

STATE SURVEY REPORT

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Resident Assessmen

Title_FD

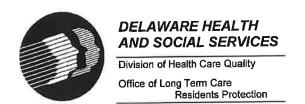


STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
11.4	The resident assessment shall be completed in conjunction with the resident.		17
	This requirement was not met as evidenced by: Based on record review, it was determined that for three (R1, R2 and R3) of three sampled residents reviewed, the facility failed to ensure that the UAI was conducted in conjunction with the resident or their designated power of attorney. Findings include: 1. Review of R2's clinical records revealed the following: 5/18/19- An annual UAI was completed by E3 (former HWD) and stated, "No changes, reviewed and discussed with resident." The	1.Resident R3 has been discharged, unable to correct the deficient practice. Resident R1 has been discharged, unable to correct the deficient practice. The UAI for Resident R2 will be updated, reviewed with the resident and POA, signed by the nurse and POA or resident as appropriate. 2. Clinical Specialist or designee will audit Resident files for UAI completeness. If needed, Resident UAI will be re-written by the Clinical Specialist or designee and re-	January 20, 2021
	UAI was not signed by the resident or her guardian. 2/26/2020- R2 was re-admitted from a SNF. The "Significant Change" UAI completed by E3 documented that the UAI was completed with the healthcare provider's information, but it was not signed by E3 or dated. Also, the document was not signed by R2 (HWD) or her guardian. 11/16/2020 9:40 AM — Findings were reviewed with E1 (ED) and E2 (HWD) via phone	viewed with the resident and/or POA, and signed per state regulation and Brookdale policy or a statement of review will be added to the UAI. The Health and Wellness Director will be educated on completing the UAI per state regulation and Brookdale policy. Re-training will be done by the Clinical Specialist and/or designee. 3. The Health and Wellness Director or designee will audit 10% of resident files and new move-is monthly for UAI completeness per state regulation and Brookdale policy. If needed corrections will be made by the	
	interview. 2. Review of R3's clinical records revealed the following: 1/24/2020 – The Annual UAI, completed by E3 (former HWD) documented that the UAI was completed with the healthcare provider and R3, however, there was lack of R3 or her guardian's signature and the date for this assessment.	Health and Wellness Director or designee. 4. The audit report will be shared with the Executive Director for review and brought to the quality assurance meeting for review and corrective action if indicated.	

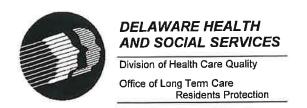


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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	There was lack of evidence that the facility completed the initial UAI in conjunction with R3 or her guardian.		
	11/16/202 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview.		
	Review of R1's clinical records revealed the following:		
igs	6/25/2020 (Completed prior to 7/3/2020 admission) — The Initial UAI completed by E3 (former DON) documented that the UAI was completed with the healthcare provider's information. The UAI was signed by FM1 on 7/19/2020, approximately 16 days after R1's admission.		2
	There was lack of evidence that the facility completed the initial UAI in conjunction with R1's Power of Attorney (FM1).		
	11/10/2020 2:30 PM — An interview with E2 (HWD) confirmed that there was a lack of evidence that the initial UAI was completed with R1's Power of Attorney (FM1).		
	Findings were reviewed during the Exit Conference on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
11.5	The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.		
	This requirement was not met as evidenced by:	2225 11 5	
Provider's S	ignatura Milly Illins	3225.11.5 Title <i>ED</i> Date	0505/2020



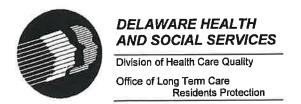
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NAME OF FACILITY: AL- Brookdale Hockessin

DATE SURVEY COMPLETED: November 16, 2020 COMPLE-ADMINISTRATOR'S PLAN FOR

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	Based on interview and record review, it was determined that for one (R2) out of three sampled residents reviewed, the facility failed to conduct an annual UAI. Findings include: Review of R2's clinical records revealed the following: 5/2020- There was lack of evidence that the facility conducted the annual UAI. The last annual UAI's were completed on 5/18/2018 and 5/18/2019, respectively. 11/16/2020 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview. Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).	 1.The UAI for Resident R2 will have an annual update completed by the Health and Wellness Director by 1/20/2021. 2. Clinical Specialist or designee will audit Resident files for UAI updates per state regulations at a minimum 30 days after admission, and when there is a change of resident condition. Resident UAI will be updated per state regulation. The Health and Wellness Director will be educated on completing the UAI per state regulation and Brookdale policy. Clinical Specialist or Designee will conduct the re-training. 3. The Health and Wellness Director or designee will audit 10% of resident files including new move-ins monthly for UAI updates per state regulation and Brookdale policy. 4 The results of the UAI audit will be given 	January 20, 2021
13.0 13.1	A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.	to the Executive Director for review and brought to the quality assurance meeting for review and corrective action if indicated.	
Provider's Si	This requirement was not met as evidenced by: Based on record review it was determined that for two (R1 and R2) out of three sample residents, the facility failed to have the resident participate in the development of the	3225.13.1 1. Resident R1 has been discharged, unable to correct the deficient practice. The UAI for Resident R2 will be updated by the Health and	January 20, 2020



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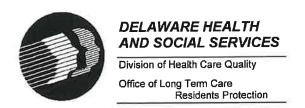
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NAME OF FACILITY: AL- Brookdale Hockessin

DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	Personalized Service Plan/ Service Agree-	Wellness Director and reviewed	
	ment. Findings include:	with the resident and POA, signed	
	1. Review of R2's clinical records revealed	by the nurse and POA or resident	
	the following:	as appropriate.	
	2/26/2020- The Significant Change UAI was	2. Clinical Specialist or designee will	
	completed by E3 (former HWD).	audit Resident files for UAI com-	
	2/27/2020- The Personalized Service Plan	pleteness. Resident UAI will be re-	
	was completed by E3 (former HWD) who	written and reviewed with the resi-	
	signed and dated the document, however,	dent and/or POA, and signed per	
	the document was not signed or dated by R2	state regulation and Brookdale pol-	
	or her guardian.	icy or a statement of review will be	
		added to the UAI. The Health and	
	8/26/2020- The Personalized Service Plan	Wellness Director will be educated	
	was not signed by staff or R2 or her guardian.	on completing the UAI per state	
		regulation and Brookdale policy.	
	11/16/2020 9:40 AM - Findings were re-	Re-education will be done by the	
	viewed with E2 (HWD) and E1 (ED) via phone interview.	Clinical Specialist or designee.	
		3. The Health and Wellness Director	
	2. Review of R1's clinical records revealed the	or designee will audit 10% of resi-	
	following:	dent files including new move-ins	
		monthly for UAI completeness per	
	7/3/2020 – R1 was admitted to the facility.	state regulation and Brookdale policy.	
	7/3/2020 - The admission Personal Service		
	Plan (PSP), dated 7/3/2020, was signed by E3		
	(Former DON) on 7/13/2020 and R1's Power	4. The UAI audit report will be given	
	of Attorney (FM1) signed and dated the PSP	to the Executive Director for review	
	on 7/17/2020, 4 days later.	and brought to the quality assur-	
		ance meeting for review and cor-	
	There was lack of evidence that a PSP was	rective action if indicated.	
	completed at the time of admission in con-		
	junction with R1 and FM1.		
	11/10/2020 2:30 PM – An interview with E2		
	(HWD) confirmed the above findings.		
	Findings were reviewed during the Exit Con-		
	ference on 11/16/2020, beginning at 2:30		
	PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
13.6	The service agreement shall be reviewed		
	when the needs of the resident have		7 7

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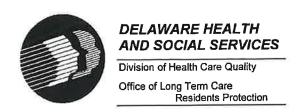
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NAME OF FACILITY: AL- Brookdale Hockessin

DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.		
	This requirement was not met as evidenced by:		
	Based on interview and record review, it was determined that for two (R1 and R3) of three sampled residents, the facility failed to revise the service agreement when the needs of the resident's change. Findings include:		
	Review of R1's clinical records, the Division's Investigative Section's records, and hospital records revealed the following:		
	7/3/2020 — R1 was admitted to the facility with diagnoses including dementia.		
	7/13/2020 12:46 AM — A Nursing Progress Note stated, "This nurse arrived at 1125 pm 911 just had left and escorted resident back into the building. Resident assessed for injuries. Noted resident with abrasions to left	3225.13.6	January 20,
	knee and large bruise to the left forearm. ED [E1] arrived shortly after me [E3]. This nurse investigated resident room and noted resident window up, screen on the outside on the ground. resident stated he climbed out of	1 Resident R1 has been discharged, unable to correct the deficient practice. Resident R3 has been discharged, unable to correct the deficient practice.	2021
	the window. He was looking to 'life (sic) my life' and get a ride to Europe. Called resident son, daughter and daughter in law. Son [FM1] made aware and will (sic) he [FM1] came in to provide 1:1 overnight. Resident is in bed at this time and appears comfortable. Regional team made aware of the incident."	2 Executive Director or designee will audit 10% of resident service agreements for need to revise due to resident changes in condition. Service agreements that require changes will be discussed with resident, family, and /or POA per state regulation and Brookdale policy.	
	7/13/2020 – The Significant Change UAI Assessment stated that R1 eloped from the facility and the UAI and PSP were revised with interventions that were put into place.	3. Executive Director or designee will review 10% of resident service agreements	7 7



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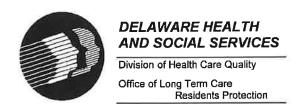
NAME OF FACILITY: AL- Brookdale Hockessin

Provider's Signature

DATE SURVEY COMPLETED: November 16, 2020

COMPLE-ADMINISTRATOR'S PLAN FOR STATEMENT OF DEFICIENCIES SECTION CORRECTION OF DEFICIENCIES TION DATE SPECIFIC DEFICIENCIES monthly and execute a revised service agreement if indicated. 7/13/2020 - The Personal Service Plan (PSP) was revised and included the following: 4 This report will be reviewed at the quality The section Cognitive/Psychological revealed assurance meeting for review and correcthat R1 needed help to participate in commutive action if indicated. nity activities because of memory loss as R1 was not always oriented to place and time. This change in orientation may impact R1's decision making. A section for Behavior Management was added to the PSP which stated that R1 attempts to exit the building without needed supervision. The interventions included, but were not limited to 1) Redirect R1 away from exit using a gentle voice and other preferred activities 2) Direct to an appropriate wandering place 3) See Cognitive/Psychological Section related to wandering 4) Be alert to resident's pattern and reason for exit attempts (e.g. change of shift, end of a party as families leave) and involve in meaningful activity prior to these points in time. The document included E3's (Former HWD's) signature and was dated 7/16/2020. There was lack of evidence that when the PSP dated 7/13/2020 was reviewed and revised that, the facility incorporated the intervention of 1:1 supervision to be provided 24 hours a day by an outside agency. 7/13/2020 - R1's Care Profile indicated that R1 had behavior in which R1 attempts to exit the building without needed supervision. Again, this document failed to include that R1 was to be on 1:1 supervision. 10/9/2020 - A Nurse Progress Note documented, "At 00:05 (12:05) AM the Nurse [E4/LPN] was notified by the 1-on-1 (1:1) aide that the resident was in a state of distress. He (R1) had mentioned that he wanted to leave the building. The resident was very com-

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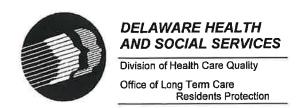


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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	bative with the nursing staff. He was punch-		
	ing and kicking and scratching. The aide in-		
	formed me that he was attempting to access		
	the 2nd floor 400 hall balcony to 'leave the		
	building'. The resident was able to be redi-		
	rected on multiple occasions to ensure his		1
	safety. The resident was repeatedly kicking,		
	scratching, and he had pushed the staff. He		
	was trying to gain access outside from the up-		1
	per floor 400 hall balcony. The resident's		
	family POA [Power of Attorney], the building		
	Executive Director [E1], and DR [R1's Attend-		
	ing Physician] were contacted. His son was		
	able to verbally convince him to listen to the		
	staff and his 1-on-1 aide in regard to 'calming		
	down' and trying to get some rest. Resident		1
	was in his room until the following morning		
	at the change of shift. His 1 on 1 aide had left		
	at 6:30 [AM] in the morning. A nurse pro-		
	ceeded to sit with him until the change of		
	shift at 7:00 AM. During the shift report the		
	resident was seen going back to his room af-		
	ter getting a cup of coffee. After giving my		
	part of the report I proceeded to go check on		
	the resident in his room. That was when I saw		
	that he wasn't in his room. So I went running		
	down the hall to the balcony and found the		
	resident standing facing me on the outside of		
	the railing. I tried to reach out and make a		
	grab for him, but he jumped. He landed on		
	the sidewalk below 0705 (7:05 AM)."		
	the sidewalk below 0703 (7.03 AM).		
	11/10/2020 2:30 PM – An interview with E2		
	, · ·		
	(HWD) confirmed that the 7/13/2020 Per-		
	sonal Service Plan completed by E3 (former		
	HWD) failed to include the 1:1 supervision as		
	a follow-up to R1's elopement on 7/13/2020.		
	Findings were reviewed during the Exit Con-		
	ference via telephone on 11/16/2020, begin-		
	ning at 2:30 PM, with E1 (ED), E2 (HWD), E10		
	(DDOCS), and E12 (RN CM).		
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NAME OF FACILITY: AL- Brookdale Hockessin

DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	O. D		
	2. Review of R3's clinical records revealed the		
	following:		
	4/24/2020 71 - 4		
	1/24/2020 – The Annual UAI was completed		
	by E3 (former HWD).		
	2/45/2020 The Developed Service Plan		
	3/16/2020 – The Personalized Service Plan		
	was completed approximately two months		
	after the annual UAI was completed on		
	1/24/2020. The Personalized Service Plan		
	was signed by E3 (former HWD) on		
	3/16/2020 and by the resident's POA on		
	3/20/2020.		
	11/16/2020 0:40 ANA Findings was		
	11/16/2020 9:40 AM - Findings were re-		
	viewed with E2 (HWD) and E1 (ED) via phone interview.		
	Findings were reviewed during the Exit Con-		
	ference via telephone on 11/16/2020, begin-		
	ning at 2:30 PM, with E1 (ED), E2 (HWD), E10		
82	(DDOCS), and E12 (RN CM).		
87	Abuse, Neglect, Mistreatment or Financial		
	Exploitation of Residents or Patients		
	Exploitation of Residents of Facions		
16 Del.	(11) "Neglect" means the failure to provide		
Code	goods and services necessary to avoid phys-		
Chapter	ical harm, mental anguish, or mental illness.		
11, Sub-	Neglect includes all of the following:		
-	a. Lack of attention to physical needs of the		
chapter	patient or resident including toileting, bath-		
III, §	ing, meals, and safety.		
L131	• •		
	This requirement was not met as evidenced		
	by:		
	Board on record review staff intensions and		
	Based on record review, staff interviews and review of other documentation as indicated		
	1 - 1 - 1 - 1		
	it was determined that for one (R1) out of		
	three (3) residents reviewed, the facility		
	failed to ensure attention to the safety needs		
	of R1. On 7/13/2020, R1 eloped from the fa- cility and was found walking on the highway.		
	cility and was fourth walking on the highway.	Title FD Date	111



STATE SURVEY REPORT

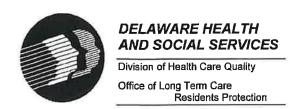
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NAME OF FACILITY: AL- Brookdale Hockessin

DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	On 10/9/2020, R1 was left unsupervised and was found behind a 2 nd floor balcony rail before falling from the balcony onto the cement sidewalk. Findings include: Review of R1's clinical records, the Division's Investigative Section's records, and the hospital records revealed the following:		
	7/3/2020 — R1 was admitted to the facility with diagnoses including dementia.		
	7/12/2020 11:39 PM — A Nurses Progress Note documented that around 10:00 PM, R1 was displaying aggressive behaviors toward the nurse who was explaining to R1 that it was not safe to leave the building as R1 was trying to follow one of the staff members who was going outside of the building. R1 became combative and pushed the nurse, held onto the door and broke his wristwatch on the door. R1 sustained a bruise on his left arm. R1 was reassured by the nurse and returned back to his room.	16.11.III,1131 1. Resident R1 has been discharged, unable to correct the deficient practice. Door alarms were placed on balcony doors on 10/22/2020.	
	There was lack of evidence that the facility assessed R1's risk of elopement after R1 attempted to leave the building at approximately 10:00 PM on 7/12/2020 and they failed to develop an individualized plan to lower R1's risk for elopement.	Health and Wellness Director will assess residents for elopement risk and need for alternative placement. Resident individualized service plans will be audited and updated if indicated. The Health and Wellness Director will re-educated.	
	7/13/2020 12:46 AM — A Nursing Progress Note stated, "This nurse arrived at 1125 pm 911 just had left and escorted resident back into the building. Resident assessed for injuries. Noted resident with abrasions to left knee and large bruise to the left forearm. ED [E1] arrived shortly after me [E3]. This nurse investigated resident room and noted resident window up, screen on the outside on the ground. resident stated he climbed out of the window. He was looking to 'life (sic) my life' and get a ride to Europe, Called resident	on Resident Neglect, elopement precautions, working with residents who have dementia, residents who have behaviors, and working with aggressive residents. Associates will re-trained on developing and updating the Individualized Service Plan for residents when indicated. Associates will be re-educated on appropriate admissions to assisted living per state regulations and Brookdale policy.	

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NAME OF FACILITY: AL- Brookdale Hockessin

DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
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son, daughter and daughter in law. Son [FM1] made aware and will (sic) he come in to provide 1:1 overnight. Resident is in bed at this time and appears comfortable. Regional team made aware of the incident."

7/13/2020 – The facility reported to the State Agency that the facility received a call at approximately 11:10 PM that there was a man walking on the highway and staff went outside and found R1 approximately 200 feet away from the community. R1 was resistive to return to the facility and 911 was called and R1 was escorted back to the facility. Upon investigation, R1 knocked the screen out of his window, climbed out of the window and sustained an abrasion to the left knee. The 5 day follow-up by the facility documented that a care plan meeting was held with R1, FM1, E1 (ED) and E3 (former HWD), 1:1 supervision was put into place indefinitely and R1's room was changed to upstairs (2nd floor) along with a 1:1 companion. All facility windows were inspected and will have stops in place that only allow the windows to be raised a certain amount of inches (without assistance) for safety.

Due to the facility's failure to assess R1's risk of elopement after the previous day's at-

- 3. The Health and Wellness Director or designee will audit 10% of resident individualized service plans monthly to maintain and verify resident assessments are documented per state regulation and Brookdale policy.
- 4. This audit report will be reviewed by the ED and brought to the quality assurance meeting for review and corrective action if indicated.

Completion date: January 20, 2021

tempt to leave the facility on 7/12/2020 at approximately 10:00 PM and failure to develop a plan to reduce R1's risk for elopement, R1 eloped from the facility and was observed walking on the highway by a passerby who was driving on the highway. After this incident, a decision was made to relocate R1 to the 2nd floor. There was lack of evidence that the facility identified that the 2nd floor balcony doors were a potential safety hazard for R1 who was exit seeking. The balcony doors were not set up to alarm when opened.



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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	The lead of the state of the st		
	7/13/2020 – The Significant Change UAI As-		
	sessment stated that R1 eloped from the fa- cility and the UAI and PSP were revised with		
	interventions that were put into place.		
	7/13/2020 – The Personal Service Plan was		
	revised and included the following:		
	The Cognitive/Psychological section revealed		
	that R1 needed help to participate in commu-		
	nity activities because of memory loss as R1		
	was not always oriented to place and time		
	This change in orientation may impact R1's		
	decision making.		
	A section for Behavior Management was		
	added to the PSP which stated that R1 attempts to exit the building without needed		
	supervision. Interventions included, but		
	were not limited to 1) Redirect R1 away from		
	exit using a gentle voice and other preferred		
	activities 2) Direct to an appropriate wander-		
	ing place 3) See Cognitive/Psychological Sec-		
	tion related to wandering 4) Be alert to resi-		
	dent's pattern and reason for exit attempts		
	(e.g. change of shift, end of a party as families		
	leave) and involve in meaningful activity prior		
	to these points in time. The document in-		
	cluded E3's (Former HWD) signature and was		
	dated 7/16/2020, however, there was no sig-		
	nature by R1's POA, FM1.		
	7/13/2020 – R1's Care Profile indicated that		
	R1 had behaviors in which R1 attempts to exit		
	the building without needed supervision.		
	9/24/2020 through 10/1/2020 - Review of		
	the following Nurses Progress Notes docu-		
	mented that R1 was not provided 1:1 super-		
	vision for safety.		
	- 9/24/2020 8:38 PM – "Resident was noted		
	walking on the hallway by himself no private		
	aide was on duty on this shift".		
	- 9/26/2020 9:19 PM — "Resident continues		
	on monitoring for exit seeking. One to One		
	aid unavailable this shift (3-11) (Name of		11
	gnature flothy diffing	Title <u>FO</u> Date	12/22/202



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NAME OF FACILITY: AL- Brookdale Hockessin

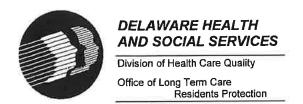
DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	outside agency) called @ 2108 (9:08 PM) to		
	notify staff that an overnight aide would not		
	be coming in tonight".		
	- 9/27/2020 9:16 PM – "Resident continues		
	on monitoring for exit seeking. Resident cur-		
	rently does not have1:1 aid this shift or for		
	overnight. Noted resident has increased agi-		
	tation and wandering this shift r/t (related to)		
	change in routine".		
	- 10/1/2020 10:59 PM — "Aide (Staff from the		
	outside agency) reports that there will not be		
	an aide for overnight and 11-7 (11:00 PM –		1
	7:00 AM). (Name of outside agency) will not		
	be here to do 1:1 on 10/3/2020 and		
	10/4/2020. Safety maintained.".		
	It was unclear what the facility's system was		
	to ensure 1:1 supervision for R1's safety dur-		
	ing the documented periods of no 1:1 super-		
	vision by the outside agency staff. There was		
	lack of evidence of reassessment of R1's risk		
	for elopement and no revision to the plan to		
	reduce R1's elopement risk.		
	10/9/2020 12:05 AM – A Nurse Progress Note		
	documented "At 00:05 (12:05) AM the Nurse		
	[E4/LPN] was notified by the 1-on-1 aide that		
	the resident was in a state of distress. He had		
	mentioned that he wanted to leave the build-		
	ing. The resident was very combative with		
	the nursing staff. He was punching and kick-		
	ing and scratching. The aide informed me that he was attempting to access the 2nd		
	floor 400 hall balcony to 'leave the building'.		
	The resident was able to be redirected on		
	multiple occasions to ensure his safety. The		
	resident was repeatedly kicking, scratching,		
	and he had pushed the staff. He was trying to		
	gain access outside from the upper floor 400		1
	hall balcony. The resident's family POA		
	[Power of Attorney], the building Executive		
	Director [E1], and DR [R1's Attending Physi-		
	cian] were contacted. His son was able to ver-	×.	
	bally convince him to listen to the staff and	1 7	11

