



DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: AL- Somerford Place

DATE SURVEY COMPLETED: August 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES
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	<p>REVISED STATE REPORT. 10/7/24 - Additional information was received from the facility.</p> <p>See Regulations 3225.9.7, 11.2, 11.4, 13.1, 16.2, and DE Code, Chapter 11-Neglect.</p> <p>An unannounced Annual and Complaint Survey was conducted at this facility from August 15, 2024 through August 20, 2024. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was thirty-eight (38). The survey sample totaled fifteen (15) residents.</p> <p>Abbreviations/definitions used in this state report are as follows:</p> <p>CG – Caregiver; CM – Centimeter; Contract – A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations; DeIVAX -A confidential online computer system used statewide by doctors, nurses, schools to keep track of their patient/student's immunizations; DMOST (Delaware Medical Orders for Scope of Treatment) - end-of-life directives used only when a patient is expected to live for less than one year. It addresses a patient's specific medical condition and contains medical orders that reflect the patient's treatment preferences; DRC – Director of Resident Care; D/T – Due to; ED - Executive Director;</p>	
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	<p>EMR – Electronic Medical Record; ER – Emergency Room; LLAM - Limited Lay Administration of Medications. In order to administer medication to a service recipient being supported by the Division of Developmental Disabilities Services (DDDS), Unlicensed Assistive Personnel (UAP) must successfully complete all sections of the DDDS Limited Lay Administration of Medication; LPN – Licensed Practical Nurse; MD – Medical Doctor; MT – Medication Tech; NP – Nurse Practitioner; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; OOB – Out of bed; PA – Physician Assistant; RMA – Room air; RN – Registered Nurse; SA (Service Agreement)– allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services; UAI (Uniform Assessment Instrument) - A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations; UKO – Unknown origin; W/C – Wheelchair;</p>	
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<p>3225.5.0</p> <p>3225.5.12</p> <p>S/S E</p>	<p>WNL – Within Normal Limits.</p> <p>General Requirements</p> <p>An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer’s disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer’s disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review and review of other facility documentation, it was determined that for one (E12) out of three employees sampled for dementia specific training, the facility failed to provide evidence of the mandated dementia specific training. Findings include:</p> <p>8/7/20 - E12 (LPN) was hired. The facility failed to provide evidence of the mandated yearly dementia specific training.</p> <p>8/16/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the training was not in evidence.</p>	<p>3225.5.0</p> <p>1. There were no residents negatively impacted by deficient practice. Dementia Training for E12 will be completed by 10/25/24. All staff of Somerford Place that will have hands on care will be in-serviced no later than 11/30/24.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>3. All staff will be going through mandated dementia specific training.</p> <p>4. The BTR Director/designee will provide the mandated dementia specific training which will include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures in-services will be held monthly x2 until all staff training is completed. Audits of staff training weekly x 4, then monthly, biweekly x4 and monthly x1 until 100% compliance is achieved.</p> <p>Completion by 11/30/2024</p>

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3225.7.0	8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM. Specialized Care for Memory Impairment	3225.7.0 1. There were no residents negatively impacted by deficient practice. This facility will disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.	
3225.7.1 S/S E	Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment provided, in addition to that care and treatment required by the rules and regulations herein.	2. All residents have the potential to be affected by this deficient practice.	Completion by 11/30/2024
3225.7.2	Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.	3. All staff will be going through mandated specialized care training by 11/30/2024. Facility currently drafting letter to be included in the community packet given to perspective families/residents. See attachment #1.	
3225.7.3	The information disclosed shall explain the additional care that is provided in each of the following areas:	4. The BTR Director designee will provide the mandated memory care training. Audits of staff training weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.	
3225.7.3.5	Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care. This requirement was not met as evidenced by: Based on interview and review of the facility's memory care information, the facility materials failed to disclose to the persons seeking specialized care the above element. Findings include:		

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<p>3225.8.0</p> <p>3225.8.3</p> <p>S/S D</p> <p>3225.8.3.1</p> <p>3225.8.3.2</p>	<p>Review of the materials did not contain the information for the staffing plan, training and the frequency of training for staff.</p> <p>8/20/24 - Per interview with E14 (Travel DRC) at approximately 12:55 PM, E14 confirmed the company's memory care information was lacking in that area.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 at the exit conference beginning at approximately 1:00 PM.</p> <p>Medication Management</p> <p>Medication stored by the assisted living facility shall be stored and controlled as follows:</p> <p>Medication shall be stored in a locked container, cabinet, or area that is only accessible to authorized personnel;</p> <p>Medication that is not in locked storage shall not be left unattended and shall not be accessible to unauthorized personnel;</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation and interview, it was determined that two medication carts located in the hallway were left unlocked and unattended. Findings include:</p> <p>1. 8/16/24 – During medication pass observation at approximately 9:00 AM, the Surveyor observed the medication cart remained unlocked when E16 (CG/MT) left</p>	<p>3225.8.0</p> <p>1. There were no residents negatively impacted by deficient practice. Employee E16 will be in-serviced by 10/6/24. All LLAM and Nurses will be in-serviced no later than 10/18/24 on the importance of making sure the med carts are locked.</p> <p>2. All residents have the potential to affected by this deficient practice.</p> <p>3. All nurses and LLAM will insure the med cart is locked at all times when unattended. See attachment #2</p> <p>4. The DHW or designee will perform random checks on med carts as followed. Audits of medication cart will be weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p> <p>Completion by 11/30/2024</p>

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<p>3225.9.0</p> <p>3225.9.6</p> <p>S/S E</p>	<p>the cart to administer a medication to a resident in the dining room.</p> <p>Per interview with E16 at approximately 9:20 AM, E16 confirmed the cart was left unlocked. E16 stated she pushed the lock but evidently it did not catch, therefore cart remained unlocked when unattended.</p> <p>2. 8/16/24 - During medication pass observation at approximately 10:15 AM, the Surveyor approached the medication cart located in the hallway and observed it was unlocked and unattended. E17 (CG/MT) came back to the medication cart while the Surveyor was there.</p> <p>Per interview with E17 at approximately 10:20 AM, E17 confirmed the cart was left unlocked.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>Infection Control</p> <p>The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against influenza must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.</p> <p>This requirement was not met as evidenced by:</p>	<p>3225.9.0</p> <p>1. There were no residents negatively impacted by deficient practice. All POA who refuse vaccinated against influenza will be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record. R4 was discharged from facility on 4/24/2024, R5's POA was offered Influenza vaccination, consent received from POA and vaccine administered 9/24/2024. R13 was discharged from facility on 6/21/2024</p> <p>2. All residents have the potential to be infected by this deficient practice.</p> <p>3. Community will ensure access to DelVax for review of vaccine as well as offering all new residents the opportunity to be vaccinated No later than 11/30/24.</p> <p>4. The DHW or designee will perform immunization Audits weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p>

