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: Brookdale Hockessin

DATE SURVEY COMPLETED: August 8, 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, and Complaint survey was conducted at this facility from August 5, 2025, through August 8, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was forty-three. The survey sample totaled fourteen residents. Abbreviations/definitions used in this report are as follows: BOM - Business Office Manager; CP – Care Partner; DSM – Dining Services Manager; DCS – Director of Clinical Services; ED - Executive Director; HWC – Health and Wellness Coordinator; HWD – Health and Wellness Director; LPN - Licensed Practical Nurse; MM – Maintenance Manager; MT – Medication Technician; RN - Registered Nurse.; Medication Administration Record (MAR) documentation of medications given to the resident; Milligrams (mg) unit of measurement; Resident Assistant (RA) also known as care partner; staff responsible for direct care to the residents.		

Provider's Signature Title Executive Director Date 10/30/25

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3225	**Assisted Living Facilities**	Resident R7 experienced no adverse effect secondary to identified issue.	10/3/25
3225.8.0	**Medication Management**		
3225.8.1	**An assisted living facility shall establish and adhere to written medication policies and procedures which shall address:**	RCA - associates did not follow community policy to re-order medications prior to medication being unavailable.	
3225.8.1.1	**Obtaining and refilling medication;**	All residents have the potential to be affected by this practice. The Health and Wellness Coordinator (HWC) and Executive Director (ED) conducted an audit of current resident's MAR's for the past 7 days for any missed or omitted doses and medications not available. Any identified medications will be re-ordered with 7 days prior to getting low.	
S/S – D	Based on record review and interview, it was determined that for one (R7) out of ten residents reviewed for medication review the facility failed to ensure adherence to policies regarding refilling medications. Findings include: The facility policy on ordering medications last reviewed June 2019, indicated, "When the resident's medication supply reaches seven days, fax a refill request to the pharmacy." Review of R7's clinical record revealed: 7/22/21 – R7 was admitted to the facility. 7/22/21 – A physician's order was written for R7 to receive Lipitor 10 mg by mouth each evening for high cholesterol. 10/5/22 – A physician's order was written for R7 to receive Tylenol Extra Strength 500 mg give two tablets by mouth three times daily for shoulder pain. 10/24/24 – A service agreement was completed for R7 that documented the facility would order and coordinate medications. July 2025 – A review of R7's MAR revealed the resident missed the doses of Lipitor on 7/5, 7/7, 7/8 and 7/9 and doses of Tylenol	The HWC will re-educate the nurses and med techs on the community policy and procedure for administering medications and verifying medication availability. To assist with ongoing compliance, the HWD or designee will audit medication availability weekly for four (4) weeks and monthly for three (3) months until 100% compliance is achieved. The audit results will be submitted and reviewed by the QAPI committee.	

Provider's Signature Crystal Marsden Title Executive Director Date 10/30/25

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	on 7/5, 7/6, 7/7 and 7/8 due to "medication not available." 7/5/25 – A prescription refill request was completed for R7's Lipitor and Tylenol. 8/6/25 12:51 PM – During an interview, R7 stated, "I missed my Tylenol because they don't refill it in time." 8/7/25 9:45 AM – During an interview E3 (HWC) confirmed the delayed refill of R7's Tylenol and Lipitor. E3 stated, "we were supposed to reorder seven days prior." 8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS).	The identified medications were immediately removed from the medication carts and cabinet and disposed of by the HWC and documented per policy. RCA- associates were not disposing of expired medications within 30 days per policy.	10/3/25
3225.8.3.5 S/S – E	**All expired or discontinued medication, including those of deceased residents, shall be disposed of according to the assisted living facility's medication policies and procedures.** Based on observation, interview and record review, it was determined that for one out of two medication carts reviewed, the facility failed to ensure disposal of expired medications. Additionally, Findings include: The facility policy on medication disposal last reviewed October 2022 indicated, "Expired Medications: Expired medications should be disposed of properly at the community within 30 days." 1.8/6/25 9:33 AM – During the medication storage inspection of cart 100 a blister pack of Metoprolol blood pressure medication containing twenty-four tablets with	The HWC completed medication cart audits on 8/7/25. No expired medications were found. The nurses and med-techs will be re-educated by the HWC on the policy and procedure regarding expired medications. To assist with ongoing compliance, med cart and storage closet audits will be conducted by the HWD or designee weekly for four (4) weeks, until 100% compliance is achieved, to verify timely compliance and disposal of expired medications. The audit results will be submitted and reviewed by the QAPI committee.	

