DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Lodge Lane Assisted Living and Memory Care **DATE SURVEY COMPLETED:** October 18, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from October 14, 2024, through October 18, 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 sixteen (16) residents. Abbreviations/definitions used in this State Report are as follows: DON – Director of Nursing; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; 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 pro-vides. 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 re-quired to use the UAI to evaluate each resident on both initial and ongoing basis in accordance with these regulations; **Title 16 Health and Safety** **Division of Health Care Quality**		

Provider's Signature Title Friedrich E. Hill Date 01/02/2025

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3225.0 3225.5.9 3225.5.9.12 3225.5.9.13 S/S - D	**Assisted Living facilities.** **An assisted living facility shall not admit, provide services to, or permit the provision of services to individuals who, as established by the resident assessment:** **Exhibit behaviors that present a threat to the health or safety of themselves or others, such that the assisted living facility would be unable to eliminate the threat either through immediate discharge or use of immediate appropriate treatment modalities with measurable documented progress within 45 days; and** **Are socially inappropriate as determined by the assisted living facility such that the facility would be unable to manage the behavior after documented, reasonable efforts such as clinical assessments and counseling for a period of no more than 60 days.** This requirement was not met as evidenced by: Based on interview, review of facility records and other documentation as indicated, it was determined that for one (R10) out of one resident sampled for behaviors, the facility failed to ensure that residents who exhibit behaviors do not present a threat to the health and safety of other residents and staff. Findings include: 12/15/23 – A Uniform Assessment Instrument (UAI) was completed by E2 (RN) which indicated that R10 had no behaviors.	**3225.5.9.12 & 3225.5.9.13** 1. Multiple attempts were made to coordinate a meeting with the family of R10 to discuss the need for a 1:1 private sitter or a discharge plan. On 11/1/24 the family agreed to a short-term 1:1 private sitter, however the agency could not meet until 11/4/24. Therefore, the Nursing department scheduled an additional aide for the Memory Care unit at Lodge Lane moving forward. The family requested another Memory Care facility accept the resident and the facility requested records and scheduled an assessment of the resident. Also, on 11/1 that facility's personnel assessed the resident and rejected his transfer. On 11/3 there was another incident between R10 and a resident. On 11/4 the family canceled a meeting with the facility. On 11/5/2024 R10 was removed from the facility by the family and taken to a hospital outside of Delaware without notice to the facility or discussion with his PCP, the resident's physician at Lodge Lane. A formal 30-day discharge notice was issued at this time. The family removed all resident belongings on 11/10/2024 and fully vacated the room. No infor-	02/01/2025

Provider's Signature Title Felicia E Ade Date 01/02/2025

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	12/21/23 – R10 was admitted to the secured memory care section of the facility with multiple diagnoses including dementia. 1/25/24 – A thirty-day update to the 12/15/23 UAI documented that R10 had behaviors and that his "medications were not working at the time." Review of facility documents indicated that the facility started discussions in mid-February 2024 with R10's family regarding the best place of residence for R10 considering his behaviors, and the safety of other facility memory care residents. The facility documents do not describe a final solution to R10's behavioral issues. Review of nursing progress notes and aide care flow sheets revealed the following timeline of R10's behavioral issues: 2/1/24 11:00 PM -7:30 AM – R10 Exit seeking all night, refusing to sit down. 2/11/24 3:00 AM – R10 found outside room without clothes below waistline. Staff attempted to help R10 get dressed and he became combative by swinging arms and legs. 4/18/24 3:00 PM – 11:00 PM – R10 attempted to go into other resident rooms, and then went into the closet of a resident room. 4/20/24 3:00 PM – 11:00 PM – Resident combative with staff, going into other resident rooms, and exit seeking from memory care unit door.	mation was provided to the facility regarding the resident's disposition upon discharge from the hospital outside of Delaware. 2. There are no other residents who exhibit behaviors that present a threat to the health and safety of other residents and staff. 3. RCA: The Lodge Transfer, Discharge, Readmission Rights Policy did not include specific language on discharging residents with unmanaged behaviors that present a threat to the health and safety to other residents and staff after reasonable efforts for more than 60 days. The policy was updated to include specific language. CEO will educate Administration Team. 4. CEO (or designee) will conduct audits of residents with behaviors present a threat to the health and safety of other residents and staff weekly x 3 to ensure that residents are discharged after reasonable efforts for more than 60 days until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