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<p>3225.9.7</p> <p>S/S E</p>	<p>Based on record review, interview and re-view of facility provided documentation, it was determined that three (R4, R5 and R13) out of nine residents sampled for an annual vaccination against influenza, the facility failed to provide evidence of the administration of the annual influenza vaccine, or the facility had no record of the vaccine being offered to the resident and declined. Findings include:</p> <p>1. 5/11/23 - R4 was admitted to the facility. The facility failed to provide evidence of R4's 2023 influenza vaccination or a declination of such.</p> <p>2. 9/6/22 - R9 was admitted to the facility. The facility failed to provide evidence of R9's 2023 influenza vaccination or a declination of such.</p> <p>3. 6/9/21 - R13 was admitted to the facility. The facility failed to provide evidence of R13's 2023 influenza vaccination or a declination of such.</p> <p>8/19/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the influenza vaccinations for the year 2023 were not in evidence.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as</p>	<p>3225.9.7</p> <p>1. There were no residents negatively impacted by deficient practice. All residents will be offered to be vaccinated against pneumococcal for residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed. R2 was discharged from facility on 1/6/2024. R3 POA was offered Pneumococcal vaccination, consented and received 9/24/2024. R6 was discharged from the facility 5/7/2024. R7 was discharged from discharged from the facility on 10/1/2023. R8 was discharged from the facility on 10/1/2023 R11 resident discharged from facility 8/9/2024. R12 POA was offered Pneumococcal vaccine, consented and re-</p> <p>Completion by 11/30/2024</p>

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	<p>recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of State DelVAX website, it was determined that for 10 (R2, R3, R6, R7, R8, R11, R12, R13, R14, R15) out of fifteen residents reviewed for pneumococcal vaccines, the facility failed to provide evidence of the residents' pneumococcal vaccine. Findings include:</p> <p>"Pneumococcal Vaccine Timing for Adults- Adults >= 65 years old Complete pneumococcal vaccine schedules... PCV13 only at any age- Option A: >= 1 year, give PVC20, Option B: >= 1 year, give PPSV23." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.</p> <p>1. 6/5/15 – R2, now aged 85 years, was admitted to the facility.</p> <p>3/4/19 – R2 received the PVC13 pneumococcal vaccine. The facility was unable to provide any documentation of R2 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine.</p>	<p>ceived on 9/24/2024. R13 resident discharged from facility 6/21/2024. R14 resident out of facility hospitalized since 9/20/2024 community's vaccination clinic was held on 9/24/2024 when resident returns vaccination will be offered to POA. R15 POA was offered Pneumococcal vaccination, consented and received on 9/24/2024. All POA's who refuse the Influenza vaccination for their family will be fully informed by the facility of the health risks involved. And the reason for the refusal shall be documented in the resident's medical record by the facility.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>3. Community will ensure access to DelVax for review of vaccination records as well as offering all new residents the opportunity to be vaccinated during influenza season.</p> <p>4. The DHW or designee will perform immunization audits weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p>
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	<p>2. 11/11/21 – R3, now aged 90 years, was admitted to the facility. The facility was unable to provide any documentation of R3 having any pneumococcal vaccination.</p> <p>8/19/24 – A search on the DelVAX website (State of Delaware, Division of Public Health, Immunization Record) revealed no record of R3 ever having received a pneumococcal vaccine.</p> <p>3. 6/13/23 – R6, now aged 82 years, was admitted to the facility. The facility was unable to provide any documentation of R6 having any pneumococcal vaccination.</p> <p>8/19/24 – A search on the DelVAX website revealed no record of R6 ever having received a pneumococcal vaccine.</p> <p>4. 10/21/22 - R7, now aged 81 years, was admitted to the facility. The facility was unable to provide any documentation of R7 having any pneumococcal vaccination.</p> <p>8/19/24 – A search on the DelVAX website revealed no record of R7 ever having received a pneumococcal vaccine.</p> <p>5. 5/2/16 – R8, now aged 81 years, was admitted to the facility.</p> <p>10/4/19 – R8 received the PCV13 pneumococcal vaccine. The facility was unable to provide any documentation of R8 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine.</p> <p>6. 4/17/24 – R11, now aged 77 years, was admitted to the facility.</p>	

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	<p>5/11/12 – R11 received the PPSV23 pneumococcal vaccination at age 65 years. The facility was unable to provide any documentation of R11 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine.</p> <p>7. 8/18/23 – R12, now aged 85 years, was admitted to the facility. The facility was unable to provide any documentation of R12 having any pneumococcal vaccination.</p> <p>8/19/24 – A search on the DelVAX website revealed no record of R12 ever having received a pneumococcal vaccine.</p> <p>8. 6/9/21 – R13, now aged 87 years, was admitted to the facility. The facility was unable to provide any documentation of R13 having any pneumococcal vaccination.</p> <p>8/19/24 – A search on the DelVAX website revealed no record of R13 ever having received a pneumococcal vaccine.</p> <p>9. 7/15/24 – R14, now aged 83 years, was admitted to the facility. Facility provided documentation that R14 had a PCV13 in 2019. The facility was unable to provide any documentation of R14 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine.</p> <p>8/19/24 – A search on the DelVAX website revealed no record of R14 ever having received a pneumococcal vaccine.</p> <p>10. 7/3/24 – R15, now aged 80 years, was admitted to the facility with documentation that R15 received the PCV13 pneumococcal</p>	
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<p>3225.10.0</p> <p>3225.10.10</p> <p>S/S D</p>	<p>vaccine on 1/23/03 at age 59 years. The facility was unable to provide any documentation of R15 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine.</p> <p>8/19/24 – A search on the DelVAX website revealed no record of R15 in their database. R15 had moved to Delaware from out of state to be closer to family members.</p> <p>8/20/24 9:16 AM – During an interview, E14 (Travel DRC) stated that the facility did not have documentation of “established” residents completed pneumococcal vaccines. “We do have documentation of pneumococcal vaccines for recent admissions. We are having a vaccine clinic in a few weeks and need to catch the established residents up.”</p> <p>8/20/24 – Findings were reviewed with E1 (ED) and E14 at the exit conference beginning at approximately 1:00 PM.</p> <p>Contracts</p> <p>No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for two (R14 and R15) out of three residents sampled for contract</p>	<p>3225.10.0</p> <p>1. There were no residents negatively impacted by deficient practice. No contract is to be signed before the full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit will be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment. R14 resident out of facility hospitalized since 9/20/2024 upon notification of intended return to facility RN/designee will assess resident utilizing the UAI, which will be reviewed for agreeance with POA signature will be obtained at that time. R15's POA will be contacted to review and discuss UAI and Service for agreeance and signature by 10/18/2024.</p> <p>2. All new residents have the potential to affected by this deficient practice.</p> <p>3. Upon admission all residents will have a signed service agreement in their medical record before or on the day of contract signing. Each resident medical record will be updated to reflect a signed contract post service agreement.</p>

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<p>3225.11.0</p> <p>3225.11.2</p> <p>S/S D</p>	<p>dates, the facility obtained a signed contract prior to the full assessment was completed and the SA executed.</p> <p>1. 7/15/24 - R14 was admitted to the facility. The UAI was completed on 7/15/24 and the SA was executed on 7/15/24. The contract was signed on 6/27/24, several weeks prior to the assessments being completed.</p> <p>2. 7/3/24 - R15 was admitted to the facility. The UAI was completed on 7/3/24 and the SA was executed on 7/3/24. The contract was signed on 6/18/24, several weeks prior to the assessments being completed.</p> <p>8/19/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the UAIs were completed the day of admission. E2 was unsure of the facility's contract signing process.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>Resident Assessment</p> <p>A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive</p>	<p>4. Staff will be in-serviced to ensure there is a signed and accepted service agreement before initiating contract signing. All service agreements and contracts will be signed on the same day with the addition of "copies provided to signer" written on the original and will be initialed and dated by the DHW or designee. The ED/ designee will audit weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p> <p>3225.11.0</p> <p>1. There were no residents negatively impacted by deficient practice. All initial UAI-based resident assessments will be completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. R11 discharged from facility on 8/9/2024. R14 resident out of facility hospitalized since 9/20/2024 upon notification of intended return to facility RN/designee will assess resident utilizing the UAI, which will be reviewed for agreeance with POA signature will be obtained at that time. R15's POA will be contacted to review and discuss UAI and Service for agreeance and signature by 10/18/2024.</p> <p>2. All residents have the potential to affected by this deficient practice.</p> <p>Completion by 11/30/2024</p>