Provider's Signature Crystal Marcin Title Executive Director Date 10/30/25

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	an expiration date of 5/31/23 was located in the medication drawer. The expired medication was immediately confirmed and removed from the drawer by E5 (MT). 8/7/25 – A medication disposal record documented that the blister pack of metoprolol that expired 5/31/23 was destroyed. 2. 8/6/25 11:45 AM – E3 (HWC) accompanied the surveyor to the facility medication room and confirmed the facility had a cabinet of expired medications awaiting disposal beyond thirty days. 8/7/25 – A medication disposal records documented destruction of the following expired medications: - Seventeen tablets of oyster shell supplement that expired 4/30/25. -One tablet of carvedilol heart medication that expired 5/21/25. - Sixty tablets of colace laxative that expired 6/30/25. - 90 Tablets of Tylenol that expired 6/30/25.		
3225.12.1.3 **Delaware Food Code** **S/S - F**	8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS). **Food service complies with the Delaware Food Code** **3-501.16 Time/Temperature Control for Safe-ty Food, Hot and Cold Holding. (A) Except during preparation, cooking, or**	The Executive Director identified the temperature logs were missing. There were no residents harmed. The dietary manager or designee will conduct daily audits at meal service times to verify the steam table and plate warmers are operating at acceptable temperatures to maintain food temps per community policy.	10/3/25

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	cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5ºC (41ºF) or less. P (B) EGGS that have not been treated to destroy all viable Salmonellae shall be stored in refrigerated EQUIP-MENT that maintains an ambient air temperature of 7°C (45°F) or less. **This requirement was not met as evidenced by:** Based on interview and review of other facility documentation, it was determined that the facility failed to comply with the Delaware Food Code. Findings include: The facility policy on Food and Beverage Temperature control last updated December 2024, indicated, "Food and beverage temperatures during meal service should be taken at the beginning of meal service...Use the food and temperature log to ensure all food and beverage holding temperatures are monitored." 8/7/25 – Review of the facilities food and temperature logs lacked evidence of documentation for food temperatures for May 2025, June 2025, and July 2025, and August 7, 2025.	The dietary manager or designee will conduct daily meal service audits to verify steam table and plate warmers temperatures. The dietary manager will re-educate kitchen staff on the policy and procedures of food temperatures. To assist with ongoing compliance, the dietary manager or designee will continue to monitor temperature log documentation for compliance weekly for four (4) weeks and monthly for three (3) months, until 100% compliance is achieved. The audit results will be submitted and reviewed by the QAPI committee.	

Provider's Signature Crystal Marcelin Title Executive Director Date 10/30/25

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3225.13.0 3225.13.3 S/S – E	8/8/25 10:51 AM – This surveyor requested the May 2025 through present temperature logs from E1 (ED). The logs were not received. 8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS). 8/13/25 – The facility submitted food and temperature logs that documented food temperatures for May 2025 and August 7, 2025; June and July 2025 logs remained unaccounted for. **Service Agreements** **The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** Based on record review and interview, it was determined that for eleven (R1, R2, R3, R4, R5, R6, R7, R8, R9, R13 and R14) out of eleven active residents reviewed the facility failed to ensure that the residents personal attending physician information was identified in the service agreement. Findings include: The facility policy on service agreements last updated May 2025 indicated, "The service agreement should include Telephone number of the provider." 10/24/24 – A service agreement was completed for R7. 11/27/24 – A service agreement was completed for R13.	R1, R2, R3, R4, R5, R6, R7, R8, R9, R13, R14 service agreements were updated to include name, address and phone number of physician. RCA- previous HWD was not following the process put in place to add physician information to the service agreements. The new HWD was educated on the process moving forward. The HWD or designee will add the physician's information to the top of the plan of care moving forward. The Executive Director or designee will retrain the HWD and HWC to add physician information/ telephone number to residents' service agreements. An audit of current resident service agreements will be conducted by the HWD or	10/3/25