Provider's Signature Title Executive Director Date 01/02/2025

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	5/2/24, 6/8/24 and 7/5/24 7:00 AM – 3:00 PM – R10 observed attempting to enter other resident rooms. 7/29/24 8:30 AM – R10 exited room without shirt and refused to put shirt on; began to wander around the unit and attempted to enter other resident's rooms. 7/30/24 10:45 AM - R10 threatened to hit another resident with a raised right hand if the staff "did not get her out of here." 8/2/24 12:30 PM – R10 pacing around unit stating that he wanted to leave. Staff attempted to provide needed personal care, R10 began to swing at aide. 8/8/24 7:30 AM – R10 aggressive verbally and physically to staff. Aide told nurse that R10 attempted to hit another resident, but that aide intervened to prevent the aggressive behavior. 8/14/24 8:00 AM – R10 came out of his room with no pants, difficult to be redirected by staff. 8/18/24 2:20 PM - R10 exit seeking by attempting to enter resident room doors. Most residents now have their rooms locked to prevent R10 from attempting to enter. 8/25/24 2:30 PM – R10 agitated with staff from their reminders to use walker and staff redirection efforts.		

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	9/6/24 2:20 PM – R10 attempting to open resident room doors to exit, also with agitated mood after lunch. 9/7/24 8:00 PM – R10 with increased anxiety with verbal aggression directed at staff. Attempts made to enter other residents' rooms. 9/22/24 6:00 PM – R10 went into another resident's room, upsetting the other resident. 9/26/24 6:45 AM – R10 wandering the unit, threatening staff both verbally and physically. 9/28/24 10:00 AM late report from 9/26 – R10 very agitated with staff; residents remained in their rooms for their safety. 10/4/24 – R10 agitated and threatened to "bust out windows if you don't let me out of here". 10/7/24 1:30 PM – R10 was agitated and cursing at staff. 10/8/24 – 12:05 PM – R10 agitated, exit seeking, banging on other residents' doors. 10/10/24 10:20 AM – R10 checking all resident room doors, states that he needs to get out. 10/14/24 10:20 AM – R10 observed to attempt to open locked resident room doors. 10/18/24 10:00 AM - R10 observed to attempt to open locked resident room doors.		

Provider's Signature Title Felisha E Hall Date 01/02/2025

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	Heard cursing under his breath when the doors would not open. 10/18/24 10:30 AM – During an interview E7 (CNA) stated that the resident room doors are locked to prevent R10 from attempting to enter other resident rooms. E7 stated that each room door can be opened from the inside by the resident and that all staff members on the memory care unit have keys to the resident room doors. R10 continues to reside in the facility's memory care unit and continues to exhibit aggressive and sometimes violent behaviors that impact the rights and safety of the other residents in the memory care unit. The residents in the facility memory care unit need to keep their room doors locked to prevent R10 from entering their rooms. R17 moved the location of her room in the memory care unit because of R10's actions when he entered her room without her permission and created a stressful situation for her. Facility staff are in safety danger as evidenced by R10's documented aggressive behaviors toward the staff. 10/18/24 at 3:20 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and a representative with the Ombudsman's Office.		
3225.8.0 **3225.8.1.5** **3225.8.1.5.3**	**Medication Management** **Provision for a quarterly pharmacy review conducted by a pharmacist which shall include:**	**3225.8.1.5.3** 1. Resident no longer at facility, unable to correct. 2. All residents with allergies have potential to be affected. Initial Audit of all residents for Medica-	02/01/2025