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<p>3225.11.4</p> <p>S/S E</p>	<p>technology, that component of the assessment must be performed by personnel qualified in that specialty area.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for three (R11, R14 and R15) out of nine sampled residents for UAI completion, the facility failed to provide evidence that a UAI was completed within 30 days prior to admission. Findings include:</p> <p>1. 4/17/24 - R11 was admitted to the facility. The initial UAI prior to admission was not in evidence.</p> <p>2. 7/15/24 - R14 was admitted to the facility. The UAI was completed on 7/15/24, the day of admission.</p> <p>3. 7/3/24 - R15 was admitted to the facility. The UAI was completed on 7/3/24, the day of admission.</p> <p>8/19/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the UAIs were completed the day of admission.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>The resident assessment shall be completed in conjunction with the resident.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was</p>	<p>3. All assessments will be completed prior to admission. The assessment will be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment will be performed by personnel qualified in that specialty area.</p> <p>All RN's will be in-serviced no later than 11/30/24 on the importance of making sure that a UAI is completed within 30 days prior to admission.</p> <p>4. The ED, BOM or designee will perform audits on all prospects to ensure that the UAI, are being completed weekly x 4, bi-weekly x4 and monthly x1 until 100% compliance is achieved.</p> <p>3225.11.4</p> <p>1. There were no residents negatively impacted by deficient practice. All initial, UAI-based resident assessment will be signed by family/POA at the time of the service agreement being signed by the resident/family confirming their agreement with the assessment. In addition, "copies will be given to signer" will be written on the original with date and initials of the DHW or designee. R4 discharged from facility on 4/24/2024. R5's POA will be contacted to discuss and formulate the residents UAI no later than 10/18/2024. R10 is currently hospitalized, upon notification of intended return UAI will be completed in conjunction with POA. R11 discharged 8/9/2024.</p>

Completion by 11/30/2024

Provider's Signature [Signature] Title ED Date 10/10/24



DELAWARE HEALTH AND SOCIAL SERVICES

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STATE SURVEY REPORT

NAME OF FACILITY: AL- Somerford Place

DATE SURVEY COMPLETED: August 20, 2024

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	<p>determined that for five (R4, R5, R10, R14 and R15) out of nine sampled residents for UAIs, the facility failed to provide evidence that the UAI was signed by the resident/family confirming their agreement with the assessment. Findings include:</p> <ol style="list-style-type: none"> 5/11/23 – R4 was admitted to the facility. The UAI completed on 1/15/24 was not signed by the resident/family confirming it was completed in conjunction with the resident/family. 7/19/19 – R5 was admitted to the facility. The UAI completed on 3/13/24 was not signed by the resident/family confirming it was completed in conjunction with the resident/family. 5/31/22 – R10 was admitted to the facility. The UAI completed on 6/21/24 was not signed by the resident/family confirming it was completed in conjunction with the resident/family. 7/15/24 – R14 was admitted to the facility. The UAI completed on 7/15/24 was not signed by the resident/family confirming it was completed in conjunction with the resident/family. 7/3/24 – R15 was admitted to the facility. The UAI completed on 7/3/24 was not signed by the resident/family confirming it was completed in conjunction with the resident/family. <p>8/19/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the signed page of the UAIs are usually scanned into the EMR and that these signature pages were not in evidence.</p>	<p>R14 resident is hospitalized, upon notification of intended return UAI will be completed in conjunction with POA. R15 POA will be contacted to review and discuss UAI and Service for agreeance and signature by 10/18/2024.</p> <ol style="list-style-type: none"> All residents have the potential to affected by this deficient practice. All assessment will be completed prior to admission. The assessment will be reviewed by the Director of Health & wellness and family/POA. All RN staff will be in-serviced to ensure there is a signed UAI. The ED or designee will perform checks on all prospects to ensure that the UAI, are being completed weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.
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Provider's Signature [Signature]

Title ED

Date 10/10/24



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<p>3225.11.5</p> <p>S/S D</p>	<p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>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.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and review of other facility documentation, it was determined that for one (R13) out of nine sampled residents for annual UAIs, the facility failed to provide evidence that an annual UAI assessment was completed. Findings include:</p> <p>6/9/21 - R13 was admitted to the facility. The facility failed to provide evidence of R13's annual UAI completion for the year 2023.</p> <p>8/19/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the UAI for the year 2023 was not in evidence.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>Services</p> <p>The assisted living facility shall ensure that:</p> <p>Food service complies with the Delaware Food Code</p>	<p>3225.11.5</p> <p>1. There were no residents negatively impacted by deficient practice. The UAI, developed by the Department, will be used to update the resident assessment. At a minimum, 30 days after admission, annually and when there is a significant change in the resident's condition. R13 discharged from the facility on 6/21/2024.</p> <p>2. All residents have the potential to affected by this deficient practice.</p> <p>3. All assessment will be completed following the developed UAI by the Department, and reviewed by an RN.</p> <p>All RN's will be in-serviced no later than 11/30/24 on the importance of making sure that the UAI updates are performed according to regulatory guidelines.</p> <p>4. The DHW or designee will perform audits weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p>
<p>3225.12.0</p>	<p>Delaware Food Code</p>	<p>Completion by 11/30/2024</p>

Provider's Signature [Signature] Title ED Date 10/10/24



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<p>3225.12.1 3225.12.1.3 S/S E</p>	<p>Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include:</p> <p>Delaware Food Code 3-401.11 Raw Animal Foods: (A) Except as specified under (B) and in (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked.</p> <p>8/16/24 – 10:30 AM - During the survey of the facility and review of requested food temperature logs, the facility failed to provide evidence of 116 mealtime temperatures out of 276 between May 1, 2024 – July 31, 2024.</p> <p>8/16/24 - Findings were reviewed with E3 (Food Services Director) at approximately 1:30 PM and with E2 (DRC) and E14 (Travel DRC) at approximately 1:45 PM.</p> <p>Service Agreements</p> <p>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.</p>	<p>3225.12.0</p> <ol style="list-style-type: none"> 1. There were no residents negatively impacted by deficient practice. Temperature Log Inservice will be completed by all Food Service/Dietary staff. 2. All residents have the potential to affected by this deficient practice. 3. All Food Service/dietary staff will be in-serviced on the importance of making sure that all temperatures are being performed during the meal time per the Delaware Food Code 3-401.11 by 10/18/2024 including newly staff will be in-serviced during orientation. 4. The ED, Dining Director or designee will perform audits of temperature logs weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.
<p>3225.13.0 3225.13.1 S/S E</p>	<p>3225.13.0</p> <p>1. There were no residents negatively impacted by deficient practice. A service agreement based on the needs identified in the UAI will be completed prior to or no later than the day of admission. The resident/POA will participate in the development of the agreement. The resident/POA and the facility will sign the agreement and each party will receive a</p>	<p>Completion by 11/30/2024</p>

Provider's Signature [Signature]