Provider's Signature Crystal Marcain Title Executive Director Date 10/30/25

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	12/20/25 – A service agreement was completed for R1. 1/20/25 - A service agreement was completed for R2. 1/27/25 – A service agreement was completed for R14. 2/5/25 - A service agreement was completed for R6. 2/7/25 - A service agreement was completed for R3. 2/19/25 - A service agreement was completed for R5. 2/27/25 – A service agreement was completed for R4. 8/7/25 – A service agreement was completed for R8. 8/8/25 – A service agreement was completed for R9. 8/5/25 – 8/8/25 – A review of service agreements for the aforementioned residents lacked documentation that identified their personal attending physician by name and the physician's telephone number and address. 8/7/25 10:00 AM – During an interview E2 (DCS) confirmed that the facility service plans lacked documentation that identified the residents personal attending physician by name, address, and phone number.	designee to review and document physician information/ phone number to resident's service agreements. The ED and or designee will complete audits on 5 random resident's service agreements weekly for four (4) weeks and monthly for three (3) months, until 100% compliance is achieved. The audit results will be submitted and reviewed by the QAPI committee.	
3225.16.0			

Provider's Signature Cyrus Marani Title Executive Director Date 10/30/25

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3225.16.2 S/S - E	8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS). **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.** Based on record review and interview it was determined that for one (E7) out of eleven employees reviewed for personnel documentation the facility failed to ensure that staff was licensed in compliance with applicable State laws and regulation. Findings include: 10/28/24 – E7 was hired by the facility to work as an LPN. E7's resume documented work experience as an LPN from June 2023 to the time of hire by the facility. 1/2/25 – An incident report was submitted to the State Agency that alleged E7 was "hired as an LPN on 10/28/24. The facility uses a third-party background check/record validating company. E7 flagged as not having submitted a copy of her nursing license. E7 was asked to provide it multiple times each time forgetting it or requesting time off. The facility was unable to validate E7's license. She has been suspended." 1/2/25 – Education on requirement of all nurses to provide a copy of their nursing	The incident for E7 was reported to the state after multiple attempts to obtain her license and the inability to validate her Delaware nursing license. E7 was suspended on 1-2-25. E7 was then terminated after multiple attempts to speak with her. All residents had the potential to be affected; however, there were no residents negatively affected by E7. The ED will provide re-education to the HWD, HWC and Business Office Manager (BOM) to verify nursing licenses prior to start of orientation. The ED will also review the Delaware Professional Regulations license verification website for newly hired nurses. The ED will audit newly hired nurse's personal files to verify status of nursing licenses for the state of Delaware by 12/31/25. To assist with ongoing compliance, the ED or designee will audit personnel files to verify nursing staff have current nursing licensing in good standing, monthly for three (3) months, until 100% compliance.	10/3/25

Provider's Signature Cyrai Mancin Title Executive Director Date 10/30/25

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	license prior to being able to attend orientation was provided to E8 (BOM) and E9 (former HWD). 8/8/24 11:00 AM – Review of the Delaware Professional Regulation's license verification website lacked evidence that E7 had a Delaware nursing license. https://dpr.delaware.gov/aboutagency/verification_request_insts/. 8/8/25 11:39 AM – This surveyor requested E7's personnel file from E1(ED). E2 (DCS) reported that the facility terminated E7 for inability to produce a nursing license. 8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS).	The results will be submitted and reviewed by the QAPI committee.	
3225.16.14 3225.16.14.3 S/S – D	**Assisted living facility resident assistants shall, at a minimum:** **Receive, at a minimum, 12 hours of regular in-service education annually which may include but not be limited to the topics listed in 16.14.2;** Based on record review and interview it was determined that for one E6 (CP) out of five resident assistants reviewed, the facility failed to ensure that twelve hours of in-service education was received. Findings include: 8/7/25 12:43 PM – This surveyor requested documentation regarding the ed-	E6 will have her 12-hour annual training completed by September 30, 2025 . The ED and Business Office Manager (BOM) will verify that current employees' 12-hour annual training is completed annually and placed in their employee files. The BOM/ED or designee will complete monthly audits for three (3) months, until 100% compliance, to verify compliance with annual education training for employees utilizing the Relias education platform. The audit results will be submitted and reviewed by the QAPI committee.	10/3/25