Provider's Signature

Title 12/2020 ED

ED Date 12/22/2020



STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	his 1-on-1 aide in regard to 'calming down'		
	and trying to get some rest. Resident was in		
	his room until the following morning at the		
	change of shift. His 1 on 1 aide had left at		
	6:30 [AM] in the morning. A nurse proceeded		
	to sit with him until the change of shift at 7:00		
	AM. During the shift report the resident was		
	seen going back to his room after getting a		
	cup of coffee. After giving my part of the re-		
	port I proceeded to go check on the resident		1
	in his room. That was when I saw that he was-		
.4	n't in his room. So I went running down the		
	hall to the balcony and found the resident		1
	standing facing me on the outside of the rail-		
	ing. I tried to reach out and make a grab for		
	him, but he jumped. He landed on the side-		
	walk below 0705 (7:05 AM)."		
	Despite that R1's POA (FM1) did not want to		
	have R1 sent to the hospital when R1 was dis-		
	tressed, combative and attempted to jump		
	over the balcony rails, the facility failed to		
	identify and eliminate a significant hazard of		
	R1 accessing the 2 nd floor balcony after the		
	incident at approximately 12:05 AM. In addi-		
	tion, the facility failed to notify E3 (former		
	HWD) and failed to reassess the current in-		
	terventions to ensure safety for R1. Due to		
	these failures, R1 was left unsupervised until		
	R1 was observed behind the 2 nd floor balcony		
	railing and subsequently fell onto the cement		
	sidewalk.		
	10/9/2020 – Review of the facility's incident		
	report to the State Agency and the Division's		
	Investigative Section records stated that R1		
	displayed distressed behavior at the begin-		
	ning of the night shift beginning at 11:00 on		
	10/8/2020 and around midnight, E4 (LPN)		
	was called by E5 (LPN) due to R1's combative		
	behavior. When E4 arrived on the 2 nd floor,		
	E4 observed E5 and OA1 (Outside Agency)		
	staff attempting to stop R1 from climbing		
	over the baccon railing in an attempt to		117
	gnature MMM D Hm	Title FO Date	17772070



DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ 3 Mili Road, Suite 308 Wilmington, Delaware 19806 (302) 421-7400

STATE SURVEY REPORT

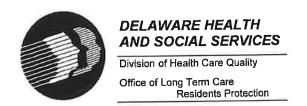
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NAME OF FACILITY: AL- Brookdale Hockessin

DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	"leave this place." After this incident, the		1
	OA1 staff provided 1:1 supervision until 6:30		
	AM on 10/9/2020 and before OA1 left R1,		
	OA1 reported to E5 (LPN) and at that time E5		
	provided 1:1 supervision. A written state-		
	ment by E5 stated that she provided 1:1 su-		
	pervision until 7:00 AM. A written statement		
1	by E4 stated that he observed R1 ambulating		
	alone at 6:45 AM. After E4 completed the		
	shift change report, E4 proceeded to check		
	on R1. E4 observed that R1 was not in his		
	room and immediately, E4 proceeded to the		
	2 nd floor balcony where R1 was observed		
	holding onto the outside of the balcony rail		
	before falling onto the cement sidewalk.		
	10/9/2020 7:10 AM – Review of the Fire Com-		
	pany and the State Police dispatch record re-		
	vealed that the call was received at 7:10 AM.		
	10/9/2020 - Review of the hospital's emer-		
	gency room records revealed that R1 sus-		
	tained multiple rib fractures, a cervical (neck		
	bone) fracture, subarachnoid hemorrhage		
	(bleeding in the space between the brain and		
	the tissue covering the brain) and non-oper-		
	ative management was recommended as R1		
	was showing tremendous signs of delirium		
	(serious disturbance in mental abilities that results in confused thinking and reduced		
	awareness of surroundings) and agitation.		
	awareness of surroundings) and agreation.		
	10/9/2020 – Review of the hospital's consul-		
	tation note for the cervical fracture stated		
	that R1's past medical history included previ-		
	ous suicidal ideations, as well as an admission		
	to a hospital after R1 was found to have ab-		
	dominal and chest stab wounds after ex-		
	pressing his intent to commit suicide.		
	10/14/2020 - Review of the hospital's Dis-		
	charge Summary documented a discharge di-		
	agnosis of subarachnoid hemofrhage and R1		
**	11 1/2/11		1 7

My John Title ED Date 12/2020



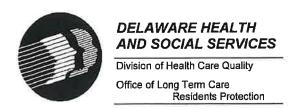
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NAME OF FACILITY: AL- Brookdale Hockessin

Provider's Signature

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	was placed on comfort care and expired on		
	10/14/2020.		
	11/10/2020 2:00 PM – An interview with E6		
	(DOM) revealed that on 10/9/2020, E6 ar-		1
	rived at the facility at 6:30 AM and was in-		
	formed by a nurse that R1 was exit seeking		
	over the course of the night shift. E6 verbal-		
	ized he did not recall which nurse reported		
	this information to him. Approximately 5		
	minutes after the conversation with the		
	nurse, E6 saw R1 on the ground and E6 stated		
	it was already day shift when this took place.		
	11/10/2020 2:30 PM – An interview with E2		
	(HWD) was conducted and revealed that E2		
	became the Interim DON on 10/6/2020. E2		
	verbalized that she was not notified when R1		
	attempted to jump from the 2 nd floor balcony		
	the first time on 10/9/2020 at approximately		
	12:05 AM. In addition, E2 was not notified		
	when R1 jumped from the 2 nd floor balcony		
	on 10/9/2020 at approximately 7:05 AM, but		
	she assisted in obtaining written statements		
	from the two LPNs who worked the night		
	shift for the facility's incident investigation.		
	E2 stated that the facility does not have a risk		
	assessment for elopement of a new resident,		
	however, in her experience as a HWD in an-		
	other facility, when an elopement occurs, the		
	residents are typically placed in a facility with		
	a secured unit. E2 stated that for a new pro-		
	spective resident, the nurse conducting the		
	review would follow the "Admission/Move-		
	In Review Criteria."		
	11/16/2020 8:10 AM – A subsequent inter-		
	view with E6 (Director of Maintenance) re-		
	vealed that the facility installed an alarm on		
	the 2 nd floor balcony doors after R1 fell from		
	the balcony on 10/9/2020.		
	11/16/2020 8:33 AM – An interview with E10		1990
	(DDOCS) revealed that E10 was made aware		111



STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin

Provider's Signature 👱

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
			i
	of the 7/13/2020 elopement, but was given		
	the "impression that the resident stepped		
	outside" by F3 (former HWD) and until E10		
	reviewed the Nurse Progress Note today, she		
	was not aware of what actually occurred.		
	E10 stated that if she was provided accurate		
	information, she would have considered		
	other living arrangements to meet the resi-		
	dent's needs. E10 verbalized that she relied		
	on what she was told by E3 and it was not her		
	practice to review documentation of the inci-		
	dent, such as the Nurse Progress Notes. E10		
	stated that she became aware of the		
	10/9/2020 incident after R1 fell from the bal-		
	cony.		
	11/16/2020 10:14 AM – An interview with E1		
	(ED) revealed that after R1 eloped from the		
	facility on 7/13/2020, a meeting was held		
	with FM1, E3 (former HWD) and E1. During the meeting, it was decided that R1 required		
	1:1 supervision for safety to remain in the fa-		
	cility. After this meeting, E1 was approached		
	by FM1 about potentially reducing some of		
	the 1:1 supervision provided by the outside		
	agency and E1 and FM1 agreed to eliminate		
	the 7:00 AM to 3:00 PM coverage because		
	there was usually enough day shift staff at		
	the facility to provide coverage without 1:1		
	supervision by the outside agency staff. E1		
	confirmed after the first attempt to jump		
	from the 2 nd floor balcony on 10/9/2020 at		
	approximately 12:05 AM, that no new inter-		
	ventions were implemented. E1 confirmed		
	that the balcony door did not have an alarm		
	and that the alarm was implemented after R1		
	fell from the balcony on the morning of		
	10/9/2020.		
	Findings was variously during the Full Con-		, a
	Findings were reviewed during the Exit Con-		
	ference via telephone on 11/16/2020, begin-		
	ning at 2:30 PM, with E1 (ED), E2 (HWD), E10		
Ll	(DDOCS), and 512 (RN CM).		7 7