Provider's Signature Title Patricia L. Hall Date 01/02/2025

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S/S - D	**Review of each resident's mediation regimen with written reports noting any identified irregularities or areas of concern.** Based on record review and interview, it was determined that for one (R5) out of four residents reviewed for medication administration, the facility failed to identify a documented Plavix allergy in the clinical records. R5 was ordered Plavix and received the medication during his entire stay at the facility. Findings include: 12/29/22 – C1 (MD) completed R5's facility Resident Health History/Physician Assessment, which was required for admission to the assisted living facility. 1/9/23- R5 was admitted to the facility. 9/30/23 – R5 was transferred to [hospital] and passed away. 10/18/24 11:10 AM - Review of R5's Admission Record (face sheet) revealed C1 (MD) as primary physician while at the facility. 10/18/24 11:15 AM - Review of R5's Resident Health History/Physician Assessment revealed, "Iodine/Crestor/Plavix" handwritten in the Allergies block and "...Plavix 75 mg (milligrams) QD (every day) ISCH.CM (ischemic cardiomyopathy)" handwritten under the name of medication, dosage, reason columns. This documented was signed by C1 on 12/29/22. 10/18/24 11:20 AM – A review of R5's chart revealed Physical Order sheets dated January 2023, February 2023, April 2023, May	tions Ordered and documented Allergies will be completed by the DON (or designee). 3. RCA: The Pharmacy Consultant stated that at the time of the first Quarterly Drug Regimen Review (DRR) the resident had been receiving Plavix for 6 weeks at the facility, tolerating it well without any issues. Therefore, there was no comment to the Physician to "evaluate resident's tolerability to Plavix with a noted Plavix allergy" since the resident was already tolerating it for an extended period of time." On 11/5/2024, the Director of Nursing contacted C1's (resident's primary physician's) office which stated they do not have the Plavix allergy documented for that resident, and if the doctor did write it on the History and Physical paperwork that he completed, most likely it was a mistake. There is no DRR pharmacy consultant policy at Lodge. A policy was created which includes specific language to review and document all allergies to ensure no medications being prescribed contain that mediation, even in cases when it is tolerated by the resident. CEO will educate Pharmacy Consultant on updated Policy. 4. Director of Nursing (or designee) will conduct audits of DDR quarterly x 3 to ensure that any medications ordered or received with	

Provider's Signature Title Director of Nursing Date 01/02/2025

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	2023, August 2023, and September 2023, that documented, "Plavix 75 mg PO (by mouth) daily." It should be noted that the January 2023 and February 2023 Physician Order sheets were handwritten. The April 2023, May 2023, August 2023 and September 2023 Physician Order sheets were computer generated and also contained "Clopidogrel tab 75 mg for Plavix 1 tablet by mouth once daily (Afib)" order. These four documents also stated, "Allergies: Plavix, iodine-131, Crestor, tositumomab." The surveyor was not able to find copies of the Physician Orders sheets for the months of March 2023, June 2023 and July 2023. 10/18/24 11:30 AM – Review of R5's Medication Administration Records (MAR) revealed nurses signed off administering the Plavix daily for the nine months that R5 was a resident of the facility. 10/18/24 11:40 AM – Review of R5's progress notes did not provide any documentation of any clarification regarding R5's documented Plavix allergy with R5, his family, his primary care provider or the pharmacy. 10/18/24 11:50 AM – During an interview, E1 (NHA) stated while reviewing R5's chart, "I don't see any documentation about his (R5's) Plavix allergy." 10/18/24 11:56 AM -During a telephone interview, C2 (consultant pharmacist) stated that he did not recall any irregularities regarding R5 and Plavix in his quarterly pharmacy review, but he was in another facility	allergies are documented until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee quarterly x 3 to ensure compliance is obtained and maintained.	

Provider's Signature Title Finishes L Adl Date 01/02/2025

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	and would check his records when he was back at his office and get back to the surveyor. 10/18/24 12:03 PM – Review of the [pharmacy consultants] handwritten irregularities report for R5 revealed R5's medication regimen reviews (MRR) occurred on 2/21/23, 5/24/23 and 8/23/23. At each of these MRR reviews, there was no mention of the irregularity on R5's chart regarding a documented Plavix allergy and R5 being ordered to receive Plavix 75 mg by mouth daily for ischemic cardiomyopathy. 10/18/24 3:20 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and a representative with the Ombudsman's Office.		
3225.8.8.2 **S/S - D**	**Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;** Based on observation, interview, and record review, it was determined that for one (R8) out of two residents reviewed for medication administration, the facility failed to ensure that R8 received the correct insulin per physician's orders. Findings include: Review of R8's clinical records revealed: 5/8/23 – R8 was admitted to the facility with diagnoses including diabetes and Alzheimer's Disease. 6/20/24 – A facility incident report submitted to the Division documented, "The nurse	**3225.8.8.2** 1. Nurse was educated on 6/19/2024 by Staff Developer and instructed to obtain a 2nd nurse witness when administering any subsequent insulin injections. 2. Medication Administrations in the past cannot be corrected. 3. RCA: Nurse reported that she was distracted with discussions of other medications at the time of assisting with administration and failed to perform the Right Medication check against the Medication Administration Record (MAR). Nurse reported she did not check the medication label to ensure the correct medication was	02/01/2025