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Date 10/10/24



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	<p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and re-view of other facility documentation, it was determined that for seven (R4, R6, R9, R10, R11, R14 and R15) out of seven sampled residents, the facility failed to provide evidence that the resident or family participated in the development of the agreement or that the resident/resident representative was provided a copy. Findings include:</p> <ol style="list-style-type: none"> 5/11/23 – R4 was admitted to the facility. The SA completed on 1/15/24 was not signed by the resident/resident representative confirming it was completed in conjunction with the resident/resident representative or that the resident representative received a copy of the SA. 6/13/23 – R6 was admitted to the facility. The SA completed on 3/4/24 was not signed by the resident/resident representative confirming it was completed in conjunction with the resident/resident representative or that the resident representative received a copy of the SA. 9/6/22 - R9 was admitted to the facility. The SA completed on 4/2/24 was not signed by the resident/resident representative confirming it was completed in conjunction with the resident/resident representative or that the resident representative received a copy of the SA. 5/31/22 – R10 was admitted to the facility. The SA completed on 10/10/23 was not signed by the resident/resident representative confirming it was completed in conjunc- 	<p>copy of the signed agreement. R4 discharged from facility on 4/24/2024. R6 discharged from facility on 5/7/2024. R9's PA will be contacted for review and discussion of Service Agreement identified in the UAI by 10/18/2024. R10 is currently hospitalized, upon notification of intended return the Service Agreement identified by the UAI will be completed in conjunction with POA. R11 discharged from facility on 8/9/2024. R14 is currently hospitalized, upon notification of intended return the Service Agreement identified by the UAI will be completed in conjunction with POA. R15 POA will be contacted to review and discuss Service Agreement identified by the UAI by 10/18/2024.</p> <ol style="list-style-type: none"> All residents have the potential to affected by this deficient practice. All service agreements will be completed as identified in the UAI And reviewed by an RN. <p>All RN's will be in-serviced no later than 11/30/24 on the importance of making sure UAI's are being performed according to regulatory guidelines.</p> <ol style="list-style-type: none"> The DHW or designee will perform UAI audits weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.

Completion by 11/30/2024

Provider's Signature [Signature]

Title EA

Date 10/10/24



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	<p>tion with the resident/resident representative or that the resident representative received a copy of the SA.</p> <p>5. 4/17/24 – R11 was admitted to the facility. The SA completed on 4/17/24 was not signed by the resident/resident representative confirming it was completed in conjunction with the resident/resident representative or that the resident representative received a copy of the SA.</p> <p>6. 7/15/24 – R14 was admitted to the facility. The SA completed on 7/15/24 was not signed by the resident/resident representative confirming it was completed in conjunction with the resident/resident representative or that the resident representative received a copy of the SA.</p> <p>7. 7/3/24 – R15 was admitted to the facility. The SA completed on 7/3/24 was not signed by the resident/resident representative confirming it was completed in conjunction with the resident/resident representative or that the resident representative received a copy of the SA.</p> <p>8/19/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the SAs reviewed were not signed by the resident/resident representative and copies were not provided to the family unless requested. E2 stated signature pages are usually uploaded to the EMR, but these were not in evidence.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p>	
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<p>3225.13.3</p> <p>S/S B</p>	<p>The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for four (R4, R9, R14 and R15) out of eight sampled residents for the SA completion, the facility failed to provide evidence that the resident's personal attending Physician was identified on the SA. Findings include:</p> <ol style="list-style-type: none"> 5/11/23 – R4 was admitted to the facility. The SA completed on 1/15/24 did not contain the resident's personal attending Physician's address or phone number. 9/6/22 - R9 was admitted to the facility. The SA completed on 4/2/24 did not contain the resident's personal attending Physician's address or phone number. 7/15/24 – R14 was admitted to the facility. The SA completed on 7/15/24 did not contain the resident's personal attending Physician's address or phone number. 7/3/24 – R15 was admitted to the facility. The SA completed on 7/3/24 did not contain the resident's personal attending Physician's address or phone number. <p>8/19/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the SAs reviewed did not contain the resident's personal attending Physician's address or phone number.</p>	<p>3225.13.3</p> <ol style="list-style-type: none"> There were no residents negatively impacted by deficient practice. Each resident service agreement will reflect the physician's name, address and phone number. R4 discharged from the facility 4/24/2024, R9's attending medical group was added to the Service Agreement on 6/4/2024. R14 currently hospitalized upon intended return physician will be added to the Service Agreement. R15's Service agreement currently reflects her physician's name, address and phone number. All residents have the potential to be affected by this deficient practice. Upon admission, all resident medical records will include the residents attending physicians name, address and phone number. <p>All nursing staff will be in-serviced by 11/30/2024 adding the resident personal physician name, address and phone number to the Service Agreement.</p> <ol style="list-style-type: none"> The DHW or designee will perform audits weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved. <p>Completion by 11/30/2024</p>

Provider's Signature

Title

ED

Date

10/10/24



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<p>3225.14.0</p> <p>3225.14.1</p> <p>S/S E</p> <p>Del.C. Ch 11, Subchapter II - § 1121. Resident's rights.</p> <p>§ 1123. Notice to patient.</p>	<p>8/20/24 – Per interview with E14 (Travel DRC) at approximately 12:55 PM, E14 stated “the Physician’s complete information should be listed in the ‘special instruction’ line of the SA which was put in place after the last survey.”</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 at the exit conference beginning at approximately 1:00 PM.</p> <p>Resident Rights</p> <p>Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein.</p> <p>(b) Copies of § 1121 of this title shall be furnished to the resident upon admittance to the facility; all residents currently residing in the facility; and the authorized representative under § 1122 of this title. The long-term care facility shall retain in its files a statement signed by each person listed in this subsection that the person has received a copy of § 1122 of this title.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and interview, it was determined for ten (R1, R2, R3, R5, R6, R7, R8, R10, R12, R13) out of fifteen residents reviewed for updated resident rights notification, the facility failed to ensure that the resident or resident representative was notified and signed off on the updated resident rights form. Findings include:</p> <p>The Resident Rights form (updated September 2023) required each resident or resi-</p>	<p>3225.14.0</p> <p>1. There were no residents negatively impacted by deficient practice. The facility has made available to all residents/POA the Resident Rights to comply with the provisions of the Rights of Patients. R1’s POA returned signed Resident Rights on 8/21/2024. R2 resident discharged from facility on 1/6/2024. R3’s POA returned signed Resident Rights on 8/21/2024. R5’s POA returned signed Resident Rights on 8/26/2024. R6 discharged from facility on 5/7/2024. R7 resident discharged 12/10/2023. R8 resident discharged 9/13/2023. R10’s POA returned signed Resident Rights on 8/21/2024. R12’s POA returned signed Resident Rights on 8/22/2024. R13 discharged from facility on 6/21/2024.</p> <p>2. All residents have the potential to affected by this deficient practice.</p> <p>3. During contract signing all resident/POA will be given the residents rights to go over acknowledge and sign. All nursing staff will be in-serviced no later than 11/30/2024 on the importance of making sure that all the resident have a copy of residents rights in their chart.</p> <p>4. The DHW or designee will perform audits weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p>

Completion by 11/30/2024

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	<p>dent representative to sign and date acknowledging the receipt of a copy of the Resident Rights.</p> <ol style="list-style-type: none"> 1. 7/22/19 – R1 was admitted to the facility. The facility was unable to provide any documentation of R1 or R1's resident representative being notified and signing off on the updated Resident Rights form. 2. 6/5/15 – R2 was admitted to the facility. The facility was unable to provide any documentation of R2 or R2's resident representative being notified and signing off on the updated Resident Rights form. 3. 11/16/21 – R3 was admitted to the facility. The facility was unable to provide any documentation of R3 or R3's resident representative being notified and signing off on the updated Resident Rights form. 4. 7/19/19 – R5 was admitted to the facility. The facility was unable to provide any documentation of R5 or R5's resident representative being notified and signing off on the updated Resident Rights form. 5. 6/13/23 – R6 was admitted to the facility. The facility was unable to provide any documentation of R6 or R6's resident representative being notified and signing off on the updated Resident Rights form. 6. 10//21/22 – R7 was admitted to the facility. The facility was unable to provide any documentation of R7 or R7's resident representative being notified and signing off on the updated Resident Rights form. 7. 5/2/16 – R8 was admitted to the facility. The facility was unable to provide any docu- 	