Jones, Tomeka N (DHSS)

From: Jones, Tomeka N (DHSS)

Sent: Thursday, December 10, 2020 9:48 AM

To: 'ghenry1@brookdale.com'

Cc: OHagan, Nancy (DHSS); Reed, Kim (DHSS); Smith, Robert (DHSS); Edwards, Melanie

(DHSS)

Subject: Brookdale - Complaint survey ending on 11/16/20

Attachments: Plan of Correction Instructions 2013.docx; AL - Brookdale Hockessin_CV_11-16-2020

_PrvdrLtr_Def.docx; AL - Brookdale Hockessin_CV_11-16-2020.docx

Categories: Egress Switch: Unprotected

Tracking: Recipient Delivery Read

'ghenry1@brookdale.com'

OHagan, Nancy (DHSS) Delivered: 12/10/2020 9:51 AM Read: 12/10/2020 9:51 AM Reed, Kim (DHSS) Delivered: 12/10/2020 9:51 AM Read: 12/10/2020 9:59 AM

Smith, Robert (DHSS)

Delivered: 12/10/2020 9:51 AM

Edwards, Melanie (DHSS)

Delivered: 12/10/2020 9:51 AM

Switch-MessageId: c115647283cf48dbbfe1d40c20e70e77

Dear Mr. Henry,

Attached please find the POC directions, provider letter and state report for the Complaint survey ending on November 16, 2020.

Please sign, complete and/or cross-reference, and date the State Report; returning to DHSS DHCQ POC@delaware.gov electronic mailbox.

Regards,

Tomeka

Tomeka Jones

Administrative Specialist I



Division of Health Care Quality - Long Term Care Residents Protection 3 Mill Road Suite 308

Wilmington, DE

Mainline: (302) 421-7410 Office: (302)-421-7438 Fax: (302) 421-7401

Tomeka.Jones@delaware.gov

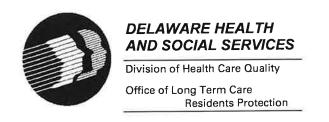


STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	An unannounced complaint survey was con-		
	ducted at this facility beginning on November		
	10, 2020 and ending on November 16, 2020. The facility census on the first day of the sur-		
	vey was 44. The survey sample included three		
	(3) residents. The survey process included		
	observations, interviews, review of residents'		
	clinical records, review of other facility docu-		
	mentation as indicated, and review of the		
	State Agency's Investigative Section's rec-		
	ords.		
	Abbreviations used in this state report are		
	as follows:		
	ED - Executive Director;		
	DDOCS - District Director of Clinical Services;		
	DOM – Director of Maintenance;		
	HWD – Health and Wellness Director; LPN - Licensed Practical Nurse;		
	OA – Outside Agency;		
	POA – Power of Attorney;		
	RN – Registered Nurse;		
	RN CM – RN Case Manager;		
	Delirium - Serious disturbance in mental abil-		
	ities that results in confused thinking and re-		
	duced awareness of surrounding;		
	Dementia - a chronic or persistent disorder of the mental processes caused by brain disease		
	or injury and marked by memory disorders,		
	personality changes, and impaired reasoning;		
	Subarachnoid hemorrhage – a bleeding in the		
	space between the brain and the tissue cov-		
	ering the brain;		
	UAI – Uniform Assessment Instrument - an		
	assessment form used to collect information		
	about the physical condition, medical status and psychosocial needs of an applicant/resi-		
	dent in order to determine eligibility for an		
	assisted living facility.		
3225.0	Regulations for Assisted Living Facilities		
11.0	Resident Assessment		
	gnature	Title Date _	



STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	GI EGII IO DEI IGIENGIEG		
11.4	The resident assessment shall be completed		
	in conjunction with the resident.		
	This requirement was not met as evidenced		
	by:		
	Based on record review, it was determined		
	that for three (R1, R2 and R3) of three sam-		
	pled residents reviewed, the facility failed to		
	ensure that the UAI was conducted in con-		
	junction with the resident or their designated		
	power of attorney. Findings include:		
	1. Review of R2's clinical records re-		
	vealed the following:		
	vealed the following.		
	5/18/19- An annual UAI was completed by E3		
	(former HWD) and stated, "No changes, re-		
	viewed and discussed with resident." The		
	UAI was not signed by the resident or her		
	guardian.		
	2/26/2020- R2 was re-admitted from a SNF.		
	The "Significant Change" UAI completed by		
	E3 documented that the UAI was completed		
	with the healthcare provider's information,		
	but it was not signed by E3 or dated. Also,		
	the document was not signed by R2 (HWD) or		
	her guardian.		
	 11/16/2020 9:40 AM — Findings were re-		
	viewed with E1 (ED) and E2 (HWD) via phone		
	interview.		
	2. Review of R3's clinical records re-		
	vealed the following:		
	1/24/2020 The Annual IIAL completed by		
	1/24/2020 – The Annual UAI, completed by E3 (former HWD) documented that the UAI		
	was completed with the healthcare provider		
	and R3, however, there was lack of R3 or her		
	guardian's signature and the date for this as-		
	sessment.		
Provider's Sign	gnature	Title Date _	

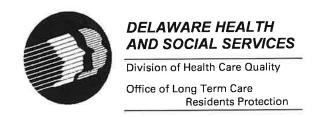


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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	There was lack of evidence that the facility completed the initial UAI in conjunction with R3 or her guardian.		
	11/16/202 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview.		
	3. Review of R1's clinical records revealed the following:		
	6/25/2020 (Completed prior to 7/3/2020 admission) – The Initial UAI completed by E3 (former DON) documented that the UAI was completed with the healthcare provider's information. The UAI was signed by FM1 on 7/19/2020, approximately 16 days after R1's admission.		
	There was lack of evidence that the facility completed the initial UAI in conjunction with R1's Power of Attorney (FM1).		
	11/10/2020 2:30 PM — An interview with E2 (HWD) confirmed that there was a lack of evidence that the initial UAI was completed with R1's Power of Attorney (FM1).		
	Findings were reviewed during the Exit Conference on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
11.5	The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.		
	This requirement was not met as evidenced by:		
Provider's Si	gnature	Title Date _	



STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
			1
	Based on interview and record review, it was determined that for one (R2) out of three sampled residents reviewed, the facility failed to conduct an annual UAI. Findings include:		
	Review of R2's clinical records revealed the following:		
	5/2020- There was lack of evidence that the facility conducted the annual UAI. The last annual UAI's were completed on 5/18/2018 and 5/18/2019, respectively.		
	11/16/2020 9:40 AM - Findings were reviewed with E1 (ED) and E2 (HWD) via phone interview.		
	Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		=
13.0	Service Agreements		
13.1	A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.		
	This requirement was not met as evidenced by:		
	Based on record review it was determined that for two (R1 and R2) out of three sample residents, the facility failed to have the resident participate in the development of the		
Provider's Sig	nature	Title Date _	

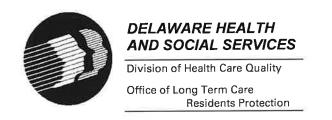


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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	Personalized Service Plan/ Service Agree-		
	ment. Findings include:		
	Review of R2's clinical records revealed		
	the following:		
	2/26/2020- The Significant Change UAI was completed by E3 (former HWD). 2/27/2020- The Personalized Service Plan was completed by E3 (former HWD) who signed and dated the document, however, the document was not signed or dated by R2 or her guardian.		
	8/26/2020- The Personalized Service Plan		
	was not signed by staff or R2 or her guardian.		
	11/16/2020 9:40 AM - Findings were re-		
	viewed with E2 (HWD) and E1 (ED) via phone interview.		
	Review of R1's clinical records revealed the following:		
	7/3/2020 – R1 was admitted to the facility.		
	7/3/2020 – The admission Personal Service Plan (PSP), dated 7/3/2020, was signed by E3 (Former DON) on 7/13/2020 and R1's Power of Attorney (FM1) signed and dated the PSP on 7/17/2020, 4 days later.		
	There was lack of evidence that a PSP was		
	completed at the time of admission in con-		
	junction with R1 and FM1.		
	11/10/2020 2:30 PM – An interview with E2		
	(HWD) confirmed the above findings.		
	Findings were reviewed during the Exit Con-		
	ference on 11/16/2020, beginning at 2:30		
	PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		
13.6	The service agreement shall be reviewed when the needs of the resident have		
		Title Date _	



STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin DATE SURVEY COMPLETED: November 16, 2020

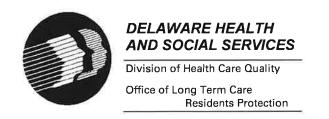
SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	COMPLE-
	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	TION DATE
	- I	M	
	changed and, minimally, in conjunction with		
	each UAI. Within 10 days of such assess-		
	ment, the resident and the assisted living fa-		
	cility shall execute a revised service agree-		
	ment, if indicated.		
	This requirement was not met as evidenced		
	by:		
	Based on interview and record review, it was		
	determined that for two (R1 and R3) of three		
	sampled residents, the facility failed to revise		
	the service agreement when the needs of the		
	resident's change. Findings include:		
	1. Review of R1's clinical records, the Divi-		
	sion's Investigative Section's records, and		
	hospital records revealed the following:		
	7/3/2020 – R1 was admitted to the facility		
	with diagnoses including dementia.		
	7/13/2020 12:46 AM – A Nursing Progress		
	Note stated, "This nurse arrived at 1125 pm		
	911 just had left and escorted resident back		
	into the building. Resident assessed for inju-		
	ries. Noted resident with abrasions to left		
	knee and large bruise to the left forearm. ED		
	[E1] arrived shortly after me [E3]. This nurse		
	investigated resident room and noted resi-		
	dent window up, screen on the outside on		
	the ground. resident stated he climbed out of		
	the window. He was looking to 'life (sic) my		
	life' and get a ride to Europe. Called resident		
	son, daughter and daughter in law. Son [FM1]		
	made aware and will (sic) he [FM1] came in		
	to provide 1:1 overnight. Resident is in bed		
	at this time and appears comfortable. Re-		
	gional team made aware of the incident."		
	7/13/2020 – The Significant Change UAI As-		
	sessment stated that R1 eloped from the fa-		
	cility and the UAI and PSP were revised with		
	interventions that were put into place.		
Provider's Si	onature	Title Date _	



STATE SURVEY REPORT

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CO CORRECTION OF DEFICIENCIES TIO	
	SPECIFIC DEL ICIENCIES		
	7/13/2020 – The Personal Service Plan (PSP)		
	was revised and included the following:		
	The section Cognitive/Psychological revealed		
	that R1 needed help to participate in commu-		
	nity activities because of memory loss as R1		
	was not always oriented to place and time.		
	This change in orientation may impact R1's		
	decision making.		
	A section for Behavior Management was		
	added to the PSP which stated that R1 at-		
	tempts to exit the building without needed		
	supervision. The interventions included, but		
	were not limited to 1) Redirect R1 away from		
	exit using a gentle voice and other preferred		
	activities 2) Direct to an appropriate wander-		
	ing place 3) See Cognitive/Psychological Sec-		
	tion related to wandering 4) Be alert to resi-		
	dent's pattern and reason for exit attempts		
	(e.g. change of shift, end of a party as families		
	leave) and involve in meaningful activity prior		
	to these points in time. The document in-		
	cluded E3's (Former HWD's) signature and		
	was dated 7/16/2020.		
	There was lack of evidence that when the PSP		
	dated 7/13/2020 was reviewed and revised		
	that, the facility incorporated the interven-		
	tion of 1:1 supervision to be provided 24		
	hours a day by an outside agency.		
	7/13/2020 – R1's Care Profile indicated that		
	R1 had behavior in which R1 attempts to exit		
	the building without needed supervision.		
	Again, this document failed to include that R1		
	_		
	was to be on 1:1 supervision.		
	10/9/2020 – A Nurse Progress Note docu-		
	mented, "At 00:05 (12:05) AM the Nurse		
	[E4/LPN] was notified by the 1-on-1 (1:1) aide		
	that the resident was in a state of distress. He		
	(R1) had mentioned that he wanted to leave		
	the building. The resident was very com-		
		Title Date	



STATE SURVEY REPORT

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NAME OF FACILITY: AL- Brookdale Hockessin DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	TION DATE
	bative with the nursing staff. He was punch-		
	ing and kicking and scratching. The aide in-		
	formed me that he was attempting to access		
	the 2nd floor 400 hall balcony to 'leave the		
	building'. The resident was able to be redi-		
	rected on multiple occasions to ensure his		
	safety. The resident was repeatedly kicking,		
	scratching, and he had pushed the staff. He		
	was trying to gain access outside from the up-		
	per floor 400 hall balcony. The resident's		
	family POA [Power of Attorney], the building		
	,		
	Executive Director [E1], and DR [R1's Attend-		
	ing Physician] were contacted. His son was		
	able to verbally convince him to listen to the		
	staff and his 1-on-1 aide in regard to 'calming		
	down' and trying to get some rest. Resident		
	was in his room until the following morning		
	at the change of shift. His 1 on 1 aide had left		
	at 6:30 [AM] in the morning. A nurse pro-		
	ceeded to sit with him until the change of		
	shift at 7:00 AM. During the shift report the		
	resident was seen going back to his room af-		
	ter getting a cup of coffee. After giving my		
	part of the report I proceeded to go check on		
	the resident in his room. That was when I saw		
	that he wasn't in his room. So I went running		
	down the hall to the balcony and found the		
	resident standing facing me on the outside of		
	the railing. I tried to reach out and make a		
	grab for him, but he jumped. He landed on		
	the sidewalk below 0705 (7:05 AM)."		
	11/10/2020 2:30 PM – An interview with E2		
	(HWD) confirmed that the 7/13/2020 Per-		
	sonal Service Plan completed by E3 (former		
	HWD) failed to include the 1:1 supervision as		
	a follow-up to R1's elopement on 7/13/2020.		
	Findings were reviewed during the Exit Con-		
	ference via telephone on 11/16/2020, begin-		
	ning at 2:30 PM, with E1 (ED), E2 (HWD), E10		
	(DDOCS), and E12 (RN CM).		

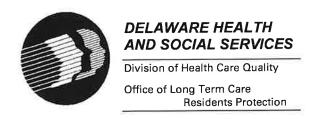


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NAME OF FACILITY: AL- Brookdale Hockessin

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE	
	2. Review of R3's clinical records revealed the			
	following:			
	Tollowing.			
	1/24/2020 – The Annual UAI was completed			
	by E3 (former HWD).			
	by E3 (former 1100b).			
	3/16/2020 – The Personalized Service Plan			
	was completed approximately two months			
	after the annual UAI was completed on			
	1/24/2020. The Personalized Service Plan			
	was signed by E3 (former HWD) on			
	3/16/2020 and by the resident's POA on			
	3/20/2020.			
	11/16/2020 9:40 AM - Findings were re-			
	viewed with E2 (HWD) and E1 (ED) via phone			
	interview.			
	Findings were reviewed during the Exit Con-			
	ference via telephone on 11/16/2020, begin-			
	ning at 2:30 PM, with E1 (ED), E2 (HWD), E10			
	(DDOCS), and E12 (RN CM).			
	Abuse, Neglect, Mistreatment or Financial			
	Exploitation of Residents or Patients			
16 Del.	(11) "Neglect" means the failure to provide			
Code	goods and services necessary to avoid phys-			
Chapter	ical harm, mental anguish, or mental illness.			
11, Sub-	Neglect includes all of the following:			
chapter	a. Lack of attention to physical needs of the			
	patient or resident including toileting, bath-			
II, §	ing, meals, and safety.			
L131		<u>.</u>		
	This requirement was not met as evidenced			
	by:			
	Based on record review, staff interviews and			
	review of other documentation as indicated			
	it was determined that for one (R1) out of			
	three (3) residents reviewed, the facility			
	failed to ensure attention to the safety needs			
	of R1. On 7/13/2020, R1 eloped from the fa-			
	cility and was found walking on the highway.			