Provider's Signature Title Trisha L. Hill Date 01/02/2025

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	reports being distracted...the resident received the wrong medication...the insulin pen belonged to someone else." 10/15/24 10:15 AM – A review of R8's clinical records revealed that she was ordered 32 units of Novolog mix 70/30 (short acting insulin.) On 6/13/23 at 5:00 PM, R8 incorrectly received 32 units of Basaglar (long-acting insulin.) This insulin error required R8's blood glucose levels to be monitored hourly by the nursing staff till 8:00 AM the next morning (6/14/24.) The blood glucose levels remained about 200. 10/15/24 10:30 AM – During a telephone interview F1 (R8's daughter) stated, "My mother had received a cortisone injection, and I was worried that her blood sugar would be high. I kept checking to make sure that it did not get high." 10/15/24 11:00 AM – During an interview, E2 (DON) stated, "The nurse gave the resident [R8] the wrong insulin pen. We have educated her on verifying medications before administering it." 10/15/25 11:30 AM- During an interview, the surveyor asked E1 (NHA) what interventions were implemented to prevent the medication error from happening again. E1 stated, "The nurse was educated on medication administration rights." The surveyor asked E1 whether the rest of the nursing staff was educated on this medication error. E1 stated, "Yes", The facility failed to provide evidence that any of the other nurses were educated on this medication error.	being administered. Staff Developer re-educated the nurse on performing Medication Checks against the MAR, and performing the five rights of medication administration (right resident, right medication, right dose, right time, and right route of administration) and on decreasing distractions while administering medications. Staff Developer (or designee) will educate nursing staff on performing the Right Medication check against the MAR, including the five rights above and on distraction elimination during medication pass. 4. Director of Nursing (or designee) will conduct audits of insulin administration daily x 3 to ensure that the resident receive the correct insulin until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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	The facility failed to ensure that R8 received the correct insulin per physician's orders. 10/18/24 at 3:20 PM – Findings were reviewed with E1 (NHA) and E2 (DON) and a State of DE Ombudsman (via telephone) during the Exit Conference.		
3225.12.0 **3225.12.1** **3255.12.1.3** **S/S - F**	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** **3-501 Temperature and Time Control 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54°C (130°F) or above.** **8-403.10 (5) Documenting Information and Observations** **Failure of the person in charge to provide records required by the regulatory authority for determining conformance.** Based on observations, interview, and review of other facility documentation it was	**3255.12.1.3** A. Temperature logs were not maintained. 1. Unable to correct in the past. 2. Logs cannot be corrected in the past. 3. RCA: Knowledge Deficit on the part of the Food Service Director (FSD), per previous State Surveyor who stated that the temperature logs only pertained to CMS facilities. FSD educated on temperature log documentation by NHA. FSD will educate cooks related to maintaining the meal temperature logs 100% of the time. Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19 of the Delaware Food Code, and except as specified under ¶ (B) and in ¶ (C) of this section of the Delaware Foode Code, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a	02/01/2025