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	<p>mentation of R8 or R8's resident representative being notified and signing off on the updated Resident Rights form.</p> <p>8. 5/31/22 – R10 was admitted to the facility. The facility was unable to provide any documentation of R10 or R10's resident representative being notified and signing off on the updated Resident Rights form.</p> <p>9. 8/18/23 – R12 was admitted to the facility. The facility was unable to provide any documentation of R12 or R12's resident representative being notified and signing off on the updated Resident Rights form.</p> <p>10. 6/9/21 – R13 was admitted to the facility. The facility was unable to provide any documentation of R13 or R13's resident representative being notified and signing off on the updated Resident Rights form.</p> <p>8/19/24 - During an interview, E14 (Travel DRC) stated, "We have updated the Resident Rights form on new admissions since 2023. But we need to get working on the established residents [to have the updated Resident Rights form signed by resident/resident representative]."</p> <p>8/26/24- A review of a sample facility's Residency Agreement, that each resident signs when admitted to the facility, revealed that Attachment B Resident's Rights was the outdated version of the Resident rights Act. The Act was updated in September 2023.</p> <p>8/20/24 – Findings were reviewed with E1 (ED) and E14 at the exit conference beginning at approximately 1:00 PM.</p> <p>Staffing</p>	
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<p>3225.16.0 3225.16.2 S/S E</p>	<p>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.</p> <p>State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties 2024...Post Fall Assessment & Documentation- RN..." Updated 4/10/24.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interviews and other facility documentation, it was determined that three (R1, R5 and R11) out of fifteen residents reviewed for Accidents, the facility failed to ensure that nursing services met professional standards as evidenced by having LPNs complete the post fall assessment and documentation for residents post fall which violates the Delaware State Board of Nursing Scope of Practice.</p> <p>Facility's policy "Fall Management and Investigation...fall means 'an unplanned descent to the floor with or without injury to the resident'... C. Post Fall Procedures: 1. The resident is evaluated immediately for visual injury by community staff or a nurse (if available); if deemed safe, the resident is assisted from the floor; community staff observe the resident and notify the nurse and healthcare provider...3. The DRC or designee assist staff to determine whether the resident requires transfer to the hospital or urgent care..." Effective date: 3/19/24. Findings include:</p>	<p>3225.16.0</p> <ol style="list-style-type: none"> 1. There were no residents negatively impacted by deficient practice. The facility will ensure that nursing services meet professional standards by having RNs complete the post fall assessment and documentation for resident's post fall to stay in compliance with the Delaware State Board of Nursing Scope of Practice. 2. All residents have the potential to be affected by this deficient practice. 3. All nursing staff will be in-serviced no later than 11/30/24. 4. The DHW or designee will perform post fall documentation by RN audits weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved. <p>Completion by 11/30/2024</p>

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	<p>1. 7/22/19 – R1 was admitted to the facility with diagnoses, including but not limited to dementia and difficulty walking.</p> <p>5/25/24 4:22 PM – E12 (LPN) documented on the facility's incident report titled Fall-Un-Witnessed, "...Nurse alerted of resident in another resident room. Resident lying on her right side on the floor next to the entrance door. Repositioned and assessed for pain and injury. (sic) in generalized pain. Unable to state specific site for pain. No swelling nor bumps noted nor open area. Resident assisted off the floor on a w/c (wheelchair). Tolerated all meds and care. Daughter and MD (medical doctor) notified. Will continue to assist. Resident unable to state how she fell...". Of note, May 25, 2024, was a Saturday.</p> <p>5/25/24 11:31 PM – E12 (LPN) documented an event note in R1's EMR stating, "...Nurse alerted of resident in another resident room. Resident lying on her right side on the floor next to the entrance door. Repositioned and assessed for pain and injury. (sic) in generalized pain. Unable to state specific site for pain. No swelling nor bumps noted nor open area. Resident assisted off the floor on a w/c. Tolerated all meds and care. Daughter and MD notified. Will continue to assist.</p> <p>This note was identical to the statement written in the facility's incident report.</p> <p>A review of R1's EMR lacked documentation of R1's assessment on the night shift of 5/25/24.</p>	
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Provider's Signature  Title  Date 10/10/24



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STATE SURVEY REPORT

NAME OF FACILITY: AL- Somerford Place

DATE SURVEY COMPLETED: August 20, 2024

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	<p>5/26/24 2:26 PM – E12 (LPN) documented a progress note in R1’s EMR stating, “...repositioned and assessed for pain and injury. In generalized pain. Unable to state specific site for pain. No swelling nor bumps noted nor open area. Resident assisted off floor on a w/c. tolerated all med and care. Daughter and MD notified (sic). Will continue to assist. VS (vital signs) 131/72, 71,17, 97.8 92% rma (room air), will continue to assist (sic).”</p> <p>This note mentioned assisting resident off floor again; however, there was no other documentation of a second fall.</p> <p>5/26/24 3:39 PM – E12 (LPN) documented a progress note in R1’s EMR stating, “... resident OOB (out of bed) via w/c. Poor PO (oral intake) and mostly head bent. Denies H/A (headache), dizziness but face gloomy. During care and assessment resident moaning in pain at every body touch. NP (nurse practitioner) informed and order obtained to send resident to ER (emergency room) for further evaluation. Daughters Dense (sic)notified and promising to join her at [hospital] ER. Resident left with paramedics to [hospital] with all paperwork. Nurse f/u (follow up) with ER and according to ER nurse, resident being admitted for possible ankle fracture. Will continue to assist.”</p> <p>8/19/24 9:20 AM – A review of R1’s EMR lacked evidence of documentation of a post fall assessment of R1 by an RN at anytime on 5/25/24 or 5/26/24.</p> <p>2. 7/19/19 – R5 was admitted to the facility.</p> <p>2/14/24 - Per EMR entry at 12:12 PM, E10 (LPN) noted that R5 “was ambulating in the</p>	

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	<p>common area without walker (sic) at a brisk pace looking for the BR (bathroom) when she lost balance and fell, landing on her left side. She was attempting to get up unassisted, ROM (range of motion) at baseline, denies pain". E10 noted "an abrasion on resident's left side of face under left eye area, (sic) cleansed with NSS (normal saline solution) and a small amount fresh bleeding noted, ice to area. Did not hit head. Daughter PCP notified to evaluate in AM. Daughter also aware". The post fall assessment was completed by E10, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p> <p>1/1/24 at 5:05 AM - the EMR entry by E12 (LPN) noted the resident was "observed (sic) on the hallway attempting to get up. Observed bleeding from the top of eye. The resident was examined for fall and injury. Top of left eye with small cut, steri-strips applied, and ice applied to left side of face". The post fall assessment was completed by E12, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p> <p>3. 4/17/24 - R11 was admitted to the facility.</p> <p>6/12/24 - Per EMR entry at 5:28 PM, E10 (LPN) noted that R11 was "found sitting on buttocks (sic) scooting across floor. R11 was assessed and assisted to recliner chair. R11's son, Physician and admin. (administration) and on-coming shift aware." The post fall assessment was completed by E10, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p>	
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Provider's Signature