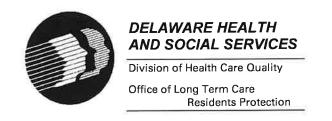


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DATE SURVEY COMPLETED: November 16, 2020 NAME OF FACILITY: AL- Brookdale Hockessin COMPLE-ADMINISTRATOR'S PLAN FOR STATEMENT OF DEFICIENCIES SECTION **TION DATE** CORRECTION OF DEFICIENCIES SPECIFIC DEFICIENCIES On 10/9/2020, R1 was left unsupervised and was found behind a 2nd floor balcony rail before falling from the balcony onto the cement sidewalk. Findings include: Review of R1's clinical records, the Division's Investigative Section's records, and the hospital records revealed the following: 7/3/2020 - R1 was admitted to the facility with diagnoses including dementia. 7/12/2020 11:39 PM - A Nurses Progress Note documented that around 10:00 PM, R1 was displaying aggressive behaviors toward the nurse who was explaining to R1 that it was not safe to leave the building as R1 was trying to follow one of the staff members who was going outside of the building. R1 became combative and pushed the nurse, held onto the door and broke his wristwatch on the door. R1 sustained a bruise on his left arm. R1 was reassured by the nurse and returned back to his room. There was lack of evidence that the facility assessed R1's risk of elopement after R1 attempted to leave the building at approximately 10:00 PM on 7/12/2020 and they failed to develop an individualized plan to lower R1's risk for elopement. 7/13/2020 12:46 AM - A Nursing Progress Note stated, "This nurse arrived at 1125 pm 911 just had left and escorted resident back into the building. Resident assessed for injuries. Noted resident with abrasions to left knee and large bruise to the left forearm. ED

[E1] arrived shortly after me [E3]. This nurse investigated resident room and noted resident window up, screen on the outside on the ground. resident stated he climbed out of the window. He was looking to 'life (sic) my life' and get a ride to Europe. Called resident



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Date _____

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SECTION	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	COMPLE-
0_0	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES	TION DATE
	son, daughter and daughter in law. Son [FM1]		
	made aware and will (sic) he come in to pro-		
	vide 1:1 overnight. Resident is in bed at this		
	time and appears comfortable. Regional		
	team made aware of the incident."		
	7/13/2020 – The facility reported to the State		
	Agency that the facility received a call at ap-		
	proximately 11:10 PM that there was a man		
	walking on the highway and staff went out-		
	side and found R1 approximately 200 feet		
	away from the community. R1 was resistive		
	to return to the facility and 911 was called		
	and R1 was escorted back to the facility.		
	Upon investigation, R1 knocked the screen		
	out of his window, climbed out of the win-		
	dow and sustained an abrasion to the left		
	knee. The 5 day follow-up by the facility doc-		
	umented that a care plan meeting was held		
	with R1, FM1, E1 (ED) and E3 (former HWD), 1:1 supervision was put into place indefi-		
	nitely and R1's room was changed to upstairs		
	(2 nd floor) along with a 1:1 companion. All fa-		
	cility windows were inspected and will have		
	stops in place that only allow the windows to		
	be raised a certain amount of inches (without		
	assistance) for safety.		
	,		
	Due to the facility's failure to assess R1's risk		
ı	of elopement after the previous day's at-		
	tempt to leave the facility on 7/12/2020 at		
	approximately 10:00 PM and failure to de-		
	velop a plan to reduce R1's risk for elope-		
	ment, R1 eloped from the facility and was ob-		
	served walking on the highway by a passerby		
	who was driving on the highway. After this		
	incident, a decision was made to relocate R1		
	to the 2 nd floor. There was lack of evidence		
	that the facility identified that the 2 nd floor		
	balcony doors were a potential safety hazard for R1 who was exit seeking. The balcony		
	doors were not set up to alarm when opened.		
	doors were not set up to diarm when opened.		

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NAME OF FACILITY: AL- Brookdale Hockessin DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	7/13/2020 – The Significant Change UAI As-		
	sessment stated that R1 eloped from the fa-		
	cility and the UAI and PSP were revised with		
	interventions that were put into place.	· ·	
	Interventions that were put into place.		
	7/13/2020 – The Personal Service Plan was		
	revised and included the following:		
	The Cognitive/Psychological section revealed		
	that R1 needed help to participate in commu-	(₩	
	nity activities because of memory loss as R1		
	was not always oriented to place and time		
	This change in orientation may impact R1's		
	decision making.		
	A section for Behavior Management was		
	added to the PSP which stated that R1 at-		
	tempts to exit the building without needed		
	supervision. Interventions included, but		
	were not limited to 1) Redirect R1 away from		
	exit using a gentle voice and other preferred		
	activities 2) Direct to an appropriate wander-		
	ing place 3) See Cognitive/Psychological Sec-		
	tion related to wandering 4) Be alert to resi-		
	dent's pattern and reason for exit attempts		
	(e.g. change of shift, end of a party as families		
	leave) and involve in meaningful activity prior		
	to these points in time. The document in-		
	cluded E3's (Former HWD) signature and was		
	dated 7/16/2020, however, there was no sig-		
	nature by R1's POA, FM1.		
	7/13/2020 – R1's Care Profile indicated that		
	R1 had behaviors in which R1 attempts to exit		
	the building without needed supervision.		
	9/24/2020 through 10/1/2020 – Review of		
	the following Nurses Progress Notes docu-		
	mented that R1 was not provided 1:1 super-		
	vision for safety.		
	- 9/24/2020 8:38 PM – "Resident was noted		
	walking on the hallway by himself no private		
	aide was on duty on this shift".		
	- 9/26/2020 9:19 PM — "Resident continues		
	on monitoring for exit seeking. One to One		
	aid unavailable this shift (3-11)(Name of		
	gnature	Title Date _	



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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	outside agency) called @ 2108 (9:08 PM) to		
	notify staff that an overnight aide would not		
	be coming in tonight".		
	- 9/27/2020 9:16 PM – "Resident continues		
	on monitoring for exit seeking. Resident cur-		
	rently does not have1:1 aid this shift or for		
	overnight. Noted resident has increased agi-		
	tation and wandering this shift r/t (related to)		
	change in routine".		
	- 10/1/2020 10:59 PM – "Aide (Staff from the		
	outside agency) reports that there will not be		
	an aide for overnight and 11-7 (11:00 PM –		
	7:00 AM). (Name of outside agency) will not		
	be here to do 1:1 on 10/3/2020 and		
	10/4/2020. Safety maintained.".		
	It was unclear what the facility's system was		
	to ensure 1:1 supervision for R1's safety dur-		
	ing the documented periods of no 1:1 super-		
	vision by the outside agency staff. There was		
	lack of evidence of reassessment of R1's risk		
	for elopement and no revision to the plan to		
	reduce R1's elopement risk.		
	10/9/2020 12:05 AM – A Nurse Progress Note		
	documented "At 00:05 (12:05) AM the Nurse		
	[E4/LPN] was notified by the 1-on-1 aide that		
	the resident was in a state of distress. He had		
	mentioned that he wanted to leave the build-		
	ing. The resident was very combative with		
	the nursing staff. He was punching and kick-		
	ing and scratching. The aide informed me		
	that he was attempting to access the 2nd		
	floor 400 hall balcony to 'leave the building'.		
	The resident was able to be redirected on		
	multiple occasions to ensure his safety. The		
	resident was repeatedly kicking, scratching,		
	and he had pushed the staff. He was trying to		
	gain access outside from the upper floor 400		
	hall balcony. The resident's family POA		
	[Power of Attorney], the building Executive		
	Director [E1], and DR [R1's Attending Physi-		
	cian] were contacted. His son was able to ver-		
	bally convince him to listen to the staff and		
	buny convince min to listen to the stan and	Title Date	

