified. The IJ was considered abated at 5:00 PM. 2. R1's clinical record revealed: 8/19/25 – An UAI signed by E2 (DAL) documented that R1 was independent with toileting, grooming, dressing, did not refuse		

Provider's Signature [signature] Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	care and had problems with short term memory. The UAI lacked evidence of documentation of R1's cognitive status. 9/8/25 – R1 was admitted to the facility with diagnoses including vascular dementia. 9/10/25 4:02 PM – E13 (LPN) documented in R1's clinical record, "[R1] arrived to facility...A&Ox2 [alert and oriented to self and place] with confusion." 9/10/25 4:13 PM – E12 (RN) documented in R1's clinical record that R1 had a wandering risk assessment score of 18. A score of 11 and above indicated a "High Risk to Wander". E12 documented in R1's clinical record, "[R1] is able to ambulate either independently or with assistive device...[R1] is displaying behaviors that could lead to elopement." 9/10/25 9:30 PM – E12 documented in R1's clinical record, "[R1] is alert and oriented x1 to person, she does not recall the day, month or year. [R1] also does not recall the name of the facility." 9/12/25 10:46 AM – E13 documented in R1's clinical record, "...[R1] refused assistance with AM care...found w/o (without) pants on, wearing clothes that she had slept on [*sic*]. Resident appeared confused. Nurse asked resident to pick out an outfit, but resident could not pick out an outfit to wear...Nurse provided perineal care and cued resident to put on a clean pull up and clothes on. Nurse had to cue resident to wash hands and brush teeth...".		

Provider's Signature K Perrone Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	9/12/25 – A note written on R1's Nursing Care Plan documented, "...increased confusion noted [*sic*] collected urine specimen...". No other interventions for R1's increased confusion was documented on the care plan. 9/12/25 10:52 PM – A nursing progress note entered in R1's clinical record documented, "[R1] had no idea when dinner was this evening, even though it is posted on the back of her door...[R1] refused PM care several times...". 9/13/25 2:57 PM – A nursing progress note entered in R1's clinical record documented, "Nurse was notified around 1450 [2:50 PM], by another resident's family that [R1] was walking along the balcony looking to deliver placemats to her parents. The family member did walk [R1] back to her apartment...Will pass on to next shift to check on [R1]." 9/13/25 – E2 documented in a facility document titled, "Critical Incident Form", "[R1] is a new move in to assisted living with worsening confusion since arrival...[R1] was found outside the building in the parking lot by Security who found her at 1950 [7:50 PM] while doing their rounds. Staff notified and found [R1] on the ground and she stated, 'I'm looking for my car but can't remember where I parked.'...[R1] was sent to the emergency room for evaluation...[R1] last seen in her room at 1845 [6:45 PM] with a friend visiting...". 9/13/25 11:25 PM – E12 documented in R1's clinical record, "...Security contacted		

Provider's Signature _____ Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	this nurse at 1950 [7:50 PM] requesting assistance in the resident's parking lot 2/2 resident fall...Assessment: AOx1 to person...[R1] last seen prior to this incident in her apartment with a visitor. She [visitor] reported that [R1] seemed to be more confused...[R1] did not recognize her [visitor]...". 9/17/25 1:50 PM – E13 documented in R1's clinical record that R1 was negative for UTI. 9/25/25 4:25 PM – A 5 day follow up report submitted to the Division documented, "...It was determined that [R1] would need to live in our locked memory care unit when a bed is available...[R1] is now being admitted to our skilled nursing unit for evaluation...wander guard will be in place...". 9/26/25 – R1 was admitted to the facility's skilled nursing unit. 10/30/25 – R1 was admitted to the facility's memory care unit. 11/20/25 3:15 PM – During an interview, E12 stated, "[R1] kept trying to leave since the first day I met her. I had to keep bringing her back." 11/21/25 10:45 AM – During an interview, the Surveyor asked E2 what actions were taken after R1 had several documented episodes of increased confusion and impaired cognition. E2 stated, "We collected a urine specimen to test for UTI to see if that was causing the confusion". The Surveyor asked E2 why R1, who had dementia, oriented only to self and assessed to be high risk for wandering, was not monitored more		

Provider's Signature [signature] Title NHA Date Revised 12/29/25

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village

DATE SURVEY COMPLETED: November 24, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	closely after her confusion worsened. E2 stated, "AL [assisted living] residents are not monitored on a 1:1 and allowed to go out. They are required to sign out before they leave." The Surveyor then asked E2 if R1, who has dementia, is documented as AOx1 and does not know the date or where she is, had the ability to sign out, leave and return to the facility. E2 stated, "We have residents in assisted living that have dementia that are able to go out and return with no problem." 11/21/25 12:00 PM – An immediate jeopardy (IJ) was called due to the facility's failure to accurately assess and supervise R1 after it was documented that R1 displayed elopement behaviors, was at high risk for wandering, was found wandering in the facility by a visitor and had repeated incidents of confusion and cognitive impairment. The facility's lack of supervision resulted in R1's elopement outside of the facility into the parking lot where she was found after sustaining a fall. 11/24/25 9:00 AM – Based on the Surveyor's review of the facility's investigation, staff interviews and resident audits completed from 11/21/25 to 11/24/25, the IJ was considered abated on 11/21/25 at 5:00 PM. The facility's corrective actions included: - Residents assessed before admission that are only oriented to self will not be admitted to the assisted living facility and instead will be admitted to the skilled nursing unit		

NAME OF FACILITY: Oakbridge Terrace at Cokesbury Village **DATE SURVEY COMPLETED: November 24, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	or the memory care unit for close supervision. - A BIMS assessment will be performed on newly admitted residents on admission by the admitting RN. The BIMS assessment results will be reviewed by the NHA and DAL, who will determine if the resident is appropriate for admission to the assisted living facility. - All RNs who conduct UAI assessments will be educated to assess cognition on the day of admission and to document the BIMS assessment in the resident's record. - Resident admission records will be audited by the DAL within 48 hours after admission for compliance. - All resident audit and staff education records will be brought to the quarterly QAPI committee for ongoing compliance monitoring. 11/24/25 1:00 PM – Findings were reviewed with E1 (NHA), E2 (DAL) and E3 (ED) during the exit conference.		

Provider's Signature [signature] Title NHA Date Revised 12-29-25