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	determined that the facility failed to comply with the Delaware Food Code. Findings include: 10/14/24 - During the survey of the facility at approximately 1:00 PM, records of temperature monitoring were not consistently being maintained to verify that safe food temperatures were being maintained in order to prevent food borne illness of highly suspectable residents. For the month of July 2024, 39% of meal temperatures were not documented. 10/14/24 – During an interview with E6 (Director of Dietary Services), at approximately 1:45 PM, E6 confirmed the findings.	temperature and for a time specified in ¶ 3-401.11(B) of the Delaware Food Code or reheated as specified in ¶ 3-403.11(E) of the Delaware Food Code may be held at a temperature of 54°C (130°F) or above; or (2) At 5°C (41°F) or less. (B) EGGS that have not been treated to destroy all viable Salmonellae shall be stored in refrigerated EQUIPMENT that maintains an ambient air temperature of 7°C (45°F) or less. 4. Food Service Director (or designee) will conduct audits meal temperature logs daily x 3 to ensure completion until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
	4-603.14 Wet Cleaning. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be effectively washed to remove or completely loosen soils by using the manual or mechanical means necessary such as the application of detergents containing wetting agents and emulsifiers; acid, alkaline,	**4-603.14** 1. The Ice Machine in the Memory Care Unit was corrected on 10/24/2024 by appliance vendor EMR. 2. All Ice machines have potential to be affected. Initial audit	02/01/25

Provider's Signature Title Finishes Exec Date 01/02/2025

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	or abrasive cleaners; hot water; brushes; scouring pads; high-pressure sprays; or ultrasonic devices. 10/14/24 – During the survey of the facility at approximately 12:30 PM, calcium build up was observed on the ice machine in the memory care unit. 10/15/24 – Findings were confirmed with E1 (Executive Director) at approximately 1:30 PM. 10/17/24 at 3:20 PM – Findings were reviewed with E1 (NHA), E2 (DON) and a State of DE Ombudsman (via telephone) during the Exit Conference.	was completed on10/24/2024 by appliance vendor EMR and necessary corrections completed. 3. RCA: The appliance vendor EMR contracted for inspections/cleaning of the ice machines quarterly had not been to the facility since 04/1/2024. When contacted, they stated the account manager had changed and they were working on getting those accounts reassigned. EMR inspecting appliances (including ice machines) was not listed on the Safety Inspection Schedule and it has been added. On 10/24/2024 EMR trained the facility maintenance staff on cleaning and sanitizing the ice machines. EMR will service the ice machines every six months, and facility maintenance staff will check ice machines monthly and clean as necessary. 4. Maintenance Director (or designee) will conduct audits of ice machines monthly x 3 to ensure that there is no calcium buildup until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

Provider's Signature Title Executive Director Date 01/02/2025

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3225.19.0 **3225.19.3** **3225.19.7** **3225.19.7.7** **3225.19.7.7.2** **S/S - D**	**Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Significant Injuries** **Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.** Based on record review and interview, it was determined that for one (R5) out of three residents sampled for falls, R5 the facility failed to report to the State agency R5's fall on 9/29/23, which required transfer to the hospital for an evaluation. Findings include: 1/9/23- R5 was admitted to the facility. 9/29/23 10:30 AM - E7 (LPN) documented an Event Statement in R5's medical record stating, "Resident was in the bathroom attempting to clean himself after an incontinence of bowel episode. [Family member] came in for a visit. Heard resident fall. Resident lost balance falling backwards hitting head on the right side. No visible bruising seen. Right lower gum bleeding. C/O (complaint of) left buttock pain. [Family member's name] present. Call placed to PCP (primary care provider). Call returned by [E8] N.P. (nurse practitioner). Send to ER (emergency room) for	**3225.19.7.7.2** 1. R5's Fall does not need to be reported as it was reviewed during survey and there is no need to trigger another triage, per the State Survey Agency. 2. All Falls with injury requiring transfer to the hospital for evaluation have potential to be affected. Initial Audit of all Falls in the past quarter requiring Transfer to the hospital to ensure they were reported to the State Agency will be completed by the Director of Nursing. 3. RCA: The nurse reported that she did not call 911, the daughter transported the resident, therefore she did not realize she had to complete the Report. The resident fell again the next day, which was reported. Staff Developer (or designee) will educate nursing staff on the State Reportables Policy, instructing that it does not matter who calls for the provider or 911, or who transports the resident to the hospital after a fall. The fall still needs to be reported. 4. The Director of Nursing (or designee) will conduct audits of all falls daily x 3 to ensure a State Reportable is completed for those who require transfer to the hospital for an evaluation until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will	02/01/2025