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<p>3225.18.0</p> <p>3225.18.1</p> <p>S/S E</p> <p>3225.18.3</p>	<p>7/25/24 - Per EMR entry at 8:00 AM, E15 (LPN) noted at 7:00 AM, (sic) R11 "was found on the floor. R11 complained of right shoulder pain and right hip pain. Assisted off the floor into a wheelchair. R11's son, DRC and Physician were notified." The post fall assessment was completed by E15, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.</p> <p>8/20/24 – Findings were reviewed with E1 (ED) and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>Emergency Preparedness</p> <p>Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.</p> <p>Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a digital format and it must conform to the template prescribed by the Division. The all-hazard emergency plan must include plans to address staffing shortages and facility demands.</p> <p>This requirement was not met as evidenced by.</p> <p>Based on review of facility documentation, it was determined that the facility failed to have the Emergency Plan Manual contain some of the required elements in the Plan. Findings include:</p>	<p>3225.18.0</p> <p>1. There were no residents negatively impacted by deficient practice community, names and contact information for resident physicians and Office of the State LTC Ombudsman will be added to comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.</p> <p>2. All residents have the potential to affected by this deficient practice.</p> <p>3. All employees will receive emergency preparedness training as per regulatory requirements. Evacuation routes will be posted in a conspicuous place at each nursing station.</p> <p>4. The BOM or designee will perform employee file audits weekly x 4, bi-weekly x4 and monthly x1 until 100% compliance is achieved.</p> <p>Completion by 11/30/2024</p>

Provider's Signature

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<p>3225.18.4 S/S E</p>	<p>8/16/24 – In review of the facility’s Emergency Operations Manual, the Emergency Plan does not include names and contact information for resident Physicians and the Office of the State LTC Ombudsman.</p> <p>8/20/24 – Findings were reviewed with E1 (ED) and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview and review of other facility documentation, it was determined that five (E7, E8, E9, E11 and E13) out of seven employees’ training record review, the facility failed to provide evidence of the Emergency Preparedness education. Findings include:</p> <ol style="list-style-type: none"> 6/2/15 - E7 (LPN) was hired. The facility had no Emergency Preparedness training in evidence. 7/19/24 - E8 (CG) was hired. The facility had no Emergency Preparedness training in evidence. 11/1/23 - E9 (Housekeeping) was hired. The facility had no Emergency Preparedness training in evidence. 5/19/20 – E11 (Maintenance Tech) was hired. The facility had no Emergency Preparedness training in evidence. 	<p>3225.18.4</p> <ol style="list-style-type: none"> There were no residents negatively impacted by deficient practice community, names and contact information for resident physicians and Office of the State LTC Ombudsman will be added to comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction. E7, E8, E9, E11 and E13 will be in-serviced by 10/18/2024 All residents have the potential to affected by this deficient practice. All employees will receive emergency preparedness training as per regulatory requirements. Evacuation routes will be posted in a conspicuous place at each nursing station. The BOM or designee will perform employee file audits weekly x 4, bi-weekly x4 and monthly x1 until 100% compliance is achieved. <p>Completion by 11/30/2024</p>

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Title ES

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<p>3225.19.0</p> <p>3225.19.6</p> <p>S/S B</p> <p>3225.19.7</p> <p>3225.19.7.7</p> <p>3225.19.7.7.1</p>	<p>5. 4/3/24 - E13 (Cook) was hired. The facility had no Emergency Preparedness training in evidence.</p> <p>8/16/24 – Per interview with E2 (DRC) at approximately 1:00 PM, E2 confirmed the training was not in evidence.</p> <p>8/20/24 - Findings were reviewed with E1 (ED), and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>Records and Reports</p> <p>Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.</p> <p>Reportable incidents include:</p> <p>Significant injuries</p> <p>Injury from an incident of unknown source in which the initial investigation concludes that there is reasonable basis to suspect that the injury is suspicious. An injury is suspicious based on; the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time or the incidence of injuries over time.</p> <p>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.</p>	<p>3225.19.0</p> <p>1. There were no residents negatively impacted by deficient practice. All reportable incidents will be reported according to regulatory guidelines. E12 and E15, E16 have been educated on Reportable Events under Title 16 3225 19.6-19. E10 has been on leave of absence as of 9/3/2024 upon return will be in-serviced on Reportable Events. E30 has resigned from the facility as of 7/11/2024.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>3. All staff will be educated on reportable incidents timelines and guidelines by 11/30/2024</p> <p>4. The DHW or designee will perform audit on all state reportable incidents weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p> <p>Completion by 11/30/2024</p>

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<p>3225.19.7.7.2</p> <p>3225.19.7.7.10</p>	<p>Areas of contusion or laceration which may be attributable to abuse or neglect.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview, other facility documentation and State Agency Incident Reporting System reports, it was determined that for four (R1, R3, R6 and R12) out of fifteen residents reviewed for Accidents, the facility failed to report the incident to the State agency within the 8-hour time frame. Findings include:</p> <p>1. 7/22/19 – R1 was admitted to the facility with diagnoses, including but not limited to dementia and difficulty walking.</p> <p>5/25/24 4:22 PM – E12 (LPN) documented on the facility's incident report titled Fall-Un-Witnessed, "...Nurse alerted of resident in another resident room. Resident lying on her right side on the floor next to the entrance door. Repositioned and assessed for pain and injury. (sic) in generalized pain. Unable to state specific site for pain. No swelling nor bumps noted nor open area. Resident assisted off the floor on a w/c (wheelchair). Tolerated all meds and care. Daughter and MD (medical doctor) notified. Will continue to assist. Resident unable to state how she fell..."</p> <p>5/26/24 3:39 PM – E12 (LPN) documented a progress note in R1's EMR stating, "... resident oob (out of bed) via w/c. Poor PO (oral intake) and mostly head bent. Denies H/a (headache), dizziness but face gloomy. During care and assessment resident moaning in pain at every body touch. NP (nurse practitioner) informed and order obtained to</p>	
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	<p>send resident to ER (emergency room) for further evaluation. Daughters Dense (sic) notified and promising to join her at [hospital] ER. Resident left with paramedics to [hospital] with all paperwork. Nurse f/u (follow up) with ER and according to ER nurse, resident being admitted for possible ankle fracture. Will continue to assist."</p> <p>5/26/24 4:30 PM – R1 was assessed by the Forensic team nurse at [hospital] ER.</p> <p>5/27/24 4:14 PM – A search on the State's Incident Referral Center revealed that the incident of R1's unwitnessed fall was reported by E14 (Travel DRC).</p> <p>The time frame between the decision to send R1 to the hospital ER and the facility reporting it to the state agency was over 23 hours, which exceeds the mandated 8-hour time frame for reporting.</p> <p>2. 11/16/21 – R3 was admitted to the facility.</p> <p>7/17/24 – E17 (CG) documented on a facility witness statement, "7/17/24 5:00 AM This morning I went to [room] R3 (sic) to change her and I notice (sic) there was an injurie (sic) (swollen) (sic) on her forehead, so I went to the nurse [E15] to report to her."</p> <p>7/17/24 7:12 AM – E15 (LPN) documented an event note in R3's electronic medical record (EMR), "...@0500AM, this nurse was notified the (sic) care giver that there is a lump on the resident's forehead above the right (sic) eye. Resident unable to describe how the lump on the forehead happened. POA – [FM1] was notified. [Hospice] was notified. DRC was notified. Vital signs obtained, WNL</p>	