Provider's Signature Crystal Marchein Title Executive Director Date 10/30/25

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3225.16.21 S/S – D	ucation and in-service hours for five resident assistants listed on a personnel audit sheet. 8/8/25 – The facility returned the personnel audit sheet and documentation of education. Review of E6's transcript lacked evidence of completion of twelve hours of in-service education. E6 had completed a total of five hours this past year. 8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS). **All personnel records for permanent employees, including employment applications, shall be maintained for a minimum of five years consistent with the assisted living facility policies and applicable state laws.** Based on record review and interview it was determined that for one (E7) out of eleven employees reviewed for personnel documentation the facility failed to maintain employee records for a minimum of five years. Findings include: 8/8/25 11:39 AM – This surveyor requested E7's personnel file from E1(ED). 8/8/25 12:25 PM – E2 (DCS) confirmed that E7 did work some shifts prior to termination. However, the facility was unable to provide documentation such as schedules or pay roll for verification. 8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1(ED) and E2 (DCS).	E7's had an employee file, but since we transitioned into a new system, I wasn't able to locate past schedules or payroll information. The ED or designee will review all current associate personnel files for completeness by 10/31/2025. To assist with ongoing compliance, the ED or designee will audit new associate personnel files for completeness monthly for three (3) months until 100% compliance. The audit results will be submitted and reviewed by the QAPI committee.	10/3/25
3225.19.0 3225.19.5 3225.19.5.1 3225.19.5.2			

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S/S – D	**Records and Reports** **Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:** **All reportable incidents.** **Falls without injury and falls with injuries that do not require transfer to an acute care facility or do not require reassessment of the resident.** Based on record review and interview, it was determined that for three (R5, R6 and R10) out of nine residents with reportable incidents reviewed the facility failed to complete incident reports with adequate documentation for each incident. Findings include: The facility policy on abuse last updated October 2019, indicated "Upon receipt of an allegation of abuse the Administrator or designee should conduct an investigation of the incident. The Administrator or designee should maintain a written record of the investigation." 1.Review of R6's clinical record revealed: 1/9/24 7:00 PM – A progress note in R6's clinical record documented, "During an altercation between resident to resident, the resident was punched on the left jaw by another male resident and ended up on the floor."	Incident report located for R10 (see attached), unable to locate incident report or investigation for R6 and R5. ED or designee will re-educate direct care staff on state reportable incidents for the state of Delaware. ED or designee will re-educate HWD/HWC on reportable incidents and the investigation process including documentation. The ED or designee will review reportable incidents during daily stand up weekly for four (4) weeks and monthly for three (3) months, until 100% compliance. The audit results will be submitted and reviewed by the QAPI committee.	10/3/25

Provider's Signature Crystal Marsden Title Executive Director Date 10/30/25

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	8/6/25 1:52 PM – This surveyor requested the incident report for the resident-to-resident altercation that occurred between R6 and R10 on 1/9/24. 8/8/25 9:34 AM – During an interview E2 (DCS) confirmed the facility did not have an incident report for the resident-to-resident altercation that occurred between R6 and R10. 2.Review of R5's clinical record revealed: 7/13/24 3:30 AM – A progress note in R5's clinical record documented, "Resident was on the floor. On assessment resident noted sitting on the floor leaning on her recliner...Resident did not want to go the hospital."	R5 returned from the hospital on 7-16, with no injuries noted from fall.	
3225.19.7 **3225.19.7.7.2** **S/S – D**	8/6/25 1:52 PM – This surveyor requested the incident report for R5's fall. 8/7/25 12:27 PM – During an interview E3 (HWC) confirmed the facility did not have an incident report related to R5's fall. 8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS). **Reportable incidents include:** **Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.** Based on record review and interview, it was determined that for one (R5) out of	ED and HWD re-educated the clinical staff on the regulation for reportable incidents. Current ED and HWD were not in position at the time of this incident. DDCS reviewed regulations with ED and HWD. ED will conduct daily audits x 3 weeks and weekly x 3 weeks to review reportable incidents and verify reporting within regulations until 100% compliance. The audit results will be submitted and reviewed by the QAPI committee.	10/3/25

Provider's Signature Crystal Marcien Title Executive Director Date 10/30/25

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	five falls reviewed, the facility failed to report a fall to the State Agency. Findings include: Review of R5's clinical record revealed: 7/13/24 3:30 AM – A progress note in R5's clinical record documented, "Resident was on the floor. On assessment resident noted sitting on the floor leaning on her recliner...Resident did not want to go the hospital." 7/13/24 11:30 AM – Resident complained of severe pain of her left leg not relieved by pain meds or repositioning...Resident sent to hospital." 8/7/25 12:27 PM – During an interview E3 (HWC) confirmed the facility did not report R5's fall to the State Agency. 8/8/25 12:30 PM – Findings were reviewed during the exit conference with E1 (ED) and E2 (DCS).		

Provider's Signature Cupid Marcelin Title Executive Director Date 10/30/25