Provider's Signature Title Felisha L Hall Date 01/02/2025

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	eval. (evaluation). Resident taken by private car by [family member] to hospital [name of hospital], left about 12:00 PM." 9/29/23 2:26 PM – [Hospital name] Emergency Department "After Visit Summary" documented R5's visit for "head injury, initial encounter, Back strain, initial encounter." 10/18/24 10:45 AM – During an interview regarding R5's fall on the morning of 9/29/23, E1 (NHA) stated, "We did not report it." 10/18/24 3:20 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and a representative with the Ombudsman's Office.	continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
3225.19.7.7.5 **S/S - D**	**Medication error or omission which causes or prolongs the resident's discomfort, jeopardizes the resident's health or safety, or requires periodic reassessment of the resident's clinical status by facility professional staff.** Based on record review and interview it was determined that the facility failed to report timely to the State Agency a medication error that required periodic reassessment of the resident by professional staff. Findings include: Review of R8's clinical records revealed: 5/8/23 – R8 was admitted to the facility with diagnoses including diabetes and Alzheimer's Disease.	**3225.19.7.7.5** 1. Medication Error was reported on 6/20/24 (6 days late) after multiple emails with DHCQ to ascertain whether a state reportable report needed to be completed. 2. All residents with medication errors have potential to be affected by timely reporting. Initial audit of all medication errors in the past quarter was completed to determine if they were reported timely by the Director of Nursing. 3. RCA: The State Reportable Incidents Policy has the exact wording of the regulation, however the	02/01/2025

Provider's Signature Title Frieda E. Abel Date 01/02/2025

NAME OF FACILITY: Lodge Lane Assisted Living and Memory Care **DATE SURVEY COMPLETED:** October 18, 2024

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	6/20/24 – A facility incident report submitted to the Division documented, "The nurse reports being distracted...the resident received the wrong medication...the insulin pen belonged to someone else." 10/15/24 10:15 AM – A review of R8's clinical records revealed that she was ordered 32 units of Novolog mix 70/30 (short acting insulin) in the evening. R8 incorrectly received 32 units of Basaglar (long-acting insulin) on 6/13/24 at 5:00 PM. This medication error required R8's blood sugar levels to be monitored hourly till 8:00 AM on the next day. The blood glucose levels remained above 200. The medication error was reported to the Division on 6/20/24, 6 days after the incident occurred. 10/15/25 11:30 AM- During an interview E1 (NHA) stated, "We did not think this was a reportable error until we contacted the State (Division], and they told us it should be reported." The surveyor asked E1 what interventions were put in place to prevent the medication from happening again. E1 stated, "The nurse was educated." The facility did not provide evidence that any of the other nurses were educated on this medication error. The facility failed to report R8's incorrect insulin medication error within the required 8 hours' time requirement. 10/18/24 at 3:20 PM – Findings were reviewed with E1 (NHA) and E2 (DON) and a	regulatory language around reassessment is unclear. The policy has been updated to report all Medication Errors to the State unless the CEO gives direction that it does not meet the criteria for reassessment. Staff Developer (or designee) will educate nursing staff on The State Report Incident Policy update. 4. Director of Nursing (or designee) will conduct audits of medication errors daily x 3 to ensure they are reported to the state if they require periodic assessment, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

Provider's Signature Title Executive Director Date 01/02/2025

NAME OF FACILITY: Lodge Lane Assisted Living and Memory Care **DATE SURVEY COMPLETED:** October 18, 2024