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	<p>(within normal limits). Nursing will continue to monitor.”</p> <p>7/17/24 4:44 PM – E10 (LPN) documented in a progress note in R3’s EMR, “...assessed d/t (due to) report of lump head UKO (unknown origin) resident noted with bruising left periorbital area and lump to left forehead...Aware resident was very restless last PM (sic) walking about unit repeatedly without walker and in stocking feet...”.</p> <p>7/17/24 8:37 PM – E16 (LPN) documented in progress note in R3’s EMR, “...Resident continues with the lump to her left side of her forehead and bruising to her left eye...Resident continues at her baseline at this time...”.</p> <p>8/19/24 10:30 AM – During a telephone interview, FM1 stated that she had visited R3 in the afternoon (after lunch but before dinner) on Tuesday, July 16th, 2024 and stated, “She [R3] was fine. Then around 5:45 AM on July 17th, I got a phone call from the [facility] stating that R3 had a bump on her head that was found when the aide went in to give her care. No one knew how she got the lump. I asked if she fell and they said ‘no.’ I told them if she had fallen, she would not have been able to get up on her own.”</p> <p>8/19/24 11:31 AM – During an interview, E14 confirmed that the facility did not have documentation to prove that R3’s injury of unknown origin had been reported to the state agency.</p> <p>8/19/24 1:35 PM – During an interview, E2 (DRC) stated, “I did not report to the State. I reported her injury to Hospice so they could tell us what they want done next...”.</p>	
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	<p>8/21/24 3:14 PM – A search of the State’s Incident Referral Center failed to produce any evidence of R3’s injury reported by the facility.</p> <p>3. 6/13/23 - R6 was admitted to the facility.</p> <p>1/27/24 – Per EMR entry at 7:13 PM, E10 (LPN) noted R6 (sic) “was leaving the dining room, yelled out and was found lying on her back on the floor. Neuro checks were completed. The Physician requested R6 to be evaluated in the ER, but the son declined and decided to come to the facility and take her there himself.” Per entry at 9:27 PM by E10, the son took R6 to the ER. Per the ER discharge report, R6 was treated for a fall with head injury. The facility reported this fall on 1/30/24 along with the 1/25/24 fall, over the mandatory 8 hour requirement.</p> <p>1/25/24 – Per EMR entry at 2:54 PM, E10 (LPN) noted R6 (sic) “was ambulating through the dayroom and fell forward landing on her face and belly to floor. Physician and son were notified and R6 was transported to the ER. Per the ER discharge report, R6 was treated for a fall with subdural bleeding. The facility reported this fall on 1/30/24 along with the 1/27/24 fall, over the mandatory 8 hour requirement.</p> <p>8/19/24 – A review of the State Incident Reporting System had no evidence of these incidents being reported or reported timely. The facility failed to provide evidence of these injuries to the State within the mandatory 8 hours of the incident.</p> <p>4. 8/18/23 - R12 was admitted to the facility. Per EMR entry on 12/1/23 at 5:50 PM,</p>	
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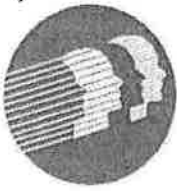
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<p>Title 16 Delaware Code Chapter 11 Sub-chapter III Abuse, Neglect, Mis-</p>	<p>E30 noted that R12 "was sitting at the dining room table when another resident approached (sic) and hit R12 in the face resulting in swelling and redness to her left cheekbone. R12 complained of face pain and was visibly upset. Ice was applied. R12's Physician was notified, and an x-ray was ordered." X-ray report indicated no acute fracture, no joint dislocation, unremarkable soft tissue, nasal bones intact with no displaced fracture.</p> <p>8/19/24 – A review of the State Incident Reporting System had no evidence of this resident-to-resident altercation being reported. The facility failed to provide evidence of these injuries to the State within the mandatory 8 hours of the incident.</p> <p>8/20/24 – Findings were reviewed with E1 (ED) and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p> <p>12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:</p> <p>a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for one (R1) out of fifteen sampled residents reviewed for accidents, the facility failed to provide appropriate assessment and services in a timely manner</p>	<p>Title 16 Delaware Code Chapter 11 Sub-Chapter III Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206 31; 83 Del. Laws, c. 22, 1.)</p> <p>1. Facility unable to determine if harm was caused to R1. E12 will be educated on providing appropriate services and notification in a timely manner after a resident incident to avoid delay in care by 10/18/2024. E7 resigned from facility as of 9/12/2024.</p> <p>2. All residents have the potential to affected by this deficient practice.</p> <p>3. All staff will be educated on providing appropriate services and notification in a timely manner after a resident incident to avoid delay in care by 11/30/2024.</p> <p>4. The DHW or designee will perform audit on all resident incidents weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.</p> <p>Completion by 11/30/2024</p>
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Provider's Signature [Signature]

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<p>treatment, Financial Exploitation, or Medication Diversion of Patients or Residents. (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)</p> <p>S/S G</p>	<p>after resident falls which resulted in a delay in medical care. Findings include:</p> <p>1. 7/22/19 – R1 was admitted to the facility with diagnoses, including but not limited to dementia and difficulty walking.</p> <p>2/14/24 1:15 PM – R1's UAI–indicated that R1 had severe confusion, was nonverbal and required constant redirection and monitoring due to her severely impaired decision-making capabilities. The UAI also documented that the staff will observe R1 for non-verbal signs/symptoms of pain e.g., crying, moaning, decrease in functional abilities due to her inability to report pain verbally.</p> <p>5/25/24 4:22 PM – E12 (LPN) documented in the facility's incident report titled Fall-Un-Witnessed, "...Nurse alerted of resident in another resident room. Resident lying on her right side on the floor next to the entrance door. Repositioned and assessed for pain and injury. (sic) in generalized pain. Unable to state specific site for pain. No swelling nor bumps noted nor open area. Resident assisted off the floor on a w/c (wheelchair). Tolerated all meds and care. Daughter and MD notified. Will continue to assist. Resident unable to state how she fell...".</p> <p>R1's clinical records lacked evidence that the physician was informed of the pain, and of any interventions including medications or non-pharmacological interventions.</p> <p>5/25/24 11:31 PM – E12 (LPN) documented an event note in R1's EMR stating, "...Nurse alerted of resident in another resident room. Resident lying on her right side on</p>	

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	<p>the floor next to the entrance door. Repositioned and assessed for pain and injury. (sic) in generalized pain. Unable to state specific site for pain. No swelling nor bumps noted nor open area. Resident assisted off the floor on a w/c. Tolerated all meds and care. Daughter and MD notified. Will continue to assist.</p> <p>This note was identical to the statement written in the facility's incident report.</p> <p>R1's clinical records lacked evidence of pain management interventions.</p> <p>A review of R1's EMR lacked documentation of R1's assessment on the night shift of 5/25/24.</p> <p>5/26/24 2:26 PM – E12 (LPN) documented a progress note in R1's EMR stating, "...repositioned and assessed for pain and injury. In generalized pain. Unable to state specific site for pain. No swelling nor bumps noted nor open area. Resident assisted off floor on a w/c. tolerated all med and care. Daughter and MD notified (sic). Will continue to assist. VS (vital signs) 131/72, 71,17, 97.8 92% rma (room air), (sic) will continue to assist (sic)."</p> <p>This note mentioned assisting resident off floor again; however, the facility was unable to provide the surveyor with documentation of a second fall.</p> <p>R1's clinical records again lacked evidence that the physician was informed of the resident's pain and that pain management interventions were implemented.</p>	
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Provider's Signature [Signature]