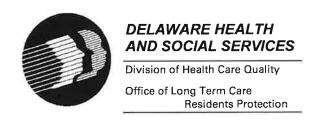


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NAME OF FACILITY: AL- Brookdale Hockessin DATE SURVEY COMPLETED: November 16, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	his 1-on-1 aide in regard to 'calming down'		
	and trying to get some rest. Resident was in		
	his room until the following morning at the		
	change of shift. His 1 on 1 aide had left at		
	6:30 [AM] in the morning. A nurse proceeded		
	to sit with him until the change of shift at 7:00		
	AM. During the shift report the resident was		
	seen going back to his room after getting a		
	cup of coffee. After giving my part of the re-		
	port I proceeded to go check on the resident in his room. That was when I saw that he was-		
	n't in his room. So I went running down the		
	hall to the balcony and found the resident		
	standing facing me on the outside of the rail-		
	ing. I tried to reach out and make a grab for		
	him, but he jumped. He landed on the side-		
	walk below 0705 (7:05 AM)."		
	Walk Science, 65 (1165 1 mill)		
	Despite that R1's POA (FM1) did not want to		
	have R1 sent to the hospital when R1 was dis-		
	tressed, combative and attempted to jump		
	over the balcony rails, the facility failed to	TE.	
	identify and eliminate a significant hazard of		
	R1 accessing the 2 nd floor balcony after the		
	incident at approximately 12:05 AM. In addi-		
	tion, the facility failed to notify E3 (former		
	HWD) and failed to reassess the current in-		
	terventions to ensure safety for R1. Due to		
	these failures, R1 was left unsupervised until		
	R1 was observed behind the 2 nd floor balcony		
	railing and subsequently fell onto the cement		
	sidewalk.		
	10/9/2020 – Review of the facility's incident		
	report to the State Agency and the Division's		
	Investigative Section records stated that R1		
	displayed distressed behavior at the begin-		
	ning of the night shift beginning at 11:00 on		
	10/8/2020 and around midnight, E4 (LPN)		
	was called by E5 (LPN) due to R1's combative		
	behavior. When E4 arrived on the 2 nd floor,		
	E4 observed E5 and OA1 (Outside Agency)		
	staff attempting to stop R1 from climbing		
	over the balcony railing in an attempt to		



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NAME OF FACILITY: AL- Brookdale Hockessin

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	TION DATE
	3FLOII TO DEFICIENCIES	SOUTH OF DEFICIENCES	HORDAIL
	"leave this place." After this incident, the		
	OA1 staff provided 1:1 supervision until 6:30		
1	AM on 10/9/2020 and before OA1 left R1,		
	OA1 reported to E5 (LPN) and at that time E5		
	provided 1:1 supervision. A written state-		
	ment by E5 stated that she provided 1:1 supervision until 7:00 AM. A written statement		
	·		
	by E4 stated that he observed R1 ambulating		
	alone at 6:45 AM. After E4 completed the		
	shift change report, E4 proceeded to check		
	on R1. E4 observed that R1 was not in his		
	room and immediately, E4 proceeded to the		
	2 nd floor balcony where R1 was observed		
	holding onto the outside of the balcony rail		
	before falling onto the cement sidewalk.		
	40/0/2020 7 40 ANA Broton of the Sine Court		
	10/9/2020 7:10 AM – Review of the Fire Com-		
	pany and the State Police dispatch record re-		
	vealed that the call was received at 7:10 AM.		
	10/9/2020 – Review of the hospital's emer-		
	gency room records revealed that R1 sus-		
	tained multiple rib fractures, a cervical (neck		
	bone) fracture, subarachnoid hemorrhage		
	(bleeding in the space between the brain and		
	the tissue covering the brain) and non-oper-		
	ative management was recommended as R1		
	was showing tremendous signs of delirium		
	(serious disturbance in mental abilities that		
	results in confused thinking and reduced		
	awareness of surroundings) and agitation.		
	awareness of surroundings) and agreetion.		
	10/9/2020 – Review of the hospital's consul-		
	tation note for the cervical fracture stated		
	that R1's past medical history included previ-		
	ous suicidal ideations, as well as an admission		
	to a hospital after R1 was found to have ab-		
	dominal and chest stab wounds after ex-		
	pressing his intent to commit suicide.		
	pressing his intent to commit suicide.		
	10/14/2020 – Review of the hospital's Dis-		
	charge Summary documented a discharge di-		
	agnosis of subarachnoid hemorrhage and R1		

Provider's Signature	Title	Date	
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	was placed on comfort care and expired on		
	10/14/2020.		
	11/10/2020 2:00 PM – An interview with E6		
	(DOM) revealed that on 10/9/2020, E6 ar-		
	rived at the facility at 6:30 AM and was in-		
	formed by a nurse that R1 was exit seeking		
	over the course of the night shift. E6 verbal-		
	ized he did not recall which nurse reported		
	this information to him. Approximately 5		
	minutes after the conversation with the		
	nurse, E6 saw R1 on the ground and E6 stated		
	it was already day shift when this took place.		
	11/10/2020 2:30 PM – An interview with E2		
	(HWD) was conducted and revealed that E2		
	became the Interim DON on 10/6/2020. E2		
	verbalized that she was not notified when R1		
	attempted to jump from the 2 nd floor balcony		
	the first time on 10/9/2020 at approximately		
	12:05 AM. In addition, E2 was not notified		
	when R1 jumped from the 2 nd floor balcony		
	on 10/9/2020 at approximately 7:05 AM, but		
	she assisted in obtaining written statements		
	from the two LPNs who worked the night		
	shift for the facility's incident investigation.		
	E2 stated that the facility does not have a risk		
	assessment for elopement of a new resident,		
	however, in her experience as a HWD in an-		
	other facility, when an elopement occurs, the		
	residents are typically placed in a facility with		
	a secured unit. E2 stated that for a new pro-		
	spective resident, the nurse conducting the review would follow the "Admission/Move-		
	In Review Criteria."		
	in Review Criteria.		
	11/16/2020 8:10 AM — A subsequent inter-		
	view with E6 (Director of Maintenance) re-		
	vealed that the facility installed an alarm on		
	the 2 nd floor balcony doors after R1 fell from		
	the balcony on 10/9/2020.		
	11/16/2020 8:33 AM – An interview with E10		
	(DDOCS) revealed that E10 was made aware		



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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLE- TION DATE
	of the 7/13/2020 elopement, but was given the "impression that the resident stepped outside" by F3 (former HWD) and until E10 reviewed the Nurse Progress Note today, she was not aware of what actually occurred. E10 stated that if she was provided accurate information, she would have considered other living arrangements to meet the resident's needs. E10 verbalized that she relied on what she was told by E3 and it was not her practice to review documentation of the incident, such as the Nurse Progress Notes. E10 stated that she became aware of the 10/9/2020 incident after R1 fell from the balcony.		
	11/16/2020 10:14 AM – An interview with E1 (ED) revealed that after R1 eloped from the facility on 7/13/2020, a meeting was held with FM1, E3 (former HWD) and E1. During the meeting, it was decided that R1 required 1:1 supervision for safety to remain in the facility. After this meeting, E1 was approached by FM1 about potentially reducing some of the 1:1 supervision provided by the outside agency and E1 and FM1 agreed to eliminate the 7:00 AM to 3:00 PM coverage because there was usually enough day shift staff at the facility to provide coverage without 1:1 supervision by the outside agency staff. E1 confirmed after the first attempt to jump from the 2 nd floor balcony on 10/9/2020 at approximately 12:05 AM, that no new interventions were implemented. E1 confirmed that the balcony door did not have an alarm and that the alarm was implemented after R1 fell from the balcony on the morning of 10/9/2020.		
	Findings were reviewed during the Exit Conference via telephone on 11/16/2020, beginning at 2:30 PM, with E1 (ED), E2 (HWD), E10 (DDOCS), and E12 (RN CM).		

rovider's Signature	Title	Date	