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	State of DE Ombudsman (via telephone) during the Exit Conference. **§ 1121. Resident's rights.**		
16 Del. C., Ch. 11, SubChapter II Rights of Residents **S/S - D**	**§ 1123. Notice to resident. (a) The Department must prepare a notice that includes § 1121 of this title in its entirety. This notice must be available in a language and format that is accessible to each resident or their authorized representative under § 1122 of this title. (b) Each long-term care facility must post the notice described in subsection (a) of this section conspicuously in a public area of the facility. (c) Each long-term care facility must furnish copies of the notice required under subsection (a) of this section to all of the following: (1) Each resident upon admittance to the facility. (2) All residents currently residing in the facility. (3) Each authorized representative under § 1122 of this title. (d) The long-term care facility must retain in its files a statement signed by each individual listed in subsection (c) of this section that the individual has received a copy of § 1121 of this title. (61 Del. Laws, c. 373, § 2; 81 Del. Laws, c. 206, § 26; 84 Del. Laws, c. 199, § 1.)** **This requirement was not met as evidenced by:** Based on observation, interview and record review, it was determined that the facility has not implemented the Delaware Resident's Rights Act that became effective on 6/27/24 for two (R4 and R13) out of two residents reviewed for resident rights. Findings include:	**16 Del. C., Ch. 11, SubChapter II** 1. The Delaware Resident Rights Act form was signed by R4 on 10/17/2024 and R13 on 10/17/2024. 2. All residents have potential to be affected. Initial audit of all residents was completed on 10/17/2024 by the Admissions Director and forms completed and signed by 11/5/2024. 3. RCA: The previous NHA sent emails to the DON and Admissions Director regarding the notice, but it was not clear who was responsible for current residents. Each Director thought the other was completing the current residents. The Lodge Resident Rights Policy was outdated and has been updated with current regulatory language. The NHA has educated the Admissions staff that it is the role of the Admissions Director (or designee) to ensure all current and new residents sign the updated Resident's Rights form. 4. The Admissions Director (or designee) will conduct audits of new admissions daily x 3 to ensure the new forms are signed, until 100% compliance is achieved. Audits will continue weekly x 3, until	02/01/2025

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	4/29/19 – R13 was admitted to the facility. Review of the resident's record lacked evidence of a signed Delaware Resident Rights Act form. 12/6/23 – R4 was admitted to the facility. Review of the resident's record lacked evidence of a signed Delaware Resident Rights Act form. 10/17/24 at 2:2 PM – During an interview, E1 (NHA) confirmed that at the present time this was not being done in the facility. 10/17/24 at 3:20 PM – Findings were reviewed with E1 (NHA), E2 (DON) and a State of DE Ombudsman (via telephone) during the Exit Conference.	100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
16 Delaware Code, Chapter 11, Subchapter III **S/S – PNC J** **S/S - D**	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents.** **1131. Definitions** **12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** **b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.**	**16 Delaware Code, Chapter 11, Subchapter III** **Past Non-compliance** A. The facility failed to ensure that R11 received adequate supervision to prevent an accident. "Past Non-compliance example #1" on 4/10/23	**04/10/2023**

Provider's Signature Title Trisha L Hall Date 01/02/2025

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	c. Failure to carry out a prescribed treatment plan for a patient or resident. This requirement was not met as evidenced by: Based on interview and review of facility records and other documentation as indicated, it was determined that for two (R11 and R12) out of two residents sampled for neglect, the facility failed to ensure residents were free from neglect. The facility failed to ensure that R11 received adequate supervision to prevent an accident. R11, a cognitively impaired resident with dementia, and who was identified as a risk for wandering, eloped from the facility on 4/10/23 at approximately 4:48 PM and was found in the adjoining neighborhood by a homeowner and the county police. R11 was out of the facility for approximately eighty-five minutes, during which her whereabouts were unknown to the facility. The facility's failure placed R11 at risk for a serious adverse outcome or death. Due to this failure, an Immediate Jeopardy (IJ) was called at 10:24 AM on 10/18/24. The facility has met the criteria for Past Non-Compliance when R11 was moved to the secure memory care unit upon her return to the facility on 4/10/23 at approximately 6:15 PM. For R12, the facility neglected to treat R12's right shoulder pain on 2/21/24. Findings include: 1. R11's record revealed the following: 10/26/22 – R11 was admitted to the facility with multiple diagnoses including dementia and an anxiety disorder. R11 was admitted		