Title EO

Date 10/10/24



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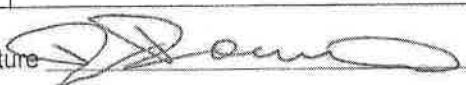

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: AL- Somerford Place

DATE SURVEY COMPLETED: August 20, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES
	<p>5/26/24 3:39 PM – E12 (LPN) documented a progress note in R1’s EMR stating, “... resident oob (out of bed) via w/c. Poor PO (oral intake) and mostly head bent. Denies H/A (headache), dizziness but face gloomy. During care and assessment resident moaning in pain at every body touch. NP (nurse practitioner) informed (sic) and order obtained to send resident to ER for further evaluation. Daughters Dense (sic) notified and promising to join her at [hospital] ER. Resident left with paramedics to [hospital] with all paperwork. Nurse f/u (follow up) with ER and according to ER nurse, resident being admitted for possible ankle fracture. Will continue to assist.”</p> <p>The facility failed to provide pain relief to R1 after her fall despite evidence of pain, “moaning in pain at every body touch,” from 5/25/24 to 5/26/24 at 3:39 PM for a total of 23 hours.</p> <p>The facility failed to provide goods (pain medication) that were necessary for R1 to avoid mental anguish.</p> <p>A review of R1’s EMR lacked evidence that R1 was assessed by a RN at any point on 5/25 or 5/26/24 after the fall on 5/25 at 4:22 PM while in the facility.</p> <p>The facility failed to have R1 assessed by an RN after a fall on 5/25/24 at 4:22 PM. R1 was observed with signs/symptoms of pain and was sent emergently to the hospital on 5/26/24 at 3:39 PM (twenty-three hours later), where she was diagnosed with right hip and lumbar vertebrae fractures.</p> <p>8/20/24 10:30 AM – E14 (Travel DRC) stated, “I already sent an email to my</p>	

Provider's Signature  Title  Date 10/10/24



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	<p>nurses, effective immediately, that all falls are to be sent to the ER unless they are assessed by RN immediately after the fall."</p> <p>c. Failure to carry out a prescribed treatment plan for a patient or resident safety.</p> <p>(39) Each resident has the right to compliance with the resident's advance health-care directive, power of attorney, Delaware medical Orders for Scope of Treatment, or similar document in accordance with and subject to Chapter 49 of Title 12 and Chapter 25 of this title.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and interview, it was determined that for one (R2) out of fifteen residents reviewed for resident rights, the facility failed to ensure R2's end-of life directive was honored when R2 had a cardiac arrest on 1/6/24. Findings include:</p> <p>8/1/23 - The facility's Emergency Response/CPR policy... provides guideline on responding to emergency situation and initiating Cardiopulmonary Resuscitation ("CPR") where indicated and necessary... if the resident has a Do Not Resuscitation Order ("DNR") or other applicable advance directive on file at the community, the DNR or advance directive will be followed."</p> <p>12/16/16 - R2 was admitted to the facility with diagnoses, including but not limited to, dementia and bipolar disorder.</p> <p>12/16/16 - FM2 (R2's POA) signed the facility's "Preferred Intensity of Medical care</p>	<p>(39)</p> <ol style="list-style-type: none"> 1. Facility was unable to determine if harm was caused. A facility audit was performed and responsible parties for residents who did not have a DMOST on file were contacted. The DMOST Form was explained with potential impact if not completed to abide by resident wishes. DMOST binder created with all completed forms and placed in an all staff accessible area. 2. All residents have the potential to affected by this deficient practice. 3. All residents upon admission will have a DMOST completed as part of the admission process. All staff will be in serviced by 11/30/2024. 4. The DHW or designee will perform DMOST audit weekly x 4, biweekly x4 and monthly x1 until 100% compliance is achieved.
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Completion by
11/30/2024

Provider's Signature [Signature]

Title ED

Date 10/10/24



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	<p>and Treatment" form stating that R2's choice was a Do Not resuscitate (DNR).</p> <p>6/6/21 - R2's service plan documented R2's Advanced Directives/ Code Status with the goal of having "my wishes for end of life/resuscitation measures" honored and interventions stating, "I request a DNR status, and a physician order has been obtained from my physician."</p> <p>1/6/24 1:49 PM - The [local Paramedic unit] prehospital report stated that "911 was called and dispatched Emergency Medical Services" to the facility after receiving a call that R2 was having difficulty breathing. The call was then upgraded to CPR.</p> <p>1/6/24 1:59 PM – [Paramedic] prehospital care report documented, "...On ALS (advance life support) arrival, BLS (basic life support) reported that there was a DNR but the staff was unable to locate it due to there being 'no nursing staff' working. BLS and ALS resuscitative efforts were continued due to no physical paperwork.. The pt (patient) was placed on the cardiac monitor and found to be in asystole...During this time, the pt's daughter showed up on the scene. An in-house DNR had been found but it was not a valid MOLST (medical orders for life-sustaining treatment) form and it had a date of 2016. DFES 638 was contacted on behalf of the daughter's request who was power of attorney. DFES honored the daughter's request for termination of services. T.O.D (time of death) was 2:16 PM...".</p> <p>8/26/24 10:34 AM –During a telephone interview, E23 (caregiver) stated, "...Sometimes on weekends we [locked dementia unit] don't have a nurse. We had to call a</p>	

Provider's Signature [Signature] Title E23 Date 10/10/24



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	<p>nurse to come from [the other facility on the campus]... Caregivers do not have access to the orders in the computer.”</p> <p>8/26/10:49 AM – During a telephone interview, E21 (caregiver) stated, “...The DNR is documented in the computer, which only the nurses have access to, in the medication book that the nurses and med techs have access to and on the spine of the green hard (paper) charts that are in the nurse’s station. We don’t always get a report at the change of shift, so you have to find out their code status for yourself, and you have to run up the hall to the nurse’s station to look at the hard chart.... But you have to run up the hall to the nurse’s station to look at the hard chart...I was in the middle of doing CPR. We did not have nurse on the floor. An LPN came over from [the other facility on the campus].</p> <p>E2 also stated, “While I was doing CPR, the resident started to have blood come from her mouth. I also could feel her ribs cracking...it was terrible. Once EMS got there, I left and went outside...The MOD (manager on duty) was E4 (Business/HR Director), the business manager. E4 does not have any clinical background. I believe there was a nurse on-call, but she was not in the building so how is she going to help during a [medical] emergency?”</p> <p>8/20/24 1:45 PM – During a telephone interview, FM2 (R2’s daughter and POA) stated, “I received a call from the facility that my mother was unresponsive. I arrived at the building about 15 minutes later and the paramedics were performing CPR on her. She was on the floor in the TV room. I</p>	
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Provider's Signature 

Title E21

Date 10/10/24



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	<p>repeatedly asked them to stop because she was a "DNR". The paramedics stated that the DNR had expired and continued performing CPR for another 10 minutes. I am sure every rib in her body must have been broken. There was a DNR in place so that this type of incident would not happen."</p> <p>The facility failed to honor R2's end of life order requesting no resuscitation in the event of a cardiac arrest. The facility failed to have staff adequately trained to regarding the location of R2's DNR order.</p> <p>8/20/24 – Findings were reviewed with E1 (ED) and E14 (Travel DRC) at the exit conference beginning at approximately 1:00 PM.</p>	

Provider's Signature [Signature]

Title ED

Date 10/10/24