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	to the non-secured section of the assisted living facility. 10/25/22 – R11's Uniform Assessment Instrument for Assisted Living Facilities (UAI) documented that R11 was oriented to person only, and not oriented to place or time, she had short term and long-term memory problems and that R11 had a history of wandering inside of buildings. 10/25/22 – R11's Resident Service Agreement/care plan lacked documentation of an elopement safety problem. 1/6/23 5:00 PM –A progress note written by E2 (DON) revealed that R11 was having increased confusion and was found wandering in the stairwell, and that a wander guard was placed on R11. 1/6/23 – R11's UAI was updated with a significant change when a wander guard was placed on R11. R11's Resident service agreement/care plan was edited to include the elopement safety problem, with the placement of a wander guard as an intervention. 4/10/23 6:30 PM – A progress note written by E4 (LPN) described that R11 had walked off the facility property and into the surrounding neighborhood. R11 had knocked on a residence door and the homeowner called 911 for assistance because R11 was confused and did not know where she lived. R11 was picked up by the police and returned to the facility after they determined that R11 was a resident of the facility.		

Provider's Signature Title Finishes Exec Dir Date 01/02/2025

NAME OF FACILITY: Lodge Lane Assisted Living and Memory Care **DATE SURVEY COMPLETED:** October 18, 2024

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	4/11/23 late entry from 4/10/23 – A progress written by E2 documented that R11 was moved to the secured memory unit upon return to the facility. 10/16/24 –Review of the facility witness statements regarding the events of R11's 4/10/23 elopement revealed the following: -R11's had exited the facility into an outside courtyard on 4/10/23 at 4:15 PM, and she was assisted to return to the facility by E5 (Activities Coordinator) shortly thereafter. -R11 was then apparently left unattended in the facility lobby for an undetermined amount of time. -R11's absence from the first-floor dining room during 5:00 PM dinner went unnoticed. -R11 received inconsistent supervision 4/10/23 from approximately 4:30 PM onward until she eloped the facility at approximately 4:50 PM. 10/17/24 2:20 PM – During an interview, E1 stated that the facility wander guard system is such that the facility exterior doors do not have sensors that would trigger if a wander guard passed through the exterior doors, at any time. The wander guard system prevents entry to the second-floor elevator (non-secured unit) to go the first floor, where facility exit doors are located, between the hours of 8:00 PM – 8:00 AM. R11's wander guard as an elopement prevention intervention did not prevent R11		

Provider's Signature Title Executive Director Date 01/02/2025

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	from eloping from the facility on 4/10/23 at 4:48 PM. 10/18/24 - R11 remains in the secure memory care unit. 2. R12's record revealed the following: 7/28/21 – R12 was admitted to the facility with diagnosis of dementia. 2/21/24 at 2:00 PM – A nurse's note documented, "resident c/o [complained of] pain to R [right] shoulder & [and] is ref [refusing] to move her arm, informed MD [medical doctor] & received order to get x-ray...". Review of R12's nurse's notes lacked evidence that Tylenol was offered to R12 on 2/21/24. Review of the February 2024 Medication Administration Record revealed that R12 had a physician order for Tylenol as needed for pain. R12 was not offered or administered Tylenol on 2/21/24. The facility failed to administer physician ordered pain medication after R12 complained of pain to her right shoulder on 2/21/24 at 2:00 PM. 10/18/24 at 3:20 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and a representative with the Ombudsman's Office.	**#2. 16 Delaware Code, Chapter 11, Subchapter III** 1. Cannot correct medication administration occurring in the past. 2. Unable to correct medication administration occurring in the past. 3. RCA: There is no documentation that any staff offered the resident pain medication or that the resident refused for several shifts. The Lodge Pain Management Policy did not include documentation. The policy was updated on offering pain medications and documenting on the 24-hour Nursing Report form verbal and/or nonverbal signs of pain, and documenting in the resident charts offers and refusals for pain medication. Staff Developer (or designee) will educate nursing staff on the new policy. 4. Director of Nursing (or designee) will conduct audits of 24-hour report for verbal/nonverbal signs of pain daily x 3 to ensure that staff document in the resident charts offers and refusals for pain medication until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	**02/01/2025**

Provider's Signature Title Tenisha L. Hall Date 01/02/2025

DELAWARE HEALTH AND SOCIAL SERVICES

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

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STATE SURVEY REPORT

NAME OF FACILITY: Lodge Lane Assisted Living and Memory Care **DATE SURVEY COMPLETED:** October 18, 2024

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Provider's Signature Title Trinidad E. Hall Date 01/02